From TBAs to 'mother companions'

Stories of change from Karonga District Malawi.

New mother Avery Chaluza Kondowe (25), her baby daughter Faith, and her 'Mother Advisor' Mbaububo Gumbo, 52, at Chilumba Rural Hospital in Karonga District, Malawi. Credit: Christian Aid/Tomilola Ajayi

A cultural practice

The use of TBAs is a deeply entrenched cultural practice. However, Malawi's high maternal mortality rates have, in part, been due to the use of low-skilled TBAs who are unable to identify obstetric complications. Mindful of this, the Malawi government imposed a ban on TBAs in 2007, in the hope that pregnant women would begin look to medical facilities instead.

That was not the case: only half of women in Karonga were delivering with the assistance of a skilled attendant, meaning half of women still delivered at home, mostly with the help of a TBA.

In 2010, the ban was lifted: the then president recognised the need to 'train TBAs in safer delivery methods'.

The motivation

'I did it out of passion and because it was the job my grandma left me: not because of any other benefit.

From observation I was able to learn how to deliver the baby and how to cut the umbilical cord. I delivered about 50 babies.'

Mbaububo Gumbo, 52, from Chambowo village in Karonga District explains how she came to be a traditional birth attendant (TBA), caring for pregnant women and helping them give birth at home.

Another former TBA, 40-year-old Sophie Nkwinka shares her own story: 'For me, I became a TBA so that I could help people who couldn't get to the health facility, because of the long distances.

'We were conducting deliveries in the village as health facilities were far away.'

Yet, despite the TBAs' good intentions, their work often had fatal consequences.

Sophie says: 'We were trained but we lacked medical knowledge or technical know-how. We didn't even know how to do a breech delivery [feet first]. There were high maternal and neonatal deaths in those days.

'We were living far from health facility, so if a women had profuse loss of blood we couldn't even help: she could bleed and bleed until she died. There were other complications, such as retained placentas. That has brought a lot of maternal deaths. These were some of the challenges we were facing as TBAs.'

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Mbaububo agrees: ‘When doing the deliveries, we were doing it without [medical] training. It had its dangers, as we TBAs couldn’t replace blood if a woman had heavy bleeding. And we were not putting on any protective wear to conduct the deliveries.’

In collaboration with district stakeholders, including health practitioners, Christian Aid and partner Adventist Health Service have been working to address the underlying social norms underpinning this customary practice.

With funding from UKAM, we have supported TBAs like Mbaububo to change their roles: they have been trained and reoriented to become ‘Mother Advisors’ – champions of skilled deliveries.

The mother companions offer women in their community an entry point for integrated care, and Christian Aid has engaged health-workers to support the TBAs’ new role.

The women now refer expectant mothers for antenatal care, and accompany them to give birth at health facilities. They also refer women with complications, encourage pregnant women to get HIV testing and treatment, and promote healthy practices at home.

In the first year of the programme, from January to December 2015, 51 TBAs were reoriented as mother advisors. In that period, a total of 2,207 women were referred by the TBAs for antenatal care (ANC) and postnatal care (PNC), according to a Christian Aid study.

Ray of hope

‘Now that we have been able train the TBAs, they are bringing awareness to women in the communities. This has resulted in increased attendance in ante-natal care and also post-natal care attendance in our facilities, which has reduced some of the obstetric complications,’ says Joseph Kasililika, Safe Motherhood Coordinator for Karonga District, who is working with Christian Aid and its partners on the UKAM project.

Mbaububo and Sophie were two of the TBAs trained and supported by the programme. They have since become champions in their communities for safe, skilled deliveries, helping to contribute to a drop in maternal deaths.

Sophie says: ‘It was Christian Aid and AHS who told us to stop conducting deliveries in the villages and that we should adopt the new government policy of identifying and referring pregnant women to the health facility.

‘I was trained in December 2015. Since then I have referred 15 pregnant women and all have had a safe delivery. No one had any complications.

‘Since the training there has been a tremendous change, because the number of deaths among women and babies has reduced, so the community is very happy with the project and I for one am very much happy. I very much enjoy my job as we are helping our mothers. It is very important.’

Mbaububo was also reoriented in 2015. ‘Since then I have referred 20 women to Chilumba Rural hospital: of the 20 women, nobody has died,’ she says. ‘The village leaders are saying there has been a drop in maternal deaths: pregnant women are no longer dying.’

‘Now, when there are danger signs we refer the pregnant women. We are very happy. The community and the traditional leaders are very appreciative of the [UKAM] project. It is helping to reduce maternal deaths in the community.’

The way forward

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25 old Avery Chaluza Kondowe was supported by Mbaububo, her mother companion. During her pregnancy she suffered from edema (swelling of the legs), but was referred to the health facility by Mbaububo.

Seminie Nyirenda, Christian Aid Malawi’s Senior Programme Officer for Community Health, a former nurse says:

‘Healthcare staff, the volunteers, the TBAs, they’re all very motivated to improve the health of their own people.

'But there are still a number of challenges, especially in terms of resources.

'We’re creating demand from the communities: we provided some of the resources at the district hospital and the District Health Office, but they’re not adequate.

'The government budget allocation to district health offices continues to be decreasing. As such, the resources will continue to be a challenge. So the support is still needed, until perhaps there’s a stabilisation in terms of resource allocation.

'As partners we need to work together, and we shall continue providing the technical support.'

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Mobile technology now helps mums in Malawi

Women and their children at an integrated outreach clinic in the rural, remote village of Kasimba, in Malawi's Karonga District. The once-monthly clinic serves over 1300 people, offering key services to mothers, infants and pregnant women. Credit: Christian Aid/Tomilola Ajayi.

The concept

The explosive growth of the telecommunications industry across the African continent is changing the way in which public services are delivered – including in the arena of healthcare.

Agencies like Christian Aid have, for some time, been tapping into the potential of communications technologies to transform health outcomes for women, girls and babies.

In Karonga District's rural communities, Christian Aid has used SMS mobile technology to connect over 5,000 women with the formal health system, bringing them closer to life-saving maternal and newborn health services that are often inaccessible to them.

Malawi's 2010 national demographic and health survey found that 56% of pregnant women in rural areas did not achieve the recommended four antenatal clinic visits.

Lack of knowledge on the importance of antenatal care (ANC), long distances to health facilities and lack of transport were among the factors.

However, things have been changing in Karonga, where Christian Aid has been running a successful mHealth platform that is bringing essential information on maternal, neonatal and child health (MCNH) direct to women's mobile phones.

Funded by the UK Aid Match (UKAM) Malawi programme, this innovative project is run by Christian Aid in partnership with US-based IT company Telerivet, and is being implemented by local partner Adventist Health Services (AHS).

(It is the second iteration of an SMS health scheme in southern Karonga that was funded by the Scottish Government from 2014. UKAM Malawi assumed funding for the project in March 2015, when Christian Aid brought Telerivet on board and rolled the project out more widely, across the entire district.)

How it works

The SMS Telerivet system operates from a computer stationed at Chilumba Rural Hospital. After a community health worker registers a pregnant women onto the system, it begins to send her regular text messages with tips on MNCH themes – each message is bespoke to her particular stage of pregnancy. Women

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also receive SMS reminders about ANC appointments, nutrition, hospital delivery and postnatal checks.

So far, the project has exceeded expectations. Keddings Mwalwanda, a health surveillance assistant (HSA), manages the Telerivet machine at the Chilumba hospital. He says: 'Our original target was to register 5,000 pregnant women, mothers and lactating mothers from 2014-15. We have registered 5,222 in that time.

'We managed to reach the target before the deadline, as we are able to send a message to 50-100 women at once. The system is very good: we can reach lots of women at once.'

He adds: 'This project has really worked: we have seen successes, as it has encouraged pregnant women to attend antenatal clinics, and most women are now meeting the appointment dates. When their due date is near, we remind women to come to hospital for delivery. So many women are being reached and attendance at ANC has increased.

'Even home deliveries have been reduced, since health surveillance assistants haven't registered any home deliveries since 2015. We attribute this to the reminders women get from Telerivet. It has complemented existing systems: as HSAs we give health information to pregnant women at outreach clinics, so the SMS messages enhance the information they receive.

'Husbands are escorting their spouses to ANC clinics, and we've seen a rise in take up of immunisation. There has also been evidence of higher attendance at the "maternity waiting home", where women go and wait before delivery.'

Challenges

The project, while successful, has experienced some challenges. 'Unreliable mobile networks' and electricity blackouts have hampered delivery of messages, explains Keddings. Meanwhile, access to mobile handsets is also an issue: 'Only women with phones were being reached, and those without phones were being left out,' he says.

The project cannot provide mobile phones to the women: however, in cases where a woman's husband owns a phone, sensitisation activities can help teach the men the importance of passing on health messages to their wives.

Christian Aid and AHS are keen to explore ways to continue building on the project's successes, many of which are not solely down to the SMS system: it is due to a combined effort of the integrated approach that the UKAM programme is taking.

'We thank Christian Aid and AHS for their work on the ground. I am very happy for their support as it has helped me do my job better and has eased part of our work,' says Keddings. 'Before, we had to go to each and every household to give messages and information. Now, upon receiving a text, the family will come on their own to the facility. This is good for time management and it means we can offer more services.'

Testimonies

Agatha Mhango, 34, from Mgoyera village (pictured above, on left), says:

'I have benefited from the SMS messaging system. I was pregnant with my third child at the time, and I noticed a difference between the first two pregnancies and the third one. Getting the SMS reminders on antenatal checks was so important, because in the middle of lots of tasks at home, I was able to get a reminder that it was time to visit the health facility.

'I was sick during the pregnancy but the SMS I received gave me the encouragement to visit the hospital, and when I arrived I was helped. The messages helped me to have a safe delivery. When I received the messages, I was also able to share the information with my friends, who were also pregnant at that time.

'It is very important that this project continues so that it can assist me in case I have another delivery, but also help my friends so that they too can have a safe delivery and no maternal or neonatal deaths.'

Mwanasha Mbewe, right, from Mgoyera village, has benefitted from the mobile technology:
'I was three months pregnant with my fourth child when I came into contact with the project.

'I started receiving SMS on different topics, including nutrition and feeding yourself properly as a pregnant mother; the danger signs in pregnancy; the danger signs after delivery and also the danger signs to the new baby. They also encouraged us on breastfeeding.

'I saw a difference. The first three pregnancies, the issue of feeding myself was a problem, but with this fourth one I had to force myself to eat enough food – for my own health and the health of my baby.

'The messages really helped us, because we did not know most of the things. We used to come to antenatal clinics, but we didn't take them seriously: sometimes we came late and missed the health education talk at the start.

'We were encouraged to attend the antenatal clinics in good time, so that we also heard the health education talks.

'After having had a safe delivery and looking at the benefits I got, I am also now involved in encouraging pregnant women in issues of nutrition and attending clinics in good time.'

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Renovations, repairs and restoring faith in medical facilities

Ngana medical facility in Karonga District, Malawi. Located in a remote and very hard-to-access area, the small medical facility offers a range of services, such as deliveries, antenatal and postnatal care, and general medical checks. Credit: Christian Aid/Tomilola Ajayi

The context

While Malawi has made great strides in healthcare in recent years, the obstacles facing clinicians in rural facilities are far too many.

Healthcare workers in Malawi – particularly rural areas – operate in extremely difficult conditions. In a country whose government is already stretched, and where the sector is largely under-resourced, medical staff are forced to do their jobs in often old, dilapidated buildings.

This only serves to hinder attempts to improve supply and use of quality health services for the poorest and most vulnerable populations – including pregnant women and breastfeeding mothers.

In light of this significant obstacle, the UKAM programme is upgrading six health facilities during the lifecycle of the programme, to help improve the supply of maternal and neonatal health services in Karonga.

One centre that has benefitted is the Ngana medical facility: the facility is in a remote and extremely hard-to-reach part of Karonga, nearly 60km from the district's centre. Steep, rocky roads leading to the centre make it a long and arduous journey for a 4x4 vehicle.

The centre has a vital role to play in this remote part of Karonga. The facilities has a dozen rooms offering a range of integrated services, such as deliveries, antenatal and postnatal care, immunisations, admissions, a dispensary and general medical checks for women, children and men.

And yet, it has had no running water, no toilets, no electricity and was in urgent need of a facelift – no renovation work had been done since it built over three decades ago, in 1985. Although the facility had solar panels to run fridges, there was no power for lights. 'It was in a poor state of disrepair,' says nurse technician Josiah Saidi, who is helping to oversee the restoration and repair work.

'There used to be bats inside the building, which wasn't sanitary. It was hard to do deliveries during the night, because there was no electricity and staff had to use a lantern,' adds Isaac Phiri, project coordinator for Adventist Health Services (AHS), Christian Aid's partner who is implementing this element of the UKAM programme.

This state of neglect was such that is was putting patients off from using the facility, including pregnant women, says Isaac.

The transformation

Now, new ceilings have been installed throughout the facility, the drug dispensary has been painted and given a new shelving system, solar panels have been installed to provide electricity for lighting, and rooms have been painted and decorated, including the labour and post-natal wards.

Our partners believe the centre has been fully renovated, they will see an increase in patient numbers and an impact on maternal health outcomes. Joseph Kasililika, Safe Motherhood Coordinator for Karonga District, says: 'Looking at our labour wards in the district, they were in a very poor state.

'I think the renovations will bring motivation and encouragement to healthcare providers and even to the mothers in Karonga. Now that the Ngana facility has been renovated, we feel this is going to have a big impact'

Isaac Phiri adds: 'Before, women went to deliver at a traditional birth attendant (TBA) because the TBA's home was in better condition than the hospital. Now they will come to hospital instead of a TBA, as the environment is more conducive. In the future, there will be more people being attended to by skilled health workers.'

Christian Aid and AHS believe the repair work will also help to improve retention of healthcare workers stationed at the centre. Ngana medical facility is staffed by a nurse/midwife, medical assistant, and two health surveillance assistants (HSAs). To save them an arduous journey to work, the Malawian government built modest brick buildings on the site of the facility, to house staff free of charge.

However, staff were reluctant to stay in the poorly-resourced homes: some moved out within a matter of weeks, due to the tough conditions, says Isaac. He explains: 'Before, health workers didn't like it here, because their houses didn't have electricity and they were living in darkness, just relying on lamps for light.

'The UKAM project has installed solar power panels to provide lighting at the health facility; it has also installed panels in one of the health workers' houses. Since the project has given them light, staff can now attend to patients and do night deliveries without any difficulties. This has motivated them.

'There is a great improvement: the community will be very happy. Now, even if a child gets sick at night they can come and get treatment. The smell of bats has gone, you can breathe. By seeing an improved structure, we expect there will be more deliveries. We believe this improvement will create a conducive environment both for women and their babies.'

Meanwhile, at the Ngana medical facility, water and sanitation remain a challenge: the building's huge outdoor tank stopped working 21 years ago: it's rusty façade is a stark reminder of the absence of pumped water.

For now, the only water source is a borehole in front of the facility. This is despite WHO recommendations that delivery rooms have running water, to aid with prevention and control of infections.

'It's a challenge,' Isaac admits. As are the fact that the toilets are located outside the facility: without access to running water, drop toilets are the only option. 'More investment is needed. There is a lot that needs to be done here, to help women and children,' he says.

Boosting performance and quality

At Chilumba Rural Hospital, health workers have received training in Performance and Quality improvement (PQI), as part of the UKAM programme.

In the box on the right, nurse midwife in charge, Wezzie Tembo tells us how the training has helped contribute to a decline in neonatal deaths.

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'Before the training, the situation was not ideal. For example, medical equipment wasn't stored in an orderly way and this would affect the care in emergencies.

Some shortcuts that were taken contributed to poor services: the junior staff had protective equipment but were not putting them on. You could have incidents, like needle pricks. There were no cleaning schedules. We had problems with refuse disposal and with teamwork: people just did as they felt. We used to have a lot of cases of newborn babies suffering from sepsis [a life-threatening illness caused by infection]: we assumed it was due to problems with our infection prevention and control (IPC).

In August 2015 we received three days of training on Performance and Quality Improvement. We learned that IPC is not just about preventing spread of infection, but also about how you provide services. We also learned how to arrange equipment and about the importance of setting aside a day for general cleaning. It's about teamwork.

There is a great difference – now, when we go to labour ward, I don't have to tell junior staff to dispose of things: they take initiative.

In September 2016, an assessment carried out by a 'support service delivery project' showed we had really improved. We got a 78% rating, which was up from our previous rating of around 30%. [These assessments use a standard tool to rate the facility's cleanliness, waste disposal, availability of resources, quality of care etc.]

I'm seeing a difference. The neonatal death rate has really improved – in three months, we have had just one death. Before the training about five babies would die in a month. It has significantly improved.

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