Presentation Title: Promoting MiP Interventions through Community Engagement
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SIERRA LEONE
COUNTRY OVERVIEW

**Health Indicators**

- ACCESS to health services = 75%
- Life Expectancy – Male (years) = 47.5 years
- Life Expectancy – Female (years) = 49.4 years
- MMR = 1165/100,000 LB
- IMR = 92/1000 LB
- U5MR = 156/1000 LB
- HIV prevalence = 1.53% (DHS 2013)

**GEOGRAPHICAL LOCATION**

- Population: 7,794,832
- Country Income Classification: LOW
- 36.7% of the population
- URBAN
- Population Below $1 a Day (70%)
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</thead>
<tbody>
<tr>
<td>IPTp 1 during pregnancy</td>
<td>67%</td>
<td>95.5%</td>
<td>90%</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>IPTp 2+ during pregnancy</td>
<td>58%</td>
<td>68.7%</td>
<td>71%</td>
<td>NA</td>
<td>61.7%</td>
</tr>
<tr>
<td>IPTp 3+ during pregnancy</td>
<td>33%</td>
<td>26.8%</td>
<td>31%</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>IPTp 4+ during pregnancy</td>
<td>NA</td>
<td>5.5%</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>ANC 1: At least once by skilled health personnel</td>
<td>NA</td>
<td>97.4%</td>
<td>NA</td>
<td>96%</td>
<td>NA</td>
</tr>
<tr>
<td>ANC: At least 4 times by any provider</td>
<td>NA</td>
<td>77.5%</td>
<td>NA</td>
<td>76%</td>
<td>NA</td>
</tr>
<tr>
<td>ANC: At least 8 times by any provider</td>
<td>NA</td>
<td>25.1%</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
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<tr>
<td>% of pregnant women who slept under an ITN the night before the survey</td>
<td>NA</td>
<td>60%</td>
<td>44%</td>
<td>52.6%</td>
<td>47%</td>
</tr>
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<td>% of pregnant women who slept under an ITN in households with at least one ITN.</td>
<td>NA</td>
<td>NA</td>
<td>75%</td>
<td>NA</td>
<td>76%</td>
</tr>
<tr>
<td>% of pregnant women who received an ITN during 1st ANC contact</td>
<td>93%</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
</tr>
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</table>
Received any SP/Fansidar during ANC: 17 in 2008 SLDHS, 62 in 2013 SLDHS, 79 in 2013 SLMIS, 90 in 2016 SLMIS.

Took 2+ doses of SP/Fansidar and received at least one during ANC: 10 in 2008 SLDHS, 45 in 2013 SLDHS, 62 in 2013 SLMIS, 71 in 2016 SLMIS.

Took 3+ doses of SP/Fansidar and received at least one during ANC: 31 in 2013 SLMIS.
• Community IPTp commenced in 2013 by 1888 Traditional Birth Attendants (TBAs) nationwide.

• ITNs and IPTp are provided as part of the basic minimum ANC package using the recommended drug (SP) at health facilities.

• The National Strategies and Guidelines for MiP updated and distributed to RBM partners & health staff.

• NMCP commenced IPTp3 in 2016 at health facilities and in communities in 2018 after 1814 TBAs were trained and IPTp 3 has been captured into the HMIS.
COMMUNITY ADMINISTRATION
OF IPTP BY TBAS (HMIS 2018)

Community IPTp Administration from January to December, 2018

- 1st Dose IPTp
- 2nd Dose IPTp
- 3rd Dose IPTp
C-IPTP ADMINISTERED BEFORE AND AFTER TRAINING IN 2018 BY TBAS

3rd Dose IPTp

- January
- February
- March
- April
- May
- June
- July
- August
- September
- October
- November
- December

Y-axis: 0, 200, 400, 600, 800, 1000, 1200, 1400
X-axis: January, February, March, April, May, June, July, August, September, October, November, December
COMMUNITY APPROACH TO ADDRESSING MIP

• Communities are engaged to promote MiP services through outreach mobilization, advocacy, sensitization, community goal setting and community IPTp.

• Community Health Workers, Community Health Clubs and Traditional Birth Attendants support community efforts to provide ANC services.

• Community Health Workers (CHWs) are trained in phases and modules using a training manual by DHMT/PHU staff and supervised by National (quarterly), DHMT/PHU (Monthly), & Peer supervisors weekly.

• MiP activities are monitored through HMIS and surveys. Data is collected in communities and PHUs (paper based), inputted into the DHIS 2 at district level and retrieved through the HMIS at national (headquarters).
CHALLENGES

• Limited implementation of MiP policy guidelines by the private sector.
• Limited support to conduct supportive supervision from district to PHUs and from PHUs to communities.
• Late commencement of 1st ANC visit by clients.
• Low motivation of CHWs and TBAs.
• No support to conduct operational research on MiP interventions.
• Irregular stockout of malaria SP/Quinine tablets and HMIS tools
LESSONS LEARNED

• Community ownership when achieved, yields best social change results.
• The use of CHWs/Club members as mobilisers promoted access and utilization of malaria MiP interventions.
• Community engagement yields ownership and increase in the utilization of malaria services and products.
• Delivery of C-IPTp by TBAs facilitated access to IPTp 1,2 & 3 in hard to reach communities.
• Integration of MiP interventions into the basic ANC package improved quality of service.
• Monthly meetings held at PHUs with CHWs/TBAs/CHCs help identified issues and improved on performance.
KEY TAKEAWAYS

• Community IPTp implementation by TBAs.

• Community goal setting approach to promote MiP interventions.

• Formation of community health clubs/women’s, support group to conduct outreach sensitization and mobilization
• Intensifying community engagement to sustain ownership.
• Motivate community Health Workers/TBAs to promote community interventions/MiP interventions.
• Conduct operational research for informed decision making.
• Strengthen partnership with the other health sectors, NGOs and the private sector to improve quality of care.
• Intensify supportive supervision from district to PHU and PHU into communities.
• Support to conduct monthly community meetings at PHU level.
THANK YOU!