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Safidy Community Health Programme: A Summary of 6 Years of Activity

The Safidy programme is a key component of Blue Ventures' integrated Population-Health-Environment (PHE) approach that empowers coastal communities to live healthily and sustainably with their marine environment.

Safidy has been operating in the Velondriake locally managed marine area on the southwest coast of Madagascar since August 2007. This report provides a summary of reproductive health services provided during the first six years of the programme (2007-2013). It includes an analysis of data gathered during this period.

blue ventures
discovery through research

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Keywords: Family planning; sexual and reproductive health; long-acting and reversible contraceptives; couple years of protection; population, health and environment; Velondriake; Madagascar.

Recommended citation: Mohan, V. Robson, L. and Savitzky, C. (2013) Safidy Community Health Programme: A Summary of 6 Years of Activity. Blue Ventures Conservation Report. Blue Ventures Conservation, London.

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Acronyms

CBD	Community-Based Distributors
CYP	Couple Year of Protection
DALY	Disability-Adjusted Life Year
LARC	Long-Acting Reversible Contraceptive
LMMA	Locally Managed Marine Area
MCH	Maternal and Child Health
MDG	Millennium Development Goal
MSI	Marie Stopes International
PHE	Population-Health-Environment
PSI	Population Services International
SRH	Sexual and Reproductive Health
USAID	United States Agency for International Development
WASH	Water, Sanitation and Hygiene
WHO	World Health Organisation

Summary

Blue Ventures first established a family planning clinic in the village of Andavadoaka, southwest Madagascar, in August 2007. In the six years since the programme's initiation, it has expanded into a comprehensive sexual and reproductive health (SRH) service, now operating across 40 villages in and around the Velondriake locally managed marine area (LMMA), delivered through a network of outreach clinics and community-based distributors (CBDs).

This report provides an overview of the SRH activities carried out during the first six years of the programme (year 1 is August 2007 – July 2008, year 2 is August 2008 – July 2009, year 3 is August 2009 – July 2010, year 4 is August 2010 – July 2011, year 5 is August 2011 – July 2012, year 6 is August 2012 – July 2013) and includes an analysis of all data gathered during this period.

Summary of data for years 1-6	
Clinic consultations held	3,531
Community based-distributor consultations held	9,187
Oral contraceptive pill packs issued	9,730
Depo-provera injections administered	3,101
Implanon implants fitted	293
Intra-uterine devices fitted	60
Summary of couple years of protection (CYPs) for years 1-6	
CYPs: oral contraceptive pill packs	648.7
CYPs: depo-provera injections	775.3
CYPs: implanon implants	732.5
CYPs: intra-uterine devices	276.0
Total number of CYPs provided	**2,432.4**

CYP is the estimated protection from unintended pregnancy provided to a couple by a contraceptive method during a one-year period, based upon the number and type of contraceptives issued to clients.

During its first six years, the programme is estimated to have averted 804 unintended pregnancies, 556 live births, 115 abortions, 2 maternal deaths and 14 child deaths. It is also estimated to have averted 109 maternal disability-adjusted life years and 471 child disability-adjusted life years, saved £29,798 in (locally adjusted) direct healthcare costs, and prevented a (locally adjusted) ecological footprint of 1,045 global hectares. These impacts have been calculated using MSI's Impact 2 toolkit which is available to download free of charge at www.mariestopes.org/impact-2.

Introduction

Blue Ventures first established a family planning clinic in the village of Andavadoaka, southwest Madagascar, in August 2007. In the six years since the programme's initiation, it has expanded into a comprehensive SRH service, with further activities addressing maternal and child health (MCH) and water, sanitation and hygiene (WASH). It has become fully incorporated into the portfolio of programmes that Blue Ventures manages, resulting in an integrated Population-Health-Environment (PHE) approach that is empowering coastal communities to live healthily and sustainably with their marine environment. The programme currently operates across 40 villages in and around the Velondriake LMMA, delivered through a network of outreach clinics and CBDs, as well as a diverse range of peer-led health education activities.

Blue Ventures recognises the links between poor health, unmet family planning needs, environmental degradation, food insecurity, gender inequality and vulnerability to climate change. As a holistic response to these interconnected challenges, the PHE approach offers couples access to reproductive health services while equipping them with the skills they need to manage their natural resources sustainably. The aim of the Safidy programme is to respond to our partner communities' expressed unmet family planning needs by offering couples the information and means to freely choose the number and spacing of their births. We are also addressing MCH and WASH needs through our network of outreach clinics and CBDs, as well as our community education activities. Results from the first six years of this programme provide clear evidence that Blue Ventures is effectively addressing these previously unmet health needs, thereby generating multiple positive social, economic and environmental impacts.

Clinical data

Clinic and community-based distributor consultations

Family planning clinics were held across multiple sites during years 1-6 of the programme:

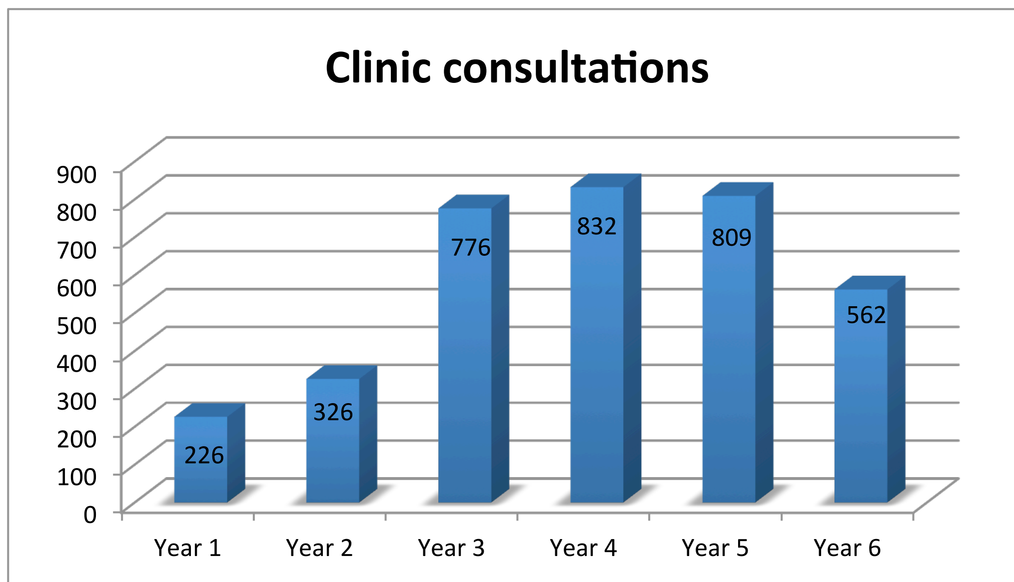
Figure 1 *Clinics held from August 2007 until end of July 2013*

Year	Month	Andavadoaka	Tampolove	Belavenoke	Befandefa	Bevohitse	Antesepoky	Lamboara	Ankitambagna	Vatoavo	Ankililaly	Antanimena	Ambatomilo	Bevato	Anjavony	Bekodoy	Beangolo	Salary
Year 1	Aug-07																	
	Sep-07																	
	Oct-07																	
	Nov-07																	
	Dec-07																	
	Jan-08																	
	Feb-08																	
	Mar-08																	
	Apr-08																	
	May-08																	
	Jun-08																	
	Jul-08																	
Year 2	Aug-08																	
	Sep-08																	
	Oct-08																	
	Nov-08																	
	Dec-08																	
	Jan-09																	
	Feb-09																	
	Mar-09																	
	Apr-09																	
	May-09																	
	Jun-09																	
	Jul-09																	
Year 3	Aug-09																	
	Sep-09																	
	Oct-09																	
	Nov-09																	
	Dec-09																	
	Jan-10																	
	Feb-10																	
	Mar-10																	
	Apr-10																	
	May-10																	
	Jun-10																	
	Jul-10																	
Year 4	Aug-10																	
	Sep-10																	
	Oct-10																	
	Nov-10																	
	Dec-10																	
	Jan-11																	
	Feb-11																	
	Mar-11																	
	Apr-11																	
	May-11																	
	Jun-11																	
	Jul-11																	
Year 5	Aug-11																	
	Sep-11																	
	Oct-11																	
	Nov-11																	
	Dec-11																	
	Jan-12																	
	Feb-12																	
	Mar-12																	
	Apr-12																	
	May-12																	
	Jun-12																	
	Jul-12																	
Year 6	Aug-12																	
	Sep-12																	
	Oct-12																	
	Nov-12																	
	Dec-12																	
	Jan-13																	
	Feb-13																	
	Mar-13																	
	Apr-13																	
	May-13																	
	Jun-13																	
	Jul-13																	
	Aug-13																	

KEY	
	Weekly

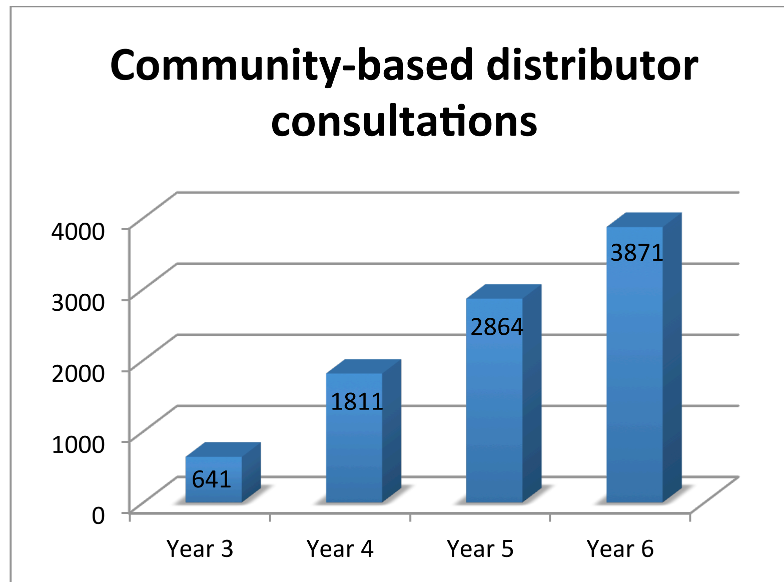
A number of clinic sites were closed during years 5 and 6 in order to take into account the capacity of local public health centres in supporting the excellent work of our CBDs, and to improve service provision in areas with previously limited access to a range of contraceptive methods. An integrated schedule was introduced in May 2013, combining SRH clinics with MCH clinics / educational village outreach tour activities on a six-weekly / three-monthly rotation.

Figure 2 *Clinic consultations held from August 2007 until end of July 2013*



A total of 3,531 clinic consultations were held during years 1-6 of the programme, with a significant increase in years 3-5 thanks to the introduction of more satellite and outreach clinic sites. The expected decline in the number of clinic consultations in year 6 is related to the increased uptake of services delivered through our network of community-based distributors (CBDs); local women trained and supported to offer basic counselling and contraceptive options within their villages. Supplies are provided to them at cost price so that they can sell them to their clients for a small income. We are focusing on transitioning from clinics to this community-based social enterprise model as a way of ensuring the long-term sustainability of service delivery.

Figure 3 *Community-based distributor consultations held from August 2009 until end of July 2013*



A total of 9,187 CBD consultations were held during years 3-6 of the programme. The number of CBDs increased from 18 in June 2010 to 33 in July 2011, with three CBDs trained to administer depo-provera injections in September 2010 and a further seven trained in November 2011, accounting for the steady increase in the uptake of community-based services each year.

Figure 4 *Clinic and community-based distributor consultations held from August 2009 until end of July 2013; showing the transition from clinic to community-based service delivery*

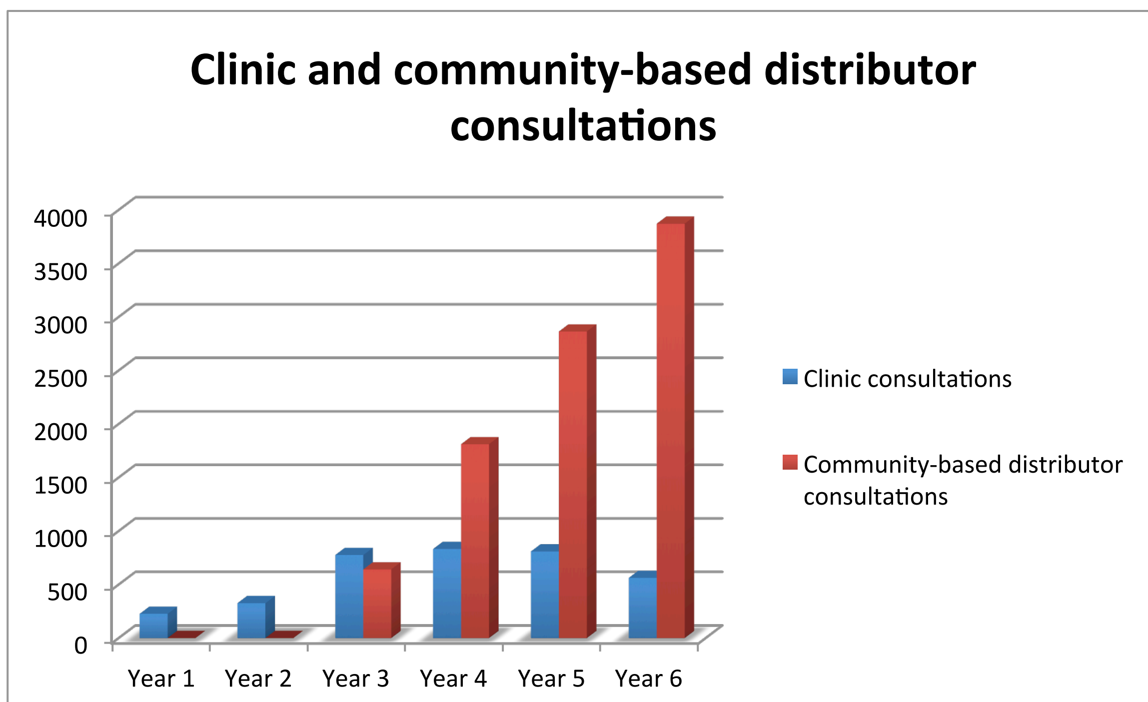
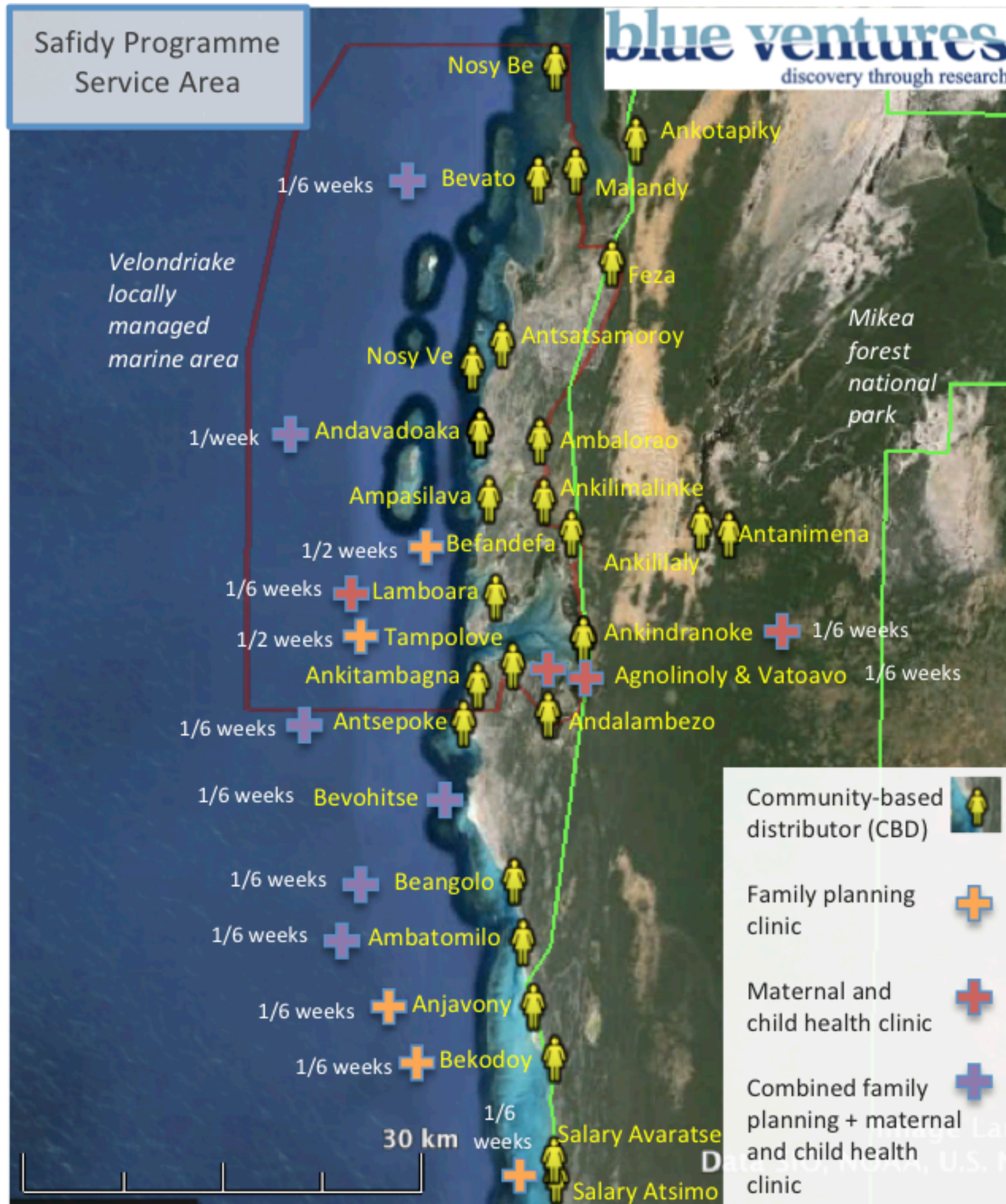


Figure 5 Map showing the Safidy programme service area as of July 2013



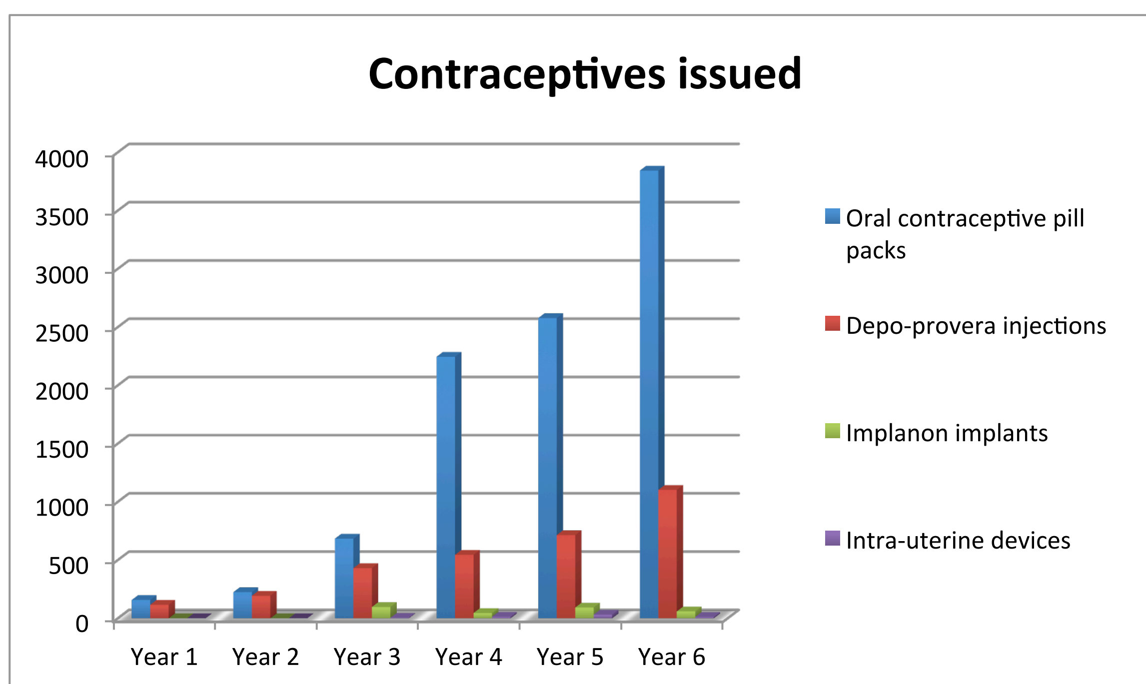
Contraceptives issued

A broad range of contraceptives are being provided by the programme in order to cater for the needs of different clients. Two types of long-acting reversible contraceptives (LARCs) – implanon implants and intra-uterine devices – have been offered since year 3. These have the benefit of providing clients in remote areas with long-acting options, and also reduce the risk of contraceptive failure due to inadequate compliance.

The different contraceptives offered by the programme provide different periods of protection:

- An oral contraceptive pill pack provides 1 month of protection
- A depo-provera injection provides 3 months of protection
- An implanon implant provides up to 3 years of protection
- An intra-uterine device provides up to 10 years of protection

Figure 6 *Contraceptives issued from August 2007 until end of July 2013*



Contraceptives issued							
Type of contraceptives	**Year 1**	**Year 2**	**Year 3**	**Year 4**	**Year 5**	**Year 6**	**Totals**
Oral contraceptive pill packs	157	224	684	2,245	2,577	3,843	**9,730**
Depo-provera injections	116	193	431	545	714	1,102	**3,101**
Implanon implants	0	0	97	45	92	59	**293**
Intra-uterine devices	0	0	4	13	31	12	**60**

The uptake of oral contraceptive pills and depo-provera injections increased significantly in years 3-6, reflecting the growing demand for and confidence in these contraceptive methods, as well as the increasing number of clients being reached by CBDs. The uptake of LARCs has also been encouraging, through quarterly LARC fitting days held in collaboration with Marie Stopes Madagascar (MSM) since year 3, resulting in a total of 293 women receiving implanon implants (each providing up to 3 years of contraceptive protection) and 60 women receiving intra-uterine devices (each providing up to 10 years of contraceptive protection) to date. The slight

decline in the uptake of these LARCs in years 4 and 6 was due to only three and two fitting days being held during those years, owing to the limited availability of MSM's mobile outreach team.

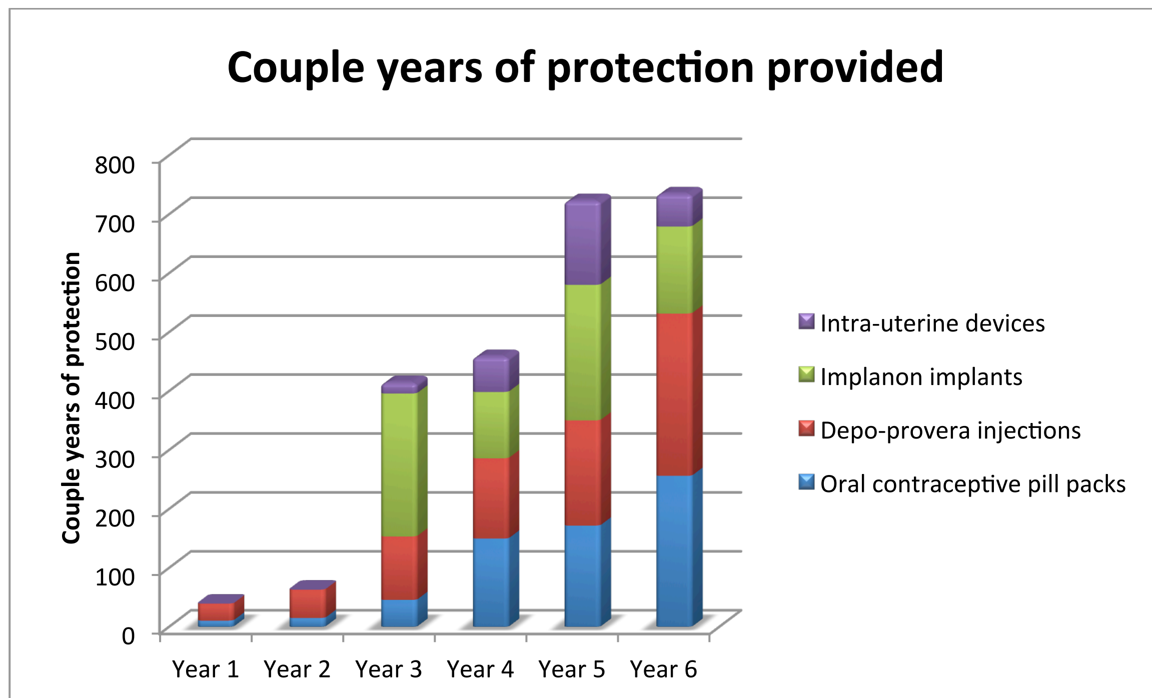
Couple years of protection provided

Couple year of protection (CYP) is the estimated protection from unintended pregnancy provided to a couple by a contraceptive method during a one year period, based upon the number and type of contraceptives issued to clients. Our CYPs have been calculated using USAID-approved conversion factors:

- 15 oral contraceptive pill packs = 1 CYP
- 4 depo-provera injections = 1 CYP
- 1 implanon implant fitted = 2.5 CYPs
- 1 intra-uterine device fitted = 4.6 CYPs

CYP is a standard indicator used to assess the volume of protection provided by SRH service provision. CYP does not include condom distribution, which would further increase the volume of protection provided.

Figure 7 *Couple years of protection provided from August 2007 until end of July 2013*



Couple years of protection provided							
Type of contraceptive	**Year 1**	**Year 2**	**Year 3**	**Year 4**	**Year 5**	**Year 6**	**Totals**
Oral contraceptive pill packs	10.5	14.9	45.6	149.7	171.8	256.2	**648.7**
Depo-provera injections	29	48.5	107.8	136.3	178.5	275.5	**775.4**
Implanon implants	0	0	242.5	112.5	230.0	147.5	**732.5**
Intra-uterine devices	0	0	18.4	59.8	142.6	55.2	**276.0**
Totals	**39.5**	**63.2**	**414.3**	**458.2**	**722.9**	**734.4**	**2,432.6**

A total of 2,432.6 CYPs were provided during years 1-6 of the programme. Just over 40% of these CYPs were provided through the two LARCs – implanon implants and intra-uterine devices – thanks to the long-lasting contraceptive protection that these methods offer.

Impacts

Estimated impacts

Figure 9 *Estimated impacts of SRH service provision from August 2007 until end of July 2013*

Estimated impacts of SRH service provision in years 1-6	
Unintended pregnancies averted	804
Live births averted	556
Abortions averted	115
Maternal deaths averted	2
Child deaths averted	14
Maternal disability-adjusted life years (DALYs) averted	109
Child disability-adjusted life years (DALYs) averted	471
Direct healthcare costs saved	£29,798
Ecological footprint prevented	1,045 global hectares

These estimated impacts have been calculated using MSI's latest Impact 2 toolkit which is available to download free of charge at www.mariestopes.org/impact-2. These standard indicators enable organisations to quantifiably demonstrate the benefits of SRH service provision in terms of social, economic and environmental impacts.

Impacts explained

Unintended pregnancies averted: an indicator that quantifies the social impact of SRH service provision in terms of providing couples with the ability to choose the number and timing of their pregnancies.

Live births averted: an indicator that quantifies the social impact of SRH service provision in terms of reducing the general fertility rate.

Abortions averted: an indicator that quantifies the social impact of SRH service provision in terms of providing couples with the ability to choose the number and timing of their pregnancies; unsafe abortions are a leading cause of maternal mortality and morbidity worldwide, so this measure also assesses contribution to MDG 5 (reduce maternal mortality).

Child deaths averted: an indicator that quantifies the social impact of SRH service provision in terms of improving child health; this measure also assesses contribution to MDG 4 (reduce child mortality).

Maternal and child disability-adjusted life years (DALYs) averted: an indicator that quantifies the social impact of SRH service provision in terms of reducing maternal and child mortality and morbidity; this measure also assesses contribution to MDG 4 (reduce child mortality) and MDG 5 (reduce maternal mortality).

According to the WHO definition[1], one DALY can be thought of as one year of 'healthy' life lost, with the sum of DALYs considered as a measurement of the gap between the current health status of a population and the ideal health situation whereby everybody lives to an advanced age, free from disease and disability. DALYs combine mortality and morbidity into a single measure that quantifies the burden of disease; adding the number of years of life lost due to premature mortality (calculated using the standard life expectancy for that population) with the number of years of 'healthy' life lost due to disability relating to particular health conditions (calculated using standard disability weightings).

Direct healthcare costs saved: an indicator that quantifies the economic impact of SRH service provision in terms of the (locally adjusted) healthcare costs saved by families or the public health system; including the direct costs of pregnancy, delivery, and treating complications resulting from unsafe abortions.

Ecological footprint prevented: an indicator that quantifies the environmental impact of SRH service provision in terms of decreasing pressure on natural resources (reflecting national consumption levels). Ecological footprint is the sum of all the cropland, grazing land, forest and fishing grounds required to produce the food, fibre and timber that each person consumes, to absorb the wastes emitted when each person uses energy, and to provide space for infrastructure.

[1] *www.who.int/healthinfo/global_burden_disease/metrics_daly/en*