PHE partnerships guide

Health service delivery

Version 1

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beyond conservation

PHE
Madagascar
Population
Health
Environment
Network

About this guide

This guide consists of 15 chapters covering the core values, skills and knowledge needed to develop and implement effective cross-sector Population-Health-Environment (PHE) partnerships. You have downloaded **chapter 12 - Health service delivery**. If you wish to download other chapters or the entire guide please visit the Madagascar PHE Network's website here.

This guide is primarily designed for use by the staff of environmental organisations wishing to develop cross-sector PHE partnerships with health service providers in line with priority community needs and their organisational missions. Many chapters will also be relevant to the staff of health organisations wishing to develop cross-sector PHE partnerships with environmental organisations working in under-served zones. And of course livelihoods-focused organisations working at the interface of sustainable development and natural resource management are also ideally placed to develop and implement collaborative PHE initiatives with relevant partners.

This guide draws on the PHE implementation experiences of Blue Ventures and other members of the Madagascar PHE Network in order to provide practical advice structured in a conversational format with case study examples. As such it should be highly relevant to organisations working in Madagascar and much material will be applicable to organisations working in other countries as well.

This guide is accompanied by various complementary resources including an integrated PHE community outreach tool (illustrated PHE story cards) available via the Madagascar PHE Network's website here. Please note that a comprehensive online library of documents relating to PHE programming has been collated by the Population Reference Bureau and can be found here.

This guide should be considered a living document and as such it will be updated regularly. Please don't hesitate to contact Blue Ventures (pheinfo@blueventures.org) if you have any suggestions for improvement or requests for elaboration. We look forward to incorporating your feedback into future versions of this guide.

Credits and acknowledgements

This guide was written and produced by Laura Robson, Blue Ventures' Health-Environment Partnerships Manager.

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Valuable feedback on the content of this guide was also received from the following organisations via a PHE training and experience sharing workshop held by the Madagascar PHE Network in March 2016: Association Cétamada, Catholic Relief Services, Centre ValBio, Community Centred Conservation, Conservation International, Durrell Wildlife Conservation Trust, Honko Mangrove Conservation & Education, JSI/MAHEFA (now Mahefa Miaraka), Madagascar Fauna & Flora Group, Madagascar Wildlife Conservation, Marie Stopes Madagascar, MIHARI Network, Ny Tanintsika, Population Services International, Reef Doctor, SEED Madagascar (formerly Azafady), Stony Brook University, USAID Mikolo, Voahary Salama, Wildlife Conservation Society and WWF. The photo on the cover page of this guide was taken by Jean-Philippe Palasi at that PHE training and experience sharing workshop. All other photo credits can be found on top of the photos included throughout this guide.

This guide should be referenced as follows: *Robson, L. (2017) PHE partnerships guide. London, UK / Antananarivo, Madagascar: Blue Ventures Conservation.*

12. Health service delivery

By the end of this chapter you should:	This chapter may be of particular relevance to:
▪ Know three different modes of health service delivery including their advantages, challenges and considerations to bear in mind ▪ Understand how environmental organisations can collaborate with health organisations to support community-based or mobile service delivery through PHE partnerships	▪ Managers and community-based staff of environmental organisations
Note: The information presented in this chapter should be generalisable across contexts but please consult Ministry of Health documents and policies in your country of operation for specific guidance.	

When developing a PHE partnership or initiative, it's important to understand and consider different modes of health service delivery that may be appropriate in your context. Often a combination will work best, with at least one mode (community-based or mobile) that ensures good physical access to services for isolated communities.

Community-based service delivery

Examples: community health agents / volunteers / workers, community-based distributors, peer educators, etc.

These are generally local community members who are trained and supervised to provide health information and also basic health services (depending on national health policies) in their villages. They may also refer clients to mobile or facility-based services for more advanced needs. They generally operate in or near their homes and/or go door-to-door to serve clients in their villages. They may also organise small group discussions to raise awareness of common health issues and the services that they / formal health facilities are able to offer.

They may or may not be paid a stipend depending on national health policies in your country of operation. For example, in Madagascar community health agents don't receive a stipend but they receive a small per diem for attending trainings and can sell products (e.g. short-acting contraception methods) to their clients at a fixed, subsidised and affordable retail price - keeping the small mark-up as a modest income for their otherwise voluntary work.

Blue Ventures collaborates with USAID Mikolo to support community health volunteers:

Blue Ventures is working with USAID Mikolo to increase access to child health services for remote coastal communities in southwest Madagascar, as part of an integrated PHE programme in the Velondriake locally managed marine area. In a region where 1 in 13 children dies before their fifth birthday, this collaboration is a critical step for advancing community-based management of preventable illnesses including diarrhoea and malaria. Not only is it set to improve child health outcomes, but it is also likely to increase demand for family planning services as couples become more able to ensure the good health of their children and more familiar with the services offered by community health volunteers.

USAID Mikolo is a five-year project implemented by Management Sciences for Health (MSH) and its local partners, covering 8 regions of Madagascar and targeting communities more than five kilometres from a public health centre, with the aim of improving access to community-based health services and promoting the adoption of healthy behaviours. Under its PHE partnership agreement with Blue Ventures, USAID Mikolo staff and local partner ASOS Sud have provided training in the management of childhood illnesses to more than 30 community health volunteers already active and supported by Blue Ventures. Next steps of the collaboration include working together to produce community outreach materials linking health and environmental topics.

Types of services offered by community-based providers *(can vary depending on national health policies)*	Advantages and strengths	Challenges and considerations
▪ Information about prevention of common illnesses, maternal health, family planning options, nutrition, water, sanitation and hygiene ▪ Promotion of health-enhancing behaviours (as detailed in chapter 13) ▪ Provision of non-hormonal and short-acting contraception methods (e.g. CycleBeads, condoms, pills, injections) ▪ Referral for long-acting and permanent contraception methods (e.g. implants, IUDs, vasectomy, tubal ligation) ▪ Provision of other health products (e.g. insecticide-treated mosquito nets, water purifying solution, oral rehydration salts) ▪ Management of common childhood illnesses (e.g. diarrhoea, respiratory infections, malaria)	▪ Community health agents should be elected by the community themselves and then approved by local authorities and health service providers ▪ Community health agents tend to have an excellent understanding of local health issues, strong and trusting relationships with other community members, and an ongoing presence in their villages ▪ Clients do not have to travel far to access services, and services / follow up should be available on an ongoing basis as community health agents live in their villages ▪ Community health agents can communicate priority health needs to health organisations active in the area	▪ Community health agents require a basic level of literacy in order to complete their training and be able to operate effectively (i.e. follow guidelines and keep reports), but adult literacy may be extremely limited in isolated communities; a short programme of literacy training may therefore be necessary prior to community health agent training ▪ Community health agents require initial training, validation, follow up reviews and supervision; generally this is provided by health organisations although environmental organisations may also be able to support with supervision in PHE partnerships ▪ Clients may have to pay for contraceptives or other products (although the prices are often fixed and subsidised heavily in order to ensure affordability) ▪ Female clients may prefer to see female community health agents for family planning - many national health policies reference giving preference to women for these roles when possible

Mobile service delivery

Examples: mobile outreach teams or clinics / brigades, mobile nurses or doctors, etc.

Mobile outreach teams or brigades are small groups of medical professionals who travel periodically by 4x4 (or other means of transport e.g. boats - sometimes provided by environmental organisations in PHE partnerships) to reach isolated communities and offer services out of host facilities (e.g. local health centres, school or community buildings). For example, Marie Stopes Madagascar's mobile outreach teams visit isolated communities every three months to offer a full range of contraception methods including long-acting and permanent options. Mobile outreach teams or brigades are often employed by health organisations with funding secured to reach under-served communities. Both environmental and health organisations can assist with the planning and facilitation of outreach missions to ensure that health services are provided to as many isolated communities as possible.

Mobile nurses or doctors are based in urban or peri-urban areas but available to travel to more isolated rural communities and offer services out of host facilities (as described above) and/or door-to-door. For example, Marie Stopes Madagascar's "MS ladies" are often able and

willing to travel occasionally to reach under-served communities in the rural areas surrounding their bases (generally environmental organisations in PHE partnerships would offer to cover their transport, accommodation and subsistence during these missions). Sometimes nurses or doctors working within national public health systems are also available to travel from their base to reach under-served communities.

Types of services offered by mobile providers *(can vary - e.g. some may specialise in family planning only)*	Advantages and strengths	Challenges and considerations
▪ Information about prevention of common illnesses and family planning options ▪ Provision of short-acting, long-acting and permanent contraception methods (e.g. condoms, pills, injections, implants, IUDs, vasectomy, tubal ligation) ▪ Antenatal and postnatal check ups ▪ Basic medical care (e.g. treatment of sores, wounds, infections) ▪ Vaccinations ▪ STI testing and treatment (including HIV)	▪ Clients do not have to travel to access services ▪ Mobile outreach teams, doctors and nurses are qualified to provide more advanced services than community health agents ▪ Community health agents can refer clients to these services and work with them ▪ Environmental organisations can leverage their operational infrastructure (e.g. transport) and frequent presence in communities to facilitate missions	▪ Follow up may be difficult if visits are infrequent or irregular ▪ Clients may be charged a small fee (although vouchers are often available) ▪ Female clients may prefer to see female medical professionals for family planning ▪ Weather and associated infrastructural challenges can alter outreach plans with little notice ▪ Service providers must be well prepared for working in remote areas, with particular attention to ensuring proper hygiene and infection prevention

Marie Stopes Madagascar (MSM) collaborates with the Lemur Conservation Foundation to reach isolated communities:

The Lemur Conservation Foundation is doing joint missions with MS ladies to several villages around the Anjanaharibe-Sud Special Reserve in northeast Madagascar. A recent visit to Befingotra village required a 90 minute drive from the commune centre of Andapa to Andasibe Mahaverika where the main road ends. From there it's a two to three hour walk uphill to Befingotra village. The Lemur Conservation Foundation hired taxi-motos and the MS ladies courageously rode them in about 60 bumpy minutes to Befingotra. Despite terrible weather (heavy rain) it all went really well and 18 women chose to receive three-year implants


Photo credit: Lemur Conservation Foundation

Facility-based service delivery

Examples: public health centres, private health clinics, etc.

Facilities are dedicated buildings from which medical professionals offer a range of services. They typically include at least one consultation room and may have a pharmacy attached. They may be part of a national public health system or they may be operated privately by health organisations or individual providers. For example, public health centres in Madagascar are called *Centres de Santé de Base* (CSBs) while health organisations such as Marie Stopes Madagascar and Population Services International operate their own franchises or networks of private health clinics (called *Blue Star* and *Top Réseau* respectively).

Types of services offered by facilities *(can vary depending on clinic level)*	Advantages and strengths	Challenges and considerations
▪ Information about family planning options ▪ Provision of short-acting, long-acting and permanent contraception methods (e.g. condoms, pills, injections, implants, IUDs, vasectomy, tubal ligation) ▪ STI testing and treatment ▪ Antenatal and postnatal check ups ▪ Safe delivery (birth with a skilled attendant) ▪ Vaccinations ▪ Basic medical care (e.g. treatment of sores, wounds, infections) ▪ Diagnosis and treatment of more complex medical conditions	▪ Facilities are equipped to provide more advanced and comprehensive services than community health agents ▪ Services in public health centres are often free ▪ Community health agents can refer clients to these services	▪ Clients often have to travel far to access services - this can be a significant barrier (addressed by the other two modes of service delivery detailed above) ▪ Female clients may prefer to see female medical professionals for family planning ▪ Public health centres in rural areas may be understaffed meaning that services may not be reliably available or comprehensive

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