FACT

Fertility Awareness for Community Transformation

Reaching Marginalized Communities through "Roving" Auxiliary Nurse Midwives

Addressing deep-seated social, structural, and geographic barriers to enhance the reach of formal health services.

Despite marked gains in most reproductive health indicators, many services still do not reach some marginalized communities in Nepal. Physical (i.e.; long distances, difficult terrain) or social (e.g.; traditional caste systems) barriers limit access to services. Structural limitations such as the number of female physicians or language barriers compound these challenges. Their impact is apparent in several reproductive health indicators including disparities in contraceptive prevalence rates (CPR). Rates of family planning use are low in Nepal and especially for particular ethnic groups (i.e.; Dalit, Janajati and Muslims) (NDHS, 2011).

To overcome these challenges, the Government of Nepal (GoN), has introduced a new cadre of community-level health workers with increased capacity to address barriers to family planning use and improve maternal and child health outcomes. "Roving" Auxiliary Nurse Midwives (RANMs) represent one action within the GoN's initiative to expand equitable access to high quality community level health services especially in marginalized communities (Nepal Health Sector Strategy 2015-2020).

The Fertility Awareness for Community Transformation (FACT) Project, in partnership with the Family Health Division and the Rupandehi District Public Health Office within the Ministry of Health, piloted RANMs in select communities of Rupandehi District to provide a replicable model for delivering family planning services at the household level.

The approach, described below, structurally linked RANMs directly with nearby health centers for supervision and reporting. In turn, the RANMs established links between health services and the communities they serve – enhancing both reach and quality of formal health services. The primary goal of this pilot project was to understand whether and how RANMs could actually contribute to health coverage to inform GoN policies.

RANMs in Communities

The RANM model built upon the community nursing approach implemented in many countries around the globe. They engaged households, provided services, and built rapport between communities and health services.

The RANMs' diverse range of services met community health needs and improved outcomes among clients who would have remained outside of existing health services.

Collaboration among the FACT team, RANMs, and local stakeholders began with an initial household needs assessment, which provided the RANMs with an understanding of the health needs in the community. Through this iterative process, RANMs prioritized clients, monitored needs, and provided referrals for cases beyond their scope.

Consistent presence in the community facilitated a strong rapport between RANMs, their clients, and other stakeholders. As articulated by several clients, households trusted the RANMs and looked forward to their visits. This facilitated initial discussions about general health concerns and later discussions about the benefits of various reproductive health services. Furthermore, the RANMs were trained and equipped to engage men and other family members in each household about reproductive, maternal and child health. Whole-family inclusion helped to address social and gender barriers that limited service utilization.

To reinforce their health messaging and commitment to the community, the RANMs used three principal strategies:

Collaboration with Female Community Health Volunteers (FCHVs): FCHVs introduced the RANMs to the community, helped to identify priority households, implemented group education sessions jointly, and referred clients to the RANMs. The RANMs, in turn, provided technical support and credibility to FCHVs' activities.

Provided group education sessions: RANMs provided regular educational sessions to interested groups of individuals, facilitating access to accurate information, and answering questions that can address myths and misconceptions associated with various family planning methods. These sessions also included playing health education games called Pragati.

Engaged with community members: RANMs maintained strong working relationships with influential community members and leaders, ensuring that messages were disseminated with authority.

RANM HEALTH SERVICES PACKAGE

Family Planning

- Counsels and provides pills, condoms, SDM, LAM, injectables, and refers clients for long-acting and permanent methods
- Manages supply and waste disposal
- Engages husbands and other family members
- Follows up with discontinued clients

Antenatal Care

- Conducts ANC visits to pregnant women; includes husband and other family when appropriate
- Counsels on pregnancy expectations, danger signs for each stage, birth preparedness, breastfeeding and newborn care, family planning, and influence of social and gender norms on pregnancy and newborn care:
  - Pregnancy expectations, healthy behaviors, and education on pregnancy, labor, postnatal and newborn danger signs
  - Maternal nutrition
  - Birth preparedness
  - Breastfeeding and essential newborn care
  - Family planning
- Conducts physical exam if requested
- Refers to health facility for complications/danger signs, antenatal checkups and for delivery

Postnatal and Newborn Care

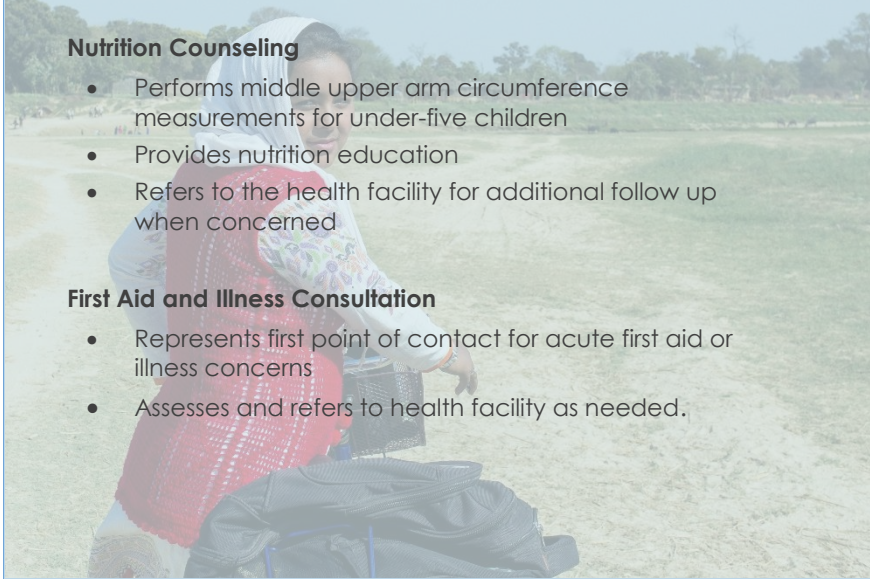
- Conducts second and third postnatal and newborn care home visits including maternal and newborn physical examination, counseling on postpartum danger signs and breastfeeding; provides essential newborn care
- Counsels on postpartum family planning
- Identifies postnatal and neonatal danger signs and timely referral for newborn or maternal illnesses

Nutrition Counseling

- Performs middle upper arm circumference measurements for under-five children
- Provides nutrition education
- Refers to the health facility for additional follow up when concerned

First Aid and Illness Consultation

- Represents first point of contact for acute first aid or illness concerns
- Assesses and refers to health facility as needed.



Who Did RANMs Reach?

Project monitoring data showed that:

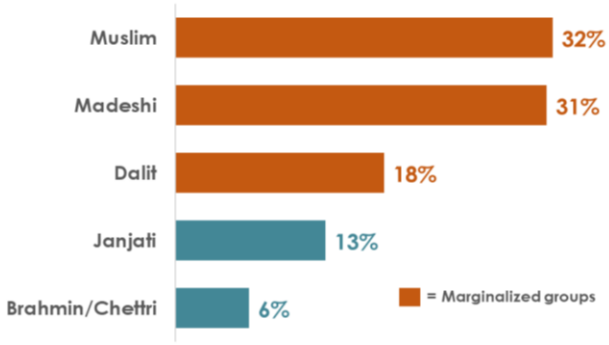
- 81% of primary RANM contacts were from marginalized communities (Muslim, Madeshi, and Dalit ethnicities).
- 62% of home visits included contact with spouses or in-laws to proliferate accurate information and build support for clients.
- 24% of primary contacts received services directly from RANMs. Approximately 30% of these services were related to pregnancy care and 20% to family planning services.
- 46% of primary contacts were with community members below the age of 26.

Evaluation Methods

A representative sample of 424 women participated in the evaluation of the intervention. Data collection included a pre-post community survey, focus group discussions, and in-depth interviews. Participants were women between 15 – 25 years old and were spread across several communities in Rupandehi. Thus, not all of the women surveyed had access to RANM services. Participants from two additional clusters of communities within Rupandehi were combined and used for comparative purposes. Neither of these clusters were exposed to the RANM intervention.

Evaluation Findings

Findings confirm that RANMs effectively reached marginalized communities in Rupandehi District. More than 72% of women who reported being an RANM client were from the Madeshi, Dalit, or Muslim communities (see graph).



A quarter of these clients also confirmed that the RANM extended conversations about reproductive, maternal, and child health to spouses and other family members.

Many women in the RANM communities experienced improvements in social norms and pressures over time. They were 2.3* [CI: 1.3, 3.9] times less likely to report pressure to have a son and 2.6* [CI: 1.1, 5.9] times less likely to report pressure to have a child immediately after marriage than women in non-RANM sites.

The additional outreach and engagement with other household members and community members may have also promoted a more enabling environment for family planning uptake. Women in the RANM sites were 2.7* [CI: 1.8, 4.2] times more likely to have a high fertility awareness score than women in the non-RANM sites. They were also 2.5 [CI: 1.2, 5.3] times more likely to be using a family planning method and 3.3 [CI: 1.5, 7.2] times more likely to intend to use a family planning method in 3 months than women in the non-RANM sites**.

**Controlling for age, ethnicity, religion, and marital status. $p < 0.05$ **Controlling for fertility awareness, family planning norms, and spousal migration. $p < 0.05$*

Lessons Learned

The project benefited from an iterative process that facilitated rapid identification of gaps and sought quick and low burden improvements that fit the context of Nepal.

Maternal and newborn care, nutrition, and first-aid trainings were used to increase relevant services in communities where RANMs worked. Approaching an RANM intervention with the goal of meeting the health priorities of your communities will help facilitate success and acceptance of the RANMs. Examples include:

- **Expanding RANM Services:** Diversifying the services RANMs provide increased contact with community members and helped to establish relationships with pregnant and postpartum women, who may later be family planning clients. Relevant family planning counseling was provided at every encounter with these women. This also created opportunities to address social and gender norms within couples and households.
- **Training RANMs to clearly organize and triage their caseloads:** Establishing a clear caseload management process that utilizes each RANM's Client Logbook was instrumental in identifying clients, prioritizing, and tracking needed services.
- **Adjusting services to local context:** Working in urban versus rural communities provided different complexities for the RANMs. While urban settings can increase efficiency, clients' work opportunities complicated meeting times. Adjusting to the local context and giving RANMs the ability to establish their movement within communities helped to transcend some structural barriers to service utilization.
- **Establishing a clear set of criteria to identify community needs:** To identify, prioritize and retain clients, especially in marginalized communities, clear parameters greatly enhanced RANMs' ability to manage caseload and follow-up duties. Additional information is needed to determine the appropriate number of households within an individual RANM's caseload. These figures should be linked to monthly targets for household and community activities and include processes for moving clients in and out of the RANM's caseload.

"We give information on family planning, the devices used for it, and their benefits. We have depo, pills, condoms, and CycleBeads [SDM]. We hand out whichever they prefer. Apart from the choices we have, if they want anything else we give references as well."

Amrita B.K., RANM

- **Identifying a clear mechanism to reach marginalized communities**: Fully integrating RANMs within the health system will require a multi-pronged approach that includes clear programmatic guidance and emphasizes their value at both the national and local levels. The FACT RANM approach reflects expanded services from other RANM interventions in Nepal. Moving forward, the GoN and local implementers should set clear expectations on the range of services and catchment areas for RANMs to facilitate a successful program. This pilot clearly established the reality that a "one size fits all" approach for reaching marginalized communities may not exist. It also emphasized the benefits of open communication and a commitment to adjust approaches to meet new and more clients.

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