

Overview

Every day approximately 830 women die from preventable causes related to pregnancy and childbirth. Of these maternal deaths, 99% occur in developing countries where the acute challenge of delivering maternal, newborn and child health services often results in poor health outcomes for women.¹ Integrating MNCH services within primary care organizations has been increasingly advocated as a strategy for advancing health care for women and children in LMICs. Including evidence based MNCH programs in primary health care can prevent 20-30% of all maternal deaths, 20-21% of newborn deaths, and 29-40% of all post neonatal deaths in children under 5.² Despite these benefits, only a fraction of primary health care organizations offer integrated services. Of the 1300 health care organizations profiled on the Center for Health Market Innovation (CHMI) database, 300 offer MNCH services, and 470 offer primary care, but only 100 programs offer both.

CHMI profiles programs that use innovative delivery and financing mechanisms to improve access, quality, or affordability of health care for the poor. Programs that specifically deliver MNCH services often include clinical social franchises, vouchers for safe deliveries, and high-volume/ low-cost maternity hospitals. In low and middle-income countries, private providers tend to predominate, and household out-of-pocket spending is a major source of health expenditures.

Often, health care organizations which provide primary care choose not to include MNCH services, as these can require specialized personnel and equipment, and may be a burden to the organization's human resources. Integrating MNCH services, such as ultrasounds and antenatal care, into primary care health organizations benefits patients by creating continuous care. A provider who knows the patient's history can more easily track the mother and child's unique conditions observed through pregnancy, birth, and early childhood. These services are often important measures to preventing complications and reducing the overall burden of MNCH-related diseases.

The inclusion of specialized services into organizations that provide primary health care, especially at the community level, may greatly reduce this disease burden. This research was conducted to better understand why primary health care organizations have been motivated to include MNCH services as part of their package, what models have worked best for them, and to share that knowledge with other organizations that are either interested in integrating from scratch, or integrating MNCH and primary care services more effectively.

Scope and Methodology

This research sought to identify 1) motivations for organizations to integrate MNCH services with primary care; and 2) challenges preventing, stalling, or slowing integration for organizations that have pursued it. Where organizations found solutions to these roadblocks, the research team explored how they might be replicated into new contexts by other programs facing similar challenges.

The primary resource for this research was the CHMI database. Out of the 100 organizations identified as offering both primary care and MNCH services, 17 agreed to participate in qualitative interviews to obtain more in-depth information on their models and experiences providing integrated primary care and MNCH services.

Motivations for integrating MNCH services and primary care:

Findings from the qualitative interviews indicated that organizations choose to integrate MNCH services with primary care for three main reasons:

- 1. Patient and community demand:** For many organizations, the local burden of disease determined which services were most essential. In India, the **Garhwal Community Development and Welfare Society (GCDWS)** noted that communities where they provided primary care experienced high rates of stillbirth and neonatal death due to low birth weight. GCDWS, in consultation with those communities, recognized that the lack of access to antenatal care was a major contributor to these poor health outcomes. Women were unable to meet with providers who could flag potential complications and counsel them on proper nutrition during pregnancy. GCDWS integrated MNCH services into their primary care offerings as a response to community demand.
- 2. Funding Opportunities:** Several organizations integrated MNCH services into their primary care program to align with government and/or donor priorities, increasing their access to funding opportunities. **Possible Health** of Nepal, which initially only offered primary care, secured more funding and support from the Ministry of Health by incorporating MNCH services at its clinics.

1. WHO Maternal Mortality Fact Sheet. <http://www.who.int/mediacentre/factsheets/fs348/en/>

2. Butta, ZA, et. al. Alma-Ata: Reberth and Revision 6: Interventions to address maternal, newborn, and child survival: what difference can integrated primary health care strategies make? The Lancet, Volume 372 Issue 9642, 972-89.

3. Efficiency: Many organizations noted that providers often focus on single episodes of treatment, rather than the patient's overall well-being. By adopting a more comprehensive approach, patients receive higher-quality, more efficient care, saving them the trouble of having to travel long distances for MNCH services. In Burundi, **Village Health Works** began offering ultrasound services at their clinics so women would not have to be referred elsewhere. This has the added benefit of potentially generating more revenue for the health care organization.

Common barriers to integrating MNCH services and primary care:

Organizations interviewed identified several common logistical barriers to integrating MNCH services with primary care.

› **Overburdened human resources:**

Organizations' efforts to integrate primary care and MNCH services are often hampered by a lack of qualified health care workers. To provide antenatal care, postnatal care, and delivery services, organizations must have providers with specialized training. The training for community health workers (CHWs) and nurses often does not cover these services, making it difficult for organizations to find and hire trained staff who can offer integrated services. Possible Health noted that this problem is especially acute for organizations that operate in rural locations. According to the organization, "there are not a lot of incentives for trained care providers to come to work in rural Nepal. In terms of retention, it is always a struggle."

Kheth'Impilo of South Africa noted that retraining an existing workforce in these new skills can be equally challenging. Adding new services may improve convenience for patients, but can also cause burnout and inefficiency for staff when a single person is expected to provide all of those services, rather than specializing.

› **Regulatory Barriers**

Regulations often restrict which health professionals can provide certain services, especially clinical ones. **Purple Source Healthcare** noted that in Nigeria, in order to perform deliveries, organizations must have a midwife or registered nurse on staff as well as an ongoing relationship with a gynecologist and an obstetrician in case of complications. Similarly, Thrive Networks' Newborn Health and **Health One** noted that ultrasound services attract patients, but regulations require they be performed by a trained radiologist or doctor.

› **Financial barriers:**

Securing qualified staff to provide integrated services can also present significant financial barriers. Where regulations may require a program to have a certain standard of health care worker to provide a particular service, the program may face an additional barrier of whether they can afford that level of health care worker. In some cases, this shift has been beneficial. **Child and Family Wellness (CFW) Shops** and **LifeNet International** shifted from using a CHW model to employing higher paid nurses and clinical officers, consequently increasing their organization's labor expenses. More research is needed to understand whether these increased costs can be sufficiently offset by increased revenue from the new service offerings.

Even if this offset is possible, it can be difficult for an organization to accrue the necessary financial capital to begin offering the new services. Providing specialized services may require investments in delivery equipment, ultrasounds, and a cold chain for pharmaceuticals—all of which can be extremely expensive.

Opportunities to Integrate Primary Care and MNCH Services:

Interviewed organizations shared three common tools they used to help manage integrating MNCH services with primary care.

› **Leveraging community health workers (CHWs)**

Relying on CHWs as a core part of the health care model addresses two of the barriers to integration; it reduces the labor burden on more qualified health care workers and is more cost effective than hiring nurses or clinical officers for nonclinical work. Integrated care organizations have effectively used CHWs to conduct behavior-change communication and health education with patients and to build linkages between communities and health care facilities. CHWs' outreach efforts were also found to increase the community's use of MNCH services and preventative practices among the organizations interviewed.

Although CHWs have limited provider capabilities, they have effectively managed protocolized diagnostics, such as identifying critical signs of malaria, diarrhea, tuberculosis, and acute respiratory infection. With minimal training, CHWs have also been used to deliver clinical screenings and promote non-clinical interventions, such as skin-to-skin care and exclusive breastfeeding.

Partnerships to build clinical skills

Organizations have partnered with clinical programs to receive training in integrated MNCH and primary care services. This training can help organizations meet regulations and provide such services in-house, improving convenience for patients through continuity of care. Village Health Works, for example, has partnered with a number of international clinical organizations to train its providers in MNCH services. They now operate a new Women's Health Pavilion in their catchment area, and have a better continuum of care for their patients from antenatal to postnatal care.

Mwayi wa Moyo in Burundi and **Last Mile Health** of Liberia also partnered with outside organizations to increase their staffs' clinical capacity through short-term, project-based trainings. Such partnerships trained government-supported CHWs to meet the needs of their communities.

Partnerships to expand financial capital

Local or regional organizations partner with larger international ones to secure capital to invest in equipment for specialized services. LifeNet International, operating in Burundi and Uganda, partners with local health care clinics that seek to join their network as franchisees. LifeNet offers "rent-to-own" opportunities for these clinics to acquire expensive medical equipment, including ultrasounds or glucometers. LifeNet also provides a "growth financing loan" to enable franchisees to increase their scope of services, such as adding a labor and delivery room to generate additional revenue.

In Kenya, CFW Shops noted that many of their clinics seek equipment to expand their scope of services. The decision to finance equipment purchases always depends on an analysis of surrounding competitors in the health care market. CFW Shops provides clinics with financing to purchase specialized equipment after determining that an area is not saturated with competitors offering similar services.

Conclusions

The landscape of global maternal, newborn, and child health today is very different from what it was 30 years ago. Ensuring skilled care during pregnancy, childbirth, and the postnatal period for women and newborns was a pivotal focus of the Millennium Development Goals (MDGs). In the era of the Sustainable Development Goals (SDGs), MNCH continues to be central to the SDG targets that have been set. However, providing quality MNCH services is an ongoing challenge, reflected in the stubbornly high rate of maternal mortality seen in LMICs.

Consequently, disparities persist and reflect barriers to scaling-up quality health care for women and newborns in low-resource contexts. To address the unfinished agenda, innovative approaches aimed at integrating MNCH and primary health care services are needed.

The MNCH care continuum historically refers to the continuity of individual care, be it the care of the mother, the infant, or the child. These continuums need to be interlinked to follow and retain both mother and baby across time and place. To date, although there is some combined delivery of primary health care and MNCH services, services are often siloed. But with increased emphasis on health systems strengthening and the integration of disease-specific initiatives within primary care, now is the time to critically examine ways in which primary health care and MNCH services can be linked to synergize successes and mitigate mutual challenges.

The similarities between primary health care and MNCH services are straightforward: services for both the mother and baby are often provided by the same clinicians, and involve a care continuum that spans a woman's reproductive years and a child's first years of life. Both fields have a plethora of evidence-based interventions that have not yet been implemented at scale, and implementation would likely benefit from integrated service delivery at all levels of the health system.

Building on the lessons from this research, we propose three areas for consideration: 1) increased integration of service delivery, 2) adaptation and scale up of successful implementation models, and 3) a reconceptualization of the primary health care and MNCH care continuums.

Despite the advantages of integrated care, incorporating MNCH services with primary care remains a new frontier for many health care delivery organizations in LMICs. The mechanism for integrating these services depends heavily on the health system in place, as well as the health care market in each country. As private non-state organizations continue to integrate MNCH services with primary care, more research is needed on the impact and effectiveness of these combined services.

The Center for Health Market Innovations will continue to track and report on organizations integrating MNCH services with primary care. For more information on any of the organizations in this document, please visit healthmarketinnovations.org.