MIDTERM REVIEW – Projet Espoir pour la Sante de la Mere et le Nouveau Ne

October, 2012 – Bankass and Bandiagara, Mopti Region

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Purpose:

The purpose of a midterm review is to offer an opportunity to step back from day to day implementation, review progress, strengths, and challenges to date, and to make program adjustments to strengthen the capacity of the project to achieve impact. Given that the specific intervention activities were developed during the early implementation phase of the project, the exercise also offered an opportunity for people to reconsider their vision for success given their now improved understanding of the project, how it is working, and the broader social impact it is trying to achieve.

Questions Framing the Midterm Review:

1. Determine whether the package of social change interventions is on track and why/why not? (Bankass)
    a. Progress on staff transformation and capacity to facilitate social change in communities? Role of reflective practice with staff, other facilitators, and counterparts
    b. Cascade training strategies – are these working to achieve social change capacity at scale at the community level?
    c. What can we say about the package of interventions? Which are working better or less well? Which are more effective? Why?
    d. How are partnerships (MOH partners) contributing or not to social change process?
        i. Their level of interest or commitment to social change strategies
        ii. Strategies to work on social change with providers / involve them in the process
    e. How do these integrate with / complement maternal health service strengthening interventions?
2. Determine whether maternal health service strengthening interventions are on track and why / why not? (both Bankass and Bandiagara)
    a. Cascade training strategies, participation in monthly CSCOM meetings, and participatory review of data – are these working to achieve improved services and utilization? Why or why not?
3. What are significant project learnings which can contribute to other programming in Mali or globally
    a. Strategies for social change/ SAA process
    b. Integration or social change and service strengthening interventions
    c. Structures for learning within the CO

Methodology

This review was carried out in two phases: a data collection phase with a range of stakeholders in the project areas, and a synthesis and review session facilitated by the project's Technical Advisor from headquarters. Due to security issues, this session took place in Segou, but the full range or partners managed to participate.

Due to the project's research design, the two phase process was carried out separately for Bandiagara and Bankass – with separate data collection teams and synthesis sessions. The Bandiagara review focused primarily on its service strengthening efforts, while the Bankass review focused on both the service strengthening and the social change interventions.

Field phase:

Two teams were developed for Bankass while one team was developed for Bandiagara. The Bandiagara team consisted of the two Junior Experts, with the team leader as the Head of Hygiene for the District. In Bankass, each team team consisted of two Junior Experts, one person from the District as the team leader (District representatives were the Head of Hygiene, and the Assistant Social Services person) and one person each from the Projet Keneya Ciwara (PKC) team.

Question guides reviewed and revised by PEMN team and then as part of team orientation for field work. All team members participated in 1 day orientation. They then tested materials in the field for an additional day.

Each team visited one of the original zones and one of the newer zones. For the village visits, an effort was also made to select villages within the CSCOM area that had no recent JE visit in order to avoid bias they may have introduced. Finally, while the JEs were visiting areas where they also work, it was the external person who was the team leader and asked the questions

In order to assess client satisfaction with health services, women in villages who had recently used services and women who happened to be at the health center at the time of the visit were interviewed.

Key informants for both districts that were interviewed either individually or in small groups included:

- Heads of Health Centers and health center staff
- Community Relais
- Women who have used health services recently

In addition, in Bankass, the following additional informants were interviewed:

- Keneya Committee
- Couples and extended families who have participated in counseling or birth planning discussions

Meetings for synthesis and debriefing including all partners:

Due to the effort to limit the influence of activities in one district on those of the other, two separate meetings were held: one with the Bandiagara team, and one with the Bankass team. A similar agenda was followed for both, and both meetings achieved similar representation from the partners.

With both teams, prior to going into the details from the midterm review, groups developed their vision for how they would define their success in July, 2013 and beyond.

One of the strength of these meetings was that all of the key actors in health in the target areas were involved. These included the people, including the District team leaders, who had worked on data collection, Senior District health staff, the person responsible for family planning from the region who has many years experience as a midwife, 2 representatives from Projet Keneya Ciwara, and all of the project staff.

The agenda and the list or participants for each of the meetings are attached.

Key Results: Bandiagara

Vision of Success:

By July, 2013:

- Health centers are clean and well-equipped
- Staff are well trained and welcoming
- Good utilization of services with a referral system that works
- The health center is well managed by the ASACO
- Relais are active and involved
- Communities aware of dangers and making timely decisions
- 50% of households with pregnant women have discussed and applied a birth plan

Three years from now

- Maintain health service utilization
- Equipment management and maintenance systems in place
- Regular supervision of health center and community staff
- Quotas reliably paid into the referral system
- Women supported to use family planning

Strengths:

1. The training in maternal and newborn care including an emphasis on infection prevention, active management of third stage labor, and using data to monitor activities seems to have been particularly effective in both districts. The participatory and practical nature led to high retention, with participants able to cite key learnings despite a lack of follow up supervision. The training of trainers with cascaded responsibilities of these trainers to then train health center heads and maternity staff also seems to have work. The inclusion of a critical mass of maternal health providers at the health center level also seems to have enhanced the impact.

2. The referral system, including community payment into the referral fund, has begun to move. This is due to significant effort on the part of the district, as well as increased pressure from outside to get the system working.

3. Data are routinely collected in registers and reviewed with health center and JE staff.

4. People's personal experience of health services seems to be OK, including that they are well received, get appropriate medicines, and don't have complications.

5. Relais have been trained in danger signs and birth planning by their health center staff, and the staff work with the relais on data collection. Also, the use of the Relais for vaccination campaigns where they receive a small amount of money provides additional motivation.

6. Agents de Sante (ASC) have recently been trained and added to the structure in an effort to strengthen the link between health centers and the community Relais.

Challenges:

1. Monthly meetings between ASACO and health center staff are inconsistent. The head of the health center and the ASACO often don't really work together. This said, the health center where the project worked intensively to strengthen the ASACO / health center meetings is maintaining these meetings, but it took more effort than the project was able to provide as it expanded to other areas. In addition, ASACO strengthening is a primary responsibility of PKC.

2. Follow up supervision by the MNH trainers did not take place as planned. Routine supervision structures are also weak, depending on resources and availability of district staff.

3. Routine supervision of Relais is weak if their supporting ASACO is also weak. It can be difficult to collect their data, alternate links with the health center have not been reinforced.

4. Confidentiality, welcoming reception, and client / provider communication still come up as service issues.

Summary of Recommendations: Bandiagara
(complete list of recommendations and next steps that were identified during the synthesis meeting is attached at the end.)

1. Strengthen the competency of the DTC
    a. Reinforce monthly technical meetings and include Relais, ASC and focal point from ASACO.
    b. Reinforce, through a coordinated effort with other partners, routince data collection tools with review during monthly meetings.
    c. Orient CSCOM staff towards routine "self'supervision" to identify and address priority quality issues.
    d. Use the monthly meeting to identify and target weaker villages for strengthening activities.
2. Strengthen supervision and support for Relais activities
    a. Take advantage of other CSCOM staff going to villages to reinforce Relais and collect reports – use monthly meeting to review team calendar to maximize village visits.
    b. Use the ASC to close the gap between the CSCOM and the Relais through the establishment of regular meetings and or supervisory contact where ASCs are available.
3. Strengthen supervision capacity of the DTC / ASC
    a. Plan for trainers to supervise providers as follow up to training, including technical preparation (abbreviated facilitative supervision) of these trainers for supervision
    b. Using this technical preparation as an opportunity to develop and gain experience in reinforcing supervision, as well as drawing on experience from the "facilitative supervision" training currently taking place throughout Mali, develop a small group to consider how to best reinforce DTC and ASC supervisory capacity within the constraints of the project – including skills in self review for problem identification and resolution.
4. Assure essential inputs

a. Provide the supplementary MNH equipment as planned, accompanied by rigorous inventory control by health center and ASACO with review by District.
b. Provide visual aids for those trained relais that don't have them.

5. Work at the District level meeting to coordinate links between different partners in the reinforcement of the ASACO / CSCOM / Mayor / Relais links.

Key Results: Bankass

Vision:

This ranged from process results to the behaviors we hope to achieve as a result of our work. Highlights include:

Process;

- Reinforcement in the capacity and link between Relais and Keneya Comite
- Improved welcome at the health center / improved quality of services
- Ongoing follow up and training

Behaviors:

- Women accompainied by their husbands to pre-natal care and delivery
- Facility deliveries
- Extended family involved in birth planning
- Couples discuss their pregnancy together and with their family
- Women's household tasks lightened during pregnancy
- Extended families develop and follow birth plans
- 4 pre-natal visits
- Men involved in supporting pregnancy

Strengths:

1. Health service strengths all the same as in Bandiagara
2. The social change package (male friendly services, couple counseling, extended family birth planning and community dialogue around social themes)is well defined and clear.
3. There is a lot of enthusiasm on the part of JEs and Relais around the questioning approach to community discussions and dialogue
4. Relais in 9 areas were trained in MNH and social change components. Even for the social components, the cascade training seems to have been strong, with good involvement by the health center heads, although there were some instances where all of the training exercises were not completed.
5. The Coordinator has provided solid, on- the- ground supervision of training activities.
6. The active Relais were selected in a participatory and transparent way such that their training does not seem to have been a disincentive for the others.
7. Keneya Committees have been formed in all villages following parameters identified by the project: transparent selection, encouraging responsibility for pregnant women, encouraging support for Relais activities, and community ownership of the committee.

8. ASACO / health center monthly meetings are generally happening, data are routinely reviewed and posted on graphs, and the District focuses on problem solving anything that comes up during its monthly meetings with health center heads.

Challenges:

1. The post partum period may have been overlooked with its opportunity to address male and family roles in newborn care, family planning, and the acceptability of daughters.
2. It is sometimes difficult to determine who and how to get the extended family together.
3. The role and links between the Keneya Committee and the Relais is unclear and under-developed.
4. Even with working CSCOM / ASACO meetings, active supervision and support for community activities is a challenge.
5. There is a range of competencies in implementing the social change package from the Relais to the health center and even the junior experts.
6. While the strategy to identify 2- 3 active Relais allowed the project to efficiently move its agenda forward, there are a significant number of additional Relais who have not been trained.
7. While people who were directly involved in the MNH training are familiar with the concept and elements of male-friendly services, the understanding and implementation throughout the health center team is lagging.

Summary of Recommendations: Bankass

(complete list of recommendations and next steps that were identified during the synthesis meeting is attached at the end.)

1. Take advantage of existing forums (monthly meetings at CSCOM and district levels and perhaps with ASC/Relais) to continue to practice and reinforce SAA exercises and approach
    a. Using available materials, the JE and health center heads to plan SAA activities, encouraging the health center head to practice the facilitation. between

2. Community dialogue – continue to use the themes and sketches to provoke dialogue, but Relais and KC to take responsibility for organization and content. This will reinforce the informal nature of the sketches, and discourage a more formal community theater approach.
    a. Use monthly SAA meetings to reinforce and prepare sketch interventions
    b. Identify strategies to strengthen Relais capacity to manage community activities including targeting of weaker Relais for additional support.

3. Focus on the joint responsibility of Relais and KC to carry out all community activities
    a. Clarify expectations and tasks including identification and resolution of problems
    b. Involve ASC and other support such as the ASACO representative in planning and implementing activities together

4. Reinforce male friendly services through a participatory process and monthly meetings at the CSCOM and CSRef levels: define the components, identify the barriers, problem solve what and how to strengthen these components, including the “welcome” of men.

5. Clarify expectations for the Keneya committee, following through on the parameters and strategy that the project has identified. This can be enhanced through coordination meetings with Relais and KC if helpful, and/or reviewing community level data.

6. Reinforce peer trainer approach as a strategy for trained Relais to share SAA / social change capacity with untrained ones. Through joint provision of couple counseling and extended family birth planning and joint use of the catalyst materials, the untrained Relais can acquire these skills.

7. Trainers from MNH training to provide supervision to CSCOMs as planned
    a. Plan for trainers to supervise providers as follow up to training, including technical preparation (abbreviated facilitative supervision) of these trainers for supervision

8. Strengthen the CSCOM / ASACO monthly meetings as a management tool for self – review and problem solving.
    a. Include SAA activities
    b. Encourage involvement of ASC and Relais
    c. Build in self – review and problem solving – part of the supervision from #10
    d. Use the ASC to close the gap between the CSCOM and the ASC - Establish Relais / ASC meetings, and capacity in data review and use

9. Provide equipment and visual aids as promised
    a. Inventory of donated equipment reviewed by CSRef, CSCOM and ASACO

10. Consider a post – partum SAA activity (male role? Newborn care? FP?) which might be part of the baptism ceremony – to be addressed later

11. **Plan feedback and planning meeting with CSRef for Nov. 3.**

<u>Other Issues</u>

While not specific to one district or the other, a few additional issues and recommendations also came up in the course of discussion:

<u>Project Scope:</u>

Recognizing that the importance of quality interventions as well as scale are essential to achieve the objectives of this project, both teams have backed off on the original number of targeted health center areas.

- Bandiagara is focusing on 8 health center areas for the full scope of activities, while they will continue to provide supervisory support to all twelve that received the initial MNH technical training.
- Bankass is focusing on 9 health center areas, and will consider adding the last three in a few months if other work is going well. The last three would not be sampled for the final evaluation.

Learning project:

Given that this is a learning project with a significant amount of research and investigation, we need to begin to develop a strategy for sharing what we are learning. This might include increasing conversations with other players in Mopti Region to raise awareness of our approach, as well as planning for national presentation (s).

- Once Rob has completed the paper focusing on the associations between social factors and maternal health behaviors, we can plan to present this paper, along with project strategies to address these issues, at a national forum – perhaps in collaborations with the ethics review committee.

Management issues:

It is unfortunate that management issues have inhibited the timely procurement of the visual aids materials, upon which many of the social change activities depend at the community level. They also impinge on the ability of partners to participate in joint activities. It is hoped that production of these materials, active procurement of the health center equipment, and improved reimbiursement systems can move forward.

Other potential Family Planning partners:

It seems there are several other organizations working in family planning in the region (World Vision, Marie Stopes, and UNICEF). We may be able to begin to collaborate with them as well.

Conclusions:

Despite the challenges of the last six months, this project has made significant progress in the overall process of developing an intervention package, refining it, and taking it to scale. The very intense training work plan of the last six months was essentially completed. Even in the district with more traditional maternal health interventions, there have been significant accomplishments in the strengthening of maternal health capacity as well as of the systems that support it.

With a decrease now in active implementation interventions and training, and an increasing focus on consolidation it will be incumbent upon the staff to shift their focus from implementing, as they did during the intervention development stage of the project, to one of supporting those who have now been trained. This will also require a new set of skills for staff which will allow them to coach and mentor their counterparts.

Synthesis Meeting Agenda:

1. Introductions / overview of project (group identification of key elements and hypothesis)
2. Project activity updates
3. Discussion of MTR questions – staff and partner perspective
4. Presentation of findings from the field teams and discussion
5. Vision of success
6. Work in groups by theme – strengths, challenges, recommendations (service strengthening, SAA / social change package, Community activities / structures (RElais, KKeneya Comite), Capacity building – training and support.
7. Recommendations
8. Next steps

Bankass Participants:

- Dr. Guindo Mahamadou, Medecin chef du district
- Seydou Kassambara – Services Socials
- Fousseyni Bamba – Hygiene Officer
- Seydou Camara – Social Services
- Maiga Badji Traore– Regional Reproductive health
- Dr. Safoura Traore, Reproductive Health Adivosr for Projet keneya Ciwara
- Dr. Mohammed Coulibaly, Projet Keneya Ciwara, responsible for Mopti REgion
- Matieu , Berthe, Hawa, Aminata, Seydou, Koman, Issa
- 2 PKC advisors also participated in the field data collection but not in the synthesis meetings
- PEMN Team: Seydou, Mathieu, Berthe, Hawa, Aminata, Issa and Koman

Bandiagara Participants :

- Dr. Aboubacar Sidiki Kouyate– Medecin chef du Distrit
- Mamadou Kamara – Services Socials
- Korko Goro – Hygiene Officer, MOH
- Maiga Badji Traore – Regional Reproductive Health
- Dr. Safoura Traore, Reproductive Health Adivosr for Projet keneya Ciwara
- Dr. Mohammed Coulibaly, Projet Keneya Ciwara, responsible for Mopti REgion
- PEMN team: Madeleine, Diallo, Issa, and Koman

Recommendations and Next Steps - Bankass

1. Take advantage of existing forums (monthly meetings at CSCOM and district levels and perhaps with ASC/Relais) to continue to practice and reinforce SAA exercises and approach
    a. Plan SAA activities between JE and DTC – when and how
        i. Use market day to organize SAA meeting with DTC, Relais, and ASC ?
    b. Materials: SAA manual, examples from JE meetings, Relais curriculum, visual aids (give SAA to DTC?)
    c. Practice SAA facilitation with DTC
    d. Which themes? Work with people to choose from the list of 13 themes

2. Community dialogue – continue to use the themes and sketches to provoke dialogue, but Relais and KC to take responsibility for organizing and content. This will reinforce the informal nature of the sketches, and not a more formal community theater approach.
    a. Work with DTC to ID weaker relais. To use monthly reunion to reinforce sketch interventions.
    b. Strategies to strengthen Relais capacity to manage: Encourage cross visits to strengthen weak relais. Target weak relais.
    c. Pick up sketch preparation as part of CSCOM SAA meeting.

3. Focus on the joint responsibility of Relais and KC to carry out all community activities
    a. Clarify expectations and tasks
        i. meeting between KC / Relais – shift towards questioning for them to identify their own needs and capacity to support.
        ii. Involve ASC, other counterparts (delegue ASACO? DTC?) – Plan these meetings <u>with</u> them

4. Consider a post – partum SAA activity (male role? Newborn care? FP?) which might be part of the baptism ceremony
    a. Address later

5. Reinforce male friendly services through a participatory process and monthly meetings at the CSCOM and CSRef levels: define components, identify barriers, problem solve what and how to strengthen. Included “welcome”
    a. Work with DTC / matron to develop strategy based on handout
        i. Identify elements: welcome, joint explanations of pregnancy, active listening,
    b. Involve full team and ASACO at CSCOM
    c. Include as part of monthly meetings

6. Clarify expectations for the KC . Parameters include transparent selection, responsibility for pregnant women, support for Relais activities, and community ownership. This can be enhanced through coordination meetings with Relais and KC if helpful, and/or reviewing community level data.
    a. See #3
    b. Expectations: ID pregnant women, follow up on decisions made during dialogue, help relais to resolve specific problems, support / participate in Relais activities
    c. Informal review of activities and progress (periodic)

7. Reinforce peer trainer approach – trained Relais can work with and role model SAA approach (counseling and extended family interventions) with active relais who were not trained.
    a. Encourage joint couple counseling and gran famille discussions with trained Relais with Relais in other areas of the village. K.C. Can help encourage this.

8. Provide equipment and visual aids as promised
    a. Inventory of donated equipment reviewed by CSRef, CSCOM and ASACO

9. *Relais motivation – as available, provide intermittent food inputs to the most active relais (principles – intermittent and as an encouragement for positive performance – not an entitlement – but project won't actually be involved with this)*

10. Trainers from MNH training to provide supervision to CSCOMs as planned
    a. Prepare the supervision team – some facilitative supervision support
    b. Determine who to participate – DRS, training team
    c. Encourage internal supervision – self review

11. Strengthen the CSCOM / ASACO monthly meetings as a management tool for self – review and problem solving.
    a. Include SAA activities
    b. Encourage involvement of ASC and Relais
    c. Build in self – review and problem solving – part of the supervision from #10

12. Use the ASC to close the gap between the CSCOM and the ASC - Establish Relais / ASC meetings, and capacity in data review and use

13. Plan feedback and planning meeting with CSRef for Nov. 3.

Recommendations and next steps: Bandiagara

1. Strengthen the competency of the DTC
    a. Monthly technical meetings – include RElais, ASC and focal point from ASACO. Cover hygiene, infection prevention, IPC, and other QI plans
        i. Feedback and recommendations from this meeting
        ii. Define terms of reference for this meeting – structure the agenda.
        iii. Plan with DTC, point person from ASACO and JE
    b. Data management and use
        i. Meeting with MOH, PKC and PEMN to agree on data collection tools and content
        ii. Reinforce JE capacity on data utilization
        iii. Make sure ASC and DTC have tools and are clear how tu use
    c. Effective supervision of ASC and Relais (see supervision)
    d. Discussion and actions for quality improvement
        i. Develop and use tool to assess QI priorities – identify and prioritize QI components
2. Select villages for strengthening
        i. Use the monthly meeting to think about this – will come later
3. Take advantage of other CSCOM staff going to villages to reinforce Relais and collect reports
        i. Include in monthly meeting agenda
        ii. JE / DTC to work with outreach staff to brief them on other activities in the village
4. Use the ASC to close the gap between the CSCOM and the Relais
    a. Establish Relais / ASC meetings
        i. Share data collection tools
        ii. Work with them to develop terms of reference, agenda, and meeting priorities
        iii. Set up ASC /Relais relationship formally (from ASACO / DTC) – set this up through the monthly meeting at the CSCOM
5. Inputs
    a. Boites d'image
        i. Define actual need from the DTC – DHO to make request to CARE
6. District level meeting to coordinate links between different partners in the reinforcement of the ASACO / CSCOM / Mayor / Relais links –
        i. MOH to plan
7. Strengthen supervision DTC / ASC
        i. Plan for trainers to supervise providers as follow up to training
        ii. Technical preparation of trainers for supervision – facilitated supervision
        iii. Task force to determine broader supervision strategy
        iv. Supervision check list for ASC with support from DTC – DTC to role model the supervision
8. Inventory control
        i. Well documented transfer of new equipment – copies to ASACO, CSRef, DTC
        ii. Do inventory control with DTC and ASACO after 6 months and submit to CSRef
        iii. CSRef include discussion in their field visit