Canada-Africa Initiative to Address Maternal, Newborn and Child Mortality (CAIA-MNCM)

Highlights and Impact Summary

Program: Canada-Africa Initiative to Address Maternal, Newborn and Child Mortality (CAIA-MNCM)

Donor: Government of Canada through Global Affairs Canada

Initiative: Partnerships for Strengthening Maternal, Newborn and Child Health (PS-MNCH)

Budget: $35,084,743; Government of Canada contribution: $31,122,612

Duration: 6 years (2016 to 2022, including COVID-19 response)

Target Countries: Ethiopia, Kenya, Malawi, Tanzania, Senegal

Consortium Partners: Amref Health Africa in Canada, Children Believe (formerly Christian Children's Fund of Canada), SickKids Centre for Global Child Health, WaterAid Canada

The **Canada-Africa Initiative to Address Maternal, Newborn and Child Mortality** (CAIA-MNCM) was a multi-year (2016-2022), multi-country, and multi-partner program which worked to strengthen health systems and improve gender equality, as well as ensure the continuity of critical health services in the face of the COVID-19 pandemic. The African-led program targeted community driven approaches and several health-related outcomes in **Ethiopia, Kenya, Malawi, Tanzania and Senegal** with sustainability and gender equality embedded within programming activities. During the COVID-19 Response extensions of CAIA-MNCM, activities were carried out in Senegal but not in Tanzania.

Through data collection across multiple indicators and anecdotal on-the-ground success stories, **several improvements were noted across standard health indicators, with significant decreases in neonatal mortality and underweight prevalence in children seen across program countries**. The program made a significant contribution to the reduction of maternal and child mortality in targeted regions by **improving service delivery/availability of health-related supplies, improving facilities, addressing nutrition and addressing WASH**.

CAIA-MNCM was African-led and focused on **community engagement and mobilization to ensure sustainability of program results**. One example of community engagement was in Malawi, where three community consultation groups were established to discuss gender issues and harmful traditional practices that impacted reproductive, maternal, newborn, and child health (RMNCH) service delivery, with the engagement of community leaders, health advisory committee members, facility and community health workers, constituency councillors, women of reproductive age and traditional birth attendants. Bringing together all these actors allowed for regular meetings to discuss traditional and cultural issues that affect

women's and girls' ability to access RMNCH services. Collectively, these parties were able to discuss accessibility and mitigation strategies. As a result of the findings from these discussions, local councillors and traditional leaders passed by-laws to encourage women to deliver their babies in health facilities.

Amref Health Africa was also able to impact the policy environment in other countries as well. Similar to Malawi, Amref was an active partner in ensuring the inclusion of key health priorities and budgeting for community health workers during the development of Kenya's County Integrated Development Plan (strategic policy document). As a result of both of these instances, **Amref was able to influence health priorities and strategy regionally and nationally, allowing for long-term sustainability and ensuring RMNCH services are prioritized on a macro level in the long term**.

Effective community engagement resulted in improved utilization of health care services, which was noted throughout the program in multiple countries. Key indicators in this area, including the percentage of fathers who were engaged in pre-natal planning, the percentage of women receiving respectful antenatal care, and the percentage of health facilities offering care from well-trained traditional birth attendants, showed **significant improvement across all four countries from baseline to endline and demonstrated the transformation of community attitudes towards maternal, child, and newborn health**.

Addressing community attitudes was a core part of the project's Gender Equality Strategy. The stigma surrounding pregnant women is a significant deterrent in accessing essential services, especially in the younger age categories (i.e. girls aged 15-19), and is a driver of poor health outcomes in many communities. As a result, the CAIA-MNCM program prioritized community-level gender equality in all target countries to improve health outcomes and prioritize women's health.

Alongside local actors and community partners, strategies were developed to target gender-equality related barriers and challenges. In Ethiopia, nearly 5,000 women participated in monthly conferences, which allowed them to gain information on their rights to institutional services and inspired women to seek out essential health services they needed. The program also engaged men in understanding the need for them to actively support maternal health. **Across the program, there was a substantial increase in men's supportive involvement in MNCH, demonstrated by an average 23% increase in men who worked with their wives in advance planning of delivery location prior to delivery**.

Among the gender-equality-related impacts of the program, the infrastructure across many of the program sites was upgraded to ensure safe, gender-sensitive latrine facilities. Overall, the program was able to work towards transforming gender relations in multiple communities, ultimately leading to women's empowerment and improvements in women and children's health.

Health systems strengthening also resulted in improved infrastructure, delivery, and utilization of essential services throughout the program. Across many of the program countries, there were substantial improvements in the delivery of services, ultimately highlighting the impact of program activities on improving services for women, children and newborns. This was indicated through high-quality antenatal care. In **Ethiopia (Amhara region), Kenya, Malawi, and Tanzania, the percentage of facilities offering delivery services that included basic postpartum/newborn interventions and had essential infection control items in place increased significantly**. High-quality infrastructure equipped with necessities for essential health care services provided mothers, pregnant women, newborns and children under five with timely access to the services they needed. Through these program initiatives, including extensive training of community health

workers and health facility workers as well as advocacy of resource availability, the infrastructure and human resources in place became part of a gender-responsive, sustainable, transformative approach to the delivery of health services.

The program highlighted the need to **ensure that sanitation and nutrition are addressed when working towards improving overall health outcomes**, reducing neonatal mortality and decreasing underweight prevalence. The transformation of infrastructure (specifically cleaner latrines) in health facilities to be more gender-responsive highlighted the need to address other non-health priority areas to positively impact health outcomes.

Throughout the course of the program, a **significant increase of soap and handwashing facilities was seen in the majority of the target areas**. Following further engagement activities, it was noted that community members and officials expressed noted commitments to integrating WASH activities to improve hygiene and infection control. This highlights the potential of future community-driven approaches toward finding health care solutions.

The program significantly improved community awareness of nutrition and the availability of nutritional supplements in most of the target areas. An impact was made in nutrition-related outcomes due to multiple activities, such as community cooking classes, community awareness campaigns, providing nutrition training to health workers, and advocacy efforts at a higher level. Advocacy was important in supply chain management and logistics to ensure continuous availability of the supply of vitamins and supplementation in health facilities. The **CAIA-MNCM program was successful in improving nutrition-related outcomes and increasing community awareness of nutrition**. This was noted through increases in available micronutrient supplements in three of the four program countries and trainings provided to district and community health management committees on micronutrient interventions.

Overall, the **CAIA-MNCM program made significant and sustainable impacts on health-related outcomes in the four target countries of Ethiopia, Kenya, Tanzania, and Malawi between 2016 to 2020**. However, the program was also able to use its lessons learned as pathways and considerations for future programming to continuously improve health outcomes and sustain the results of the program. Some of these lessons include:

- Enhancing engagement of community leaders to build trust, leading to breaking down gender-related barriers even further.
- Integrating of best practices in training of community health workers to build their expertise and skills.
- Providing hands-on, experiential learning opportunities to community health workers to build their expertise and skills.
- Ensuring sustainable impact through advocacy around funding and supply chain management, as these will directly impact the availability of essential products and services.

COVID-19 Response

In early 2021, GAC provided additional funding to Amref Health African in Canada to implement COVID-19 interventions in three of the original program countries (Kenya, Malawi, Ethiopia) as well as in Senegal; COVID-19 related interventions were implemented between January 2021 and June 2022. Central to Amref's interventions was to work closely with the respective Ministry of Health in the targeted program countries to support their respective COVID-19 response plans in three key areas: health worker training; information dissemination and community engagement; and improved water, sanitation and hygiene (WASH) at the community level.