Is Demand Generation or Quality Services the Chicken or the Egg?

Ethics and Experience of Increasing Demand for Facility Births for PMTCT in One Remote Rural District of Zimbabwe

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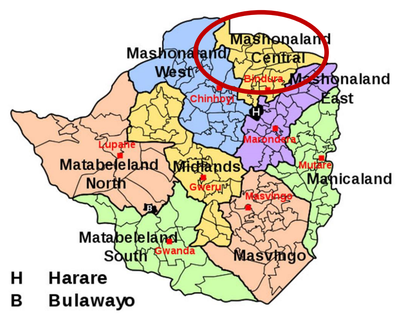
ISSUES

- HIV prevalence among women attending antenatal care (ANC) in Zimbabwe is 15.9%.[1]
- Mashonaland Central Province has some of the lowest uptake rates for services along the PMTCT cascade in Zimbabwe.[2]
- Unskilled birth attendance through home delivery increases risk of vertical transmission of HIV, as well as preventable morbidity and mortality among mothers and infants.



- At the time of intervention approximately ½ of all women in Mashonaland Central delivered at home.[2]
- Through the Australian NGO Cooperation Project (ANCP), from 2012-2015 OPHID Trust, in collaboration with the Ministry of Health and Child Care and Burnet Institute aimed to increase demand and uptake of facility based delivery in the remote and underserved, Rushinga District.

DESCRIPTION

ANCP Project

- **<u>Demand</u>:** In 2011, OPHID Trust conducted the **Home Delivery Study** among women who had delivered at home:
  - Waiting mothers homes and support for planning for service uptake identified as preferred interventions to increase demand and uptake of facility delivery.
- **<u>Supply</u>: ANCP District baseline assessment** revealed the limited capacity of rural health facilities to provide Basic Emergency Obstetric and Newborn Care (BEmONC).
- The ethics of creating community demand for under-capacitated institutional delivery services were raised.

WHAT COMES FIRST, SUPPLY (QUALITY) OR DEMAND (COVERAGE)?

INTERSECTION of ETHICS with EVIDENCE

- *In lowest resource and very rural settings, how long will it take until 'guideline concordant' care can be provided?*
- *Are sub-standard facility services comparable to unskilled home-based services or none at all?*
- *How long do we wait before generating demand for underutilised services in high HIV burden settings?*
- *What are the roles of health system, facility and community-based stakeholders in improving standard of PMTCT and related maternal health care?*

Adaptation of project plans based on identified needs

- Project plans were revised to prioritize rapid roll-out of **competency-based BEmONC training** provided based on capacity-needs assessments
- **Clinical mentorships** of rural nurses at District hospital obstetric wards were tailored to meet identified skills and confidence gaps at site level
- Supply-side strengthening implemented along side interventions to **reduce demand-side barriers** and support **community engagement**

LESSONS LEARNED

A holistic approach to simultaneously improving supply <u>and</u> demand

As a result of the ANCP project:

- ✓ 11 nurses stationed at remote clinics in Rushinga received BEmONC training
- ✓ 25 nurses completed clinical attachments at Rushinga District Hospital
- ✓ 10 family-friendly maternity waiting homes, residential facilities on property of rural health clinics were refurbished or built to support women to be close to the facility at the time of labour[3]
- ✓ 9 956 Action Birth Cards were disseminated to pregnant women to support planning for service uptake along the PMTCT cascade using locally available resources[4]

LESSONS LEARNED

Improving quality increases supply and 'consumer demand'

Endline evaluation feedback revealed inter-relatedness of simultaneous supply and demand generation:

- Increasing **nurse confidence to conduct safe deliveries** and effective use of emergency referral networks
- Increasing **community confidence in quality of services** perceived to contribute to increased demand for facility-based delivery

Picture 1. Linette Musayidzi and Abigail Nyamushamba, Nyamatikiti Clinic nurses that received training and mentorship through ANCP project activities

"As a result of this project we are now having about 15 facility deliveries a month against say, one home delivery, unlike in the past when we had 1 institutional delivery against about 8 home deliveries." Sister in charge, Chimhanda clinic

Supply + Demand = Increased coverage and uptake of quality services

- End line evaluations conducted in June 2015 demonstrated the ANCP Project successfully increased both quality and uptake of facility-based deliveries in Rushinga District both over time (Figure 1) and relative to national and provincial facility delivery rates (Figure 2) over the same time period.
- In 2014, 192 of the 2,267 facility deliveries conducted in Rushinga were among HIV positive mothers (8.5%).
- Within that same year, only 1 maternal death, and 16 neonatal deaths were recorded in the District, mortality rates well below the national average of 614 per 100 000 and 29 per 1000 deaths per live birth respectively.

Figure 1. Facility deliver rates ANCP supported clinics

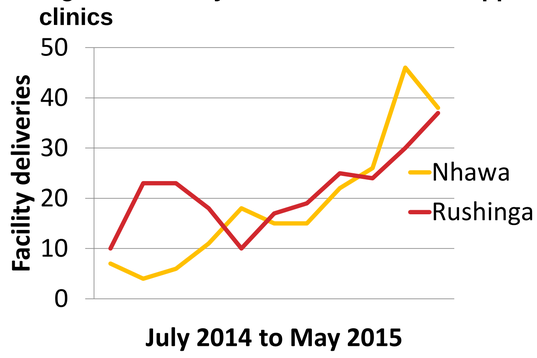
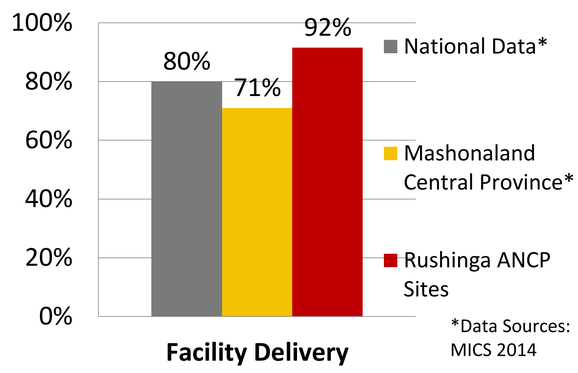


Figure 2. Facility delivery rates, 2014



NEXT STEPS

- Generating uptake and coverage required to achieve the goal of virtual elimination of paediatric HIV in Zimbabwe will require strategic efforts to increase uptake for underutilised services across the PMTCT cascade.
- The ANCP project experience indicates **quality and demand generation should be undertaken *simultaneously*** to reach ambitious policy-level targets.
- **Site-level needs assessments** to identify supply-side gaps are crucial for ethical demand generation.
- Responsive funds that allow adaptation of project plans to address **context-based needs** in line with national policy and plans = ethical good practice for effective and sustainable programming.
- **Pragmatic implementation research** is required to develop evidence regarding cost and clinical effectiveness of multi-component interventions seeking to improve supply and demand for quality services along the PMTCT cascade.

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