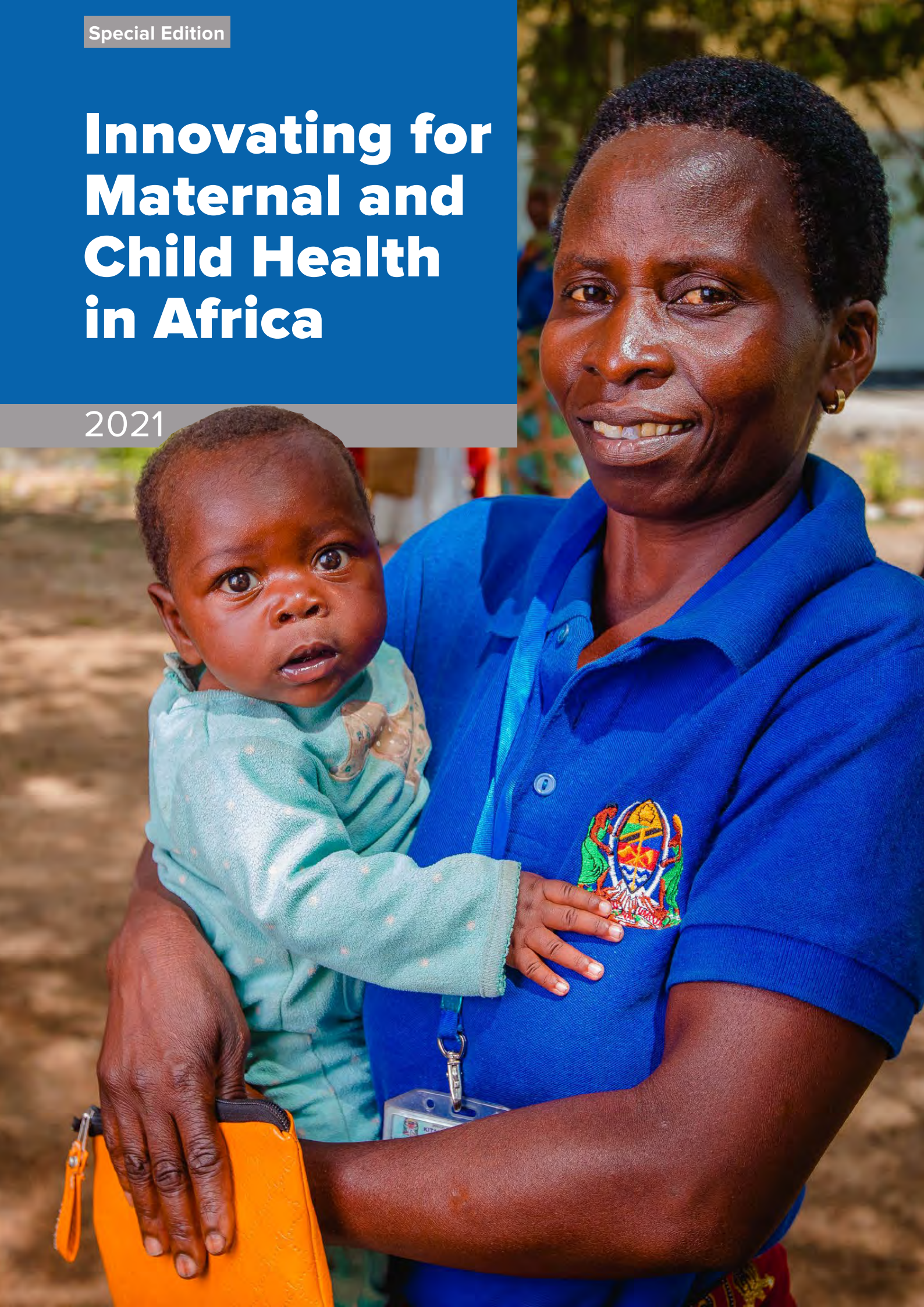
Special Edition

Innovating for Maternal and Child Health in Africa

2021



Contents

Editorial

We believe no woman should die while giving life and that every child should grow up healthy and be a productive member of society. A strong health system is key to achieving this reality. There are many existing yet removable barriers to healthcare, and sometimes more than one barrier affects access to quality care for women and children.

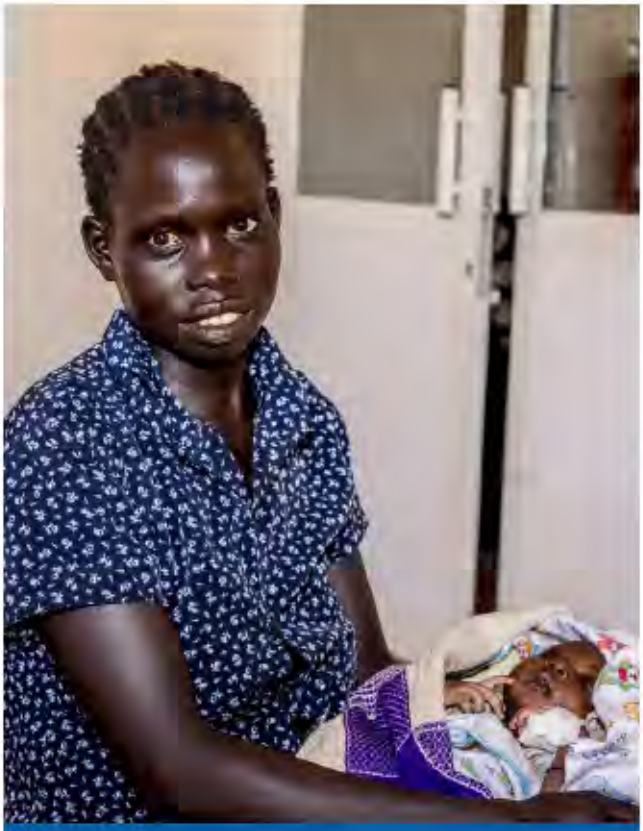
According to the WHO, maternal health refers to women's health during pregnancy, childbirth, and postpartum. For Africa to achieve targets of reducing maternal deaths, there is a need to ensure equity in access to needed health services.

The third Sustainable Development Goal aims to ensure healthy lives and promote wellbeing at all ages. The first two targets of this goal aim specifically to improve maternal and child health. Significant and diverse investments need to be made to address the systemic barriers and strengthen health systems in sub-Saharan Africa.

For this reason, since 2014, the Innovating for Maternal and Child Health in Africa (IMCHA) Initiative seeks to improve maternal, newborn, and child health outcomes by strengthening health systems, using primary healthcare as an entry point. IMCHA has supported 19 research teams in 11 countries in sub-Saharan Africa to test innovative approaches. The research teams are implementing these research projects to inform evidence-based decision-making and interventions based on good practice.

On their own, research findings are rarely sufficient to trigger policy or programmatic actions to improve people's health and wellbeing. Researchers and donors have grappled with the best way to promote compelling findings and boost the uptake of research evidence among policymakers. For this reason, the Initiative has two HPROs: one in East Africa and one in West Africa. The East Africa HPRO is made up of a consortium of the African Population and Health Research Center (APHRC - Lead), based in Kenya; the East, Central, and Southern Africa Health Community (ECSA-HC), based in Tanzania; and Partners in Population and Development (PPD) – Africa Regional Office, based in Uganda. The West Africa HPRO is the West African Health Organization (WAHO), based in Burkina Faso.

The IMCHA Initiative has been implementing a three-pronged approach: generating evidence, influencing policy and programming, and implementing best practices through effective interventions.



© APHRC

> **We believe no woman should die while giving life and that every child should grow up healthy and be a productive member of society.**

This newsletter focuses on the six countries; Ethiopia, Malawi, Mozambique, South Sudan, Tanzania, and Uganda supported by the East Africa HPRO. We share the impactful stories on research done on access to quality services, community engagement, and human resources for health to improve the health outcomes of women and children.

Enjoy reading.

Increasing the use of maternal waiting areas in Ethiopia

Most maternal deaths occur in Africa, in settings where pregnant women must travel great distances to access health facilities. The WHO recommends using maternal waiting areas (MWAs) to address geographical barriers to accessing health facilities. However, a study in Ethiopia demonstrates, the decision to make use of this seemingly simple solution is more complicated than it appears.

Barriers

Maternal waiting areas are residential homes near health facilities where pregnant women can live while waiting to give birth. These have been cited in scientific literature since the 1960s. However, it was not until the 1990s that the WHO shifted its focus to maternal waiting areas to deliver essential obstetric care.

With their inclusion in the safe motherhood programs, MWAs have become a popular part of health systems in developing countries. One of these countries is Ethiopia, where MWAs have been adopted in primary health care units and communities to improve maternal health outcomes in rural areas.

A recent study in Jimma Zone, Oromia, southwestern Ethiopia, found that women with younger children are less likely to use MWAs because they have nobody to look after their children. Women who have had previous childbirth experiences at home with no complications were less inclined to use the service. The study found that in most households, the decision on whether or not to use the MWAs lies with the husbands, who often do not want their partners away.

The costs associated with staying at the MWAs, such as transport and food, are also discouraging, especially for poor women. Those with family members or neighbors who can step in and carry out house chores in their absence find it easier to attend MWAs. For cultural reasons, women will not use a facility where the attendants are male.

Solutions

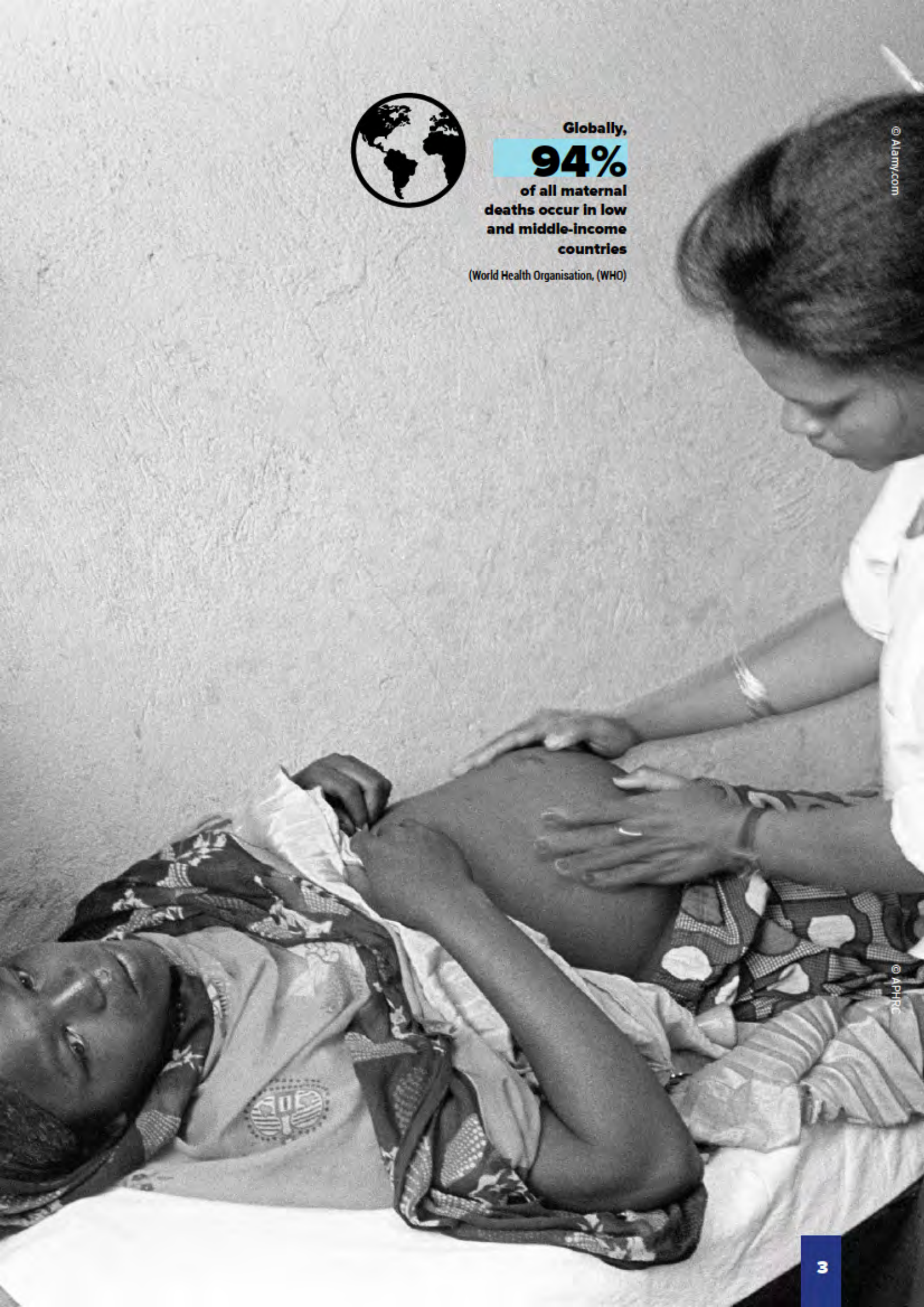
The study made an important discovery: health extension workers (HEWs) are key to influencing women's attitudes towards MWAs. HEWs have the power to convince women who live far from health centers or women with high-risk pregnancies to consider MWAs, by, among other things, emphasizing to them the dangers of not doing so.

Further, the HEWs are vital in promoting the use of the service to the community at large. Health extension workers will or will not promote the maternal waiting areas, depending on their opinion of the facilities' quality. Lack of water, food, and private sleeping areas, and unhygienic conditions make some MWAs uninhabitable. Where HEWs are satisfied with the quality of the service available at MWAs, they engage and negotiate with the women's husbands and community members, persuading them to take on the women's roles and responsibilities at home so that they can go to MWAs. With more training, resources, and opportunities to participate in policy processes, the role of HEWs in expanding the use of health care facilities among the most vulnerable can be strengthened.

In addition to the influence of HEWs, the study also found that a woman who has used a health facility in the past is likely to consider the MWAs. The communities help maintain MWAs through monetary and in-kind donations. This also encourages women to use them.

For women in rural areas, the question of whether or not to give birth at a maternal waiting area is riddled with complexities. Though, with HEWs in the picture, women and families have the support to navigate these barriers.

To read more about this study, click here



Globally,

94%

of all maternal deaths occur in low and middle-income countries

(World Health Organisation, (WHO)

© Alamy.com

© APHRC

Health extension workers, critical to spreading information on maternal health

Poor women in remote rural areas of middle and low-income countries are least likely to receive adequate health care during pregnancy and childbirth due to, among other things, lack of information (World Health Organization, WHO). Despite this, little research has been carried out on which sources or channels communities in rural areas prefer to receive health information and why. A study carried out in south western Ethiopia demonstrates that health extension workers (HEWs) are highly trusted sources of health information. They can, therefore, help improve maternal health for mothers in rural areas. The study also found that rural communities prefer to receive health information through in-person interactions, traditional storytelling, and radio.

Trusted sources of health information

The study carried out in Gomma, Seka Chekorsa, and Kersa districts of Ethiopia's southwestern Jimma Zone explored different sources of health information and trusted channels in rural communities. Through a series of in-depth interviews and focus group discussions, the study found that the rural communities demonstrate a clear preference for information from HEWs in making health decisions. A similar study in Nigeria found that HEWs are easily accessible, reliable, and unbiased as in Ethiopia. The in-person interactions during home visits by HEWs build good rapport and trust. A comment by one female community leader from Ethiopia's Kersa district demonstrates the positive role HEWs play in promoting maternal health services:

"HEW give us awareness by going house to house to reach each household. They also give information when mothers go to their office. In this way, mothers are advised to access health care and to modify their lifestyles".

Another female community member echoes this sentiment:

"We prefer health extension workers. We have many reasons: we meet them physically and answer our questions empathetically. Sometimes health professionals from district health office came and taught us about health and healthy life like utilization of maternal and child health cares".

Other trusted sources of health information are government officials, healthcare providers, community leaders, Male and Women Development Armies, family members, religious leaders, and even guests from outside communities.

Communication channels

The communities most prefer to receive health information through face-to-face communication because it provides an opportunity for dialogue between providers and receivers of information. Low literacy levels among rural mothers make it difficult for them to understand complex messaging through radio or TV. One male community member from Kersa district summed it up as follows:

"Teaching community through face-to-face conversation is better than media. Most people didn't trust what they heard from television or radio. Therefore, it is better to teach through face-to-face communication to make it lively".

Despite this community member's views, the study found radio to be the most popular mass communication channel because most households have them, and they do not require high literacy levels to operate. One female community member explained the other reasons why radio is popular:

"Radio is preferable to reach everyone in the locality. The HEWs can't cover everywhere as the radio does. The appropriate timing for listening radio is after 2:00 pm since all household members are free at this time".

Traditional communication methods like dramas, role play are also popular because they are entertaining ways to deliver health messages. Community meetings are efficient ways of reaching large numbers, as a male community member from Gomma District explained:

"Look, if we provide information through a meeting, like a group of 300 people per village, then, these 300 peoples teach their family members. At last, we can educate the whole village. Therefore, if we want to be successful, a meeting is the best option than other modes".

A smaller number of community members prefer television because they can watch live demonstrations, while even fewer like leaflets for reference and training.

In Africa, most modern health care services are clinic-based and urban-centered, leaving behind nearly 60% of rural populations. Health extension workers play a critical role in health messaging, addressing an information gap on maternal health in rural areas. Governments should take a further step and invest in strengthening the role of HEWs through regular training, educational opportunities, and compensation. Radio is also key in reaching large numbers with maternal health messages, mainly if they use traditional storytelling.

To read more about this study, click here

Solutions to improve the use of Bubble CPAP to save newborn lives in Malawi

Malawi has the world's highest rate of preterm births. Many preterm newborns die as a result of the poor management of breathing difficulties. A cost-effective variant of bubble CPAP, a ventilation system for newborns, was introduced in Malawi to help reduce the infant mortality rate. Despite this, newborns continue to die at a high rate. A study has uncovered the reasons for this failure and highlighted possible solutions, some of which have been tried in Kenya, Nigeria, and South Africa.

Factors and mitigating strategies

One reason bubble CPAP is not effective in Malawi is that staff are not adequately trained. Some of the medical staff interviewed in the study said they received formal one-time training on using the Pumani bubble CPAP system, which they then passed on to their colleagues informally. This means that over half the staff do not have formal training. Some nurses and clinicians said they do not feel competent to operate the equipment or wean babies off bubble CPAP. Delays in weaning babies off CPAP means delays in using it on other neonates in respiratory distress.

The interviewees say comprehensive and ongoing training of clinicians and nurses together would help them feel more confident. The training should provide consistent information on when to initiate bubble CPAP, monitor a newborn on the treatment, and wean a baby off it. Mobile platforms such as WhatsApp can be used to teach and supervise healthcare workers and ensure consistency of training. This has been trialed in Kenya, Nigeria, and South Africa.

A second factor contributing to the poor use of CPAP is power dynamics within medical teams. Even where nurses are trained on bubble CPAP and encouraged to exercise their discretion in using it, clinicians have higher decision-making authority. They can question or overrule a nurse's decision. This leads nurses to hesitate to initiate bubble CPAP. The study calls for deliberate efforts, supported by policy, to empower nurses in clinical decision-making.

Closely related to power dynamics is poor communication between clinicians and nurses. Newborns are at risk in situations where these two groups do not communicate effectively. One district hospital nurse's testimony illustrated this communication gap:

"That one time, the clinician ordered CPAP on the baby without telling us, and he went. Maybe he forgot, I don't know, but he didn't tell us (nurses). We were also busy, and it took us time to see the orders. It was morning around 8:00, and by the time we discovered that the baby was supposed to be on CPAP, it was around 4:00 pm."

Also, the failure to properly communicate to sick babies' mothers or guardians why the bubble CPAP is required leads them to resist it, with negative consequences.

Nurses in district hospitals have a high burden of care, which negatively affects their ability to monitor bubble CPAP treatment properly. Even in rare cases where nurses are explicitly assigned to the nursery, they must divide their time between labor, delivery, and post-natal care wards due to staff shortages. This means that they cannot monitor bubble CPAP as often as required. Further, the practice of rotating staff to other wards means that staff trained on the bubble CPAP equipment often leave untrained staff behind in the nursery. The shortage of staff makes the few available personnel to make difficult choices and also poses a real danger to the lives of newborns. One nurse's story illustrates this:

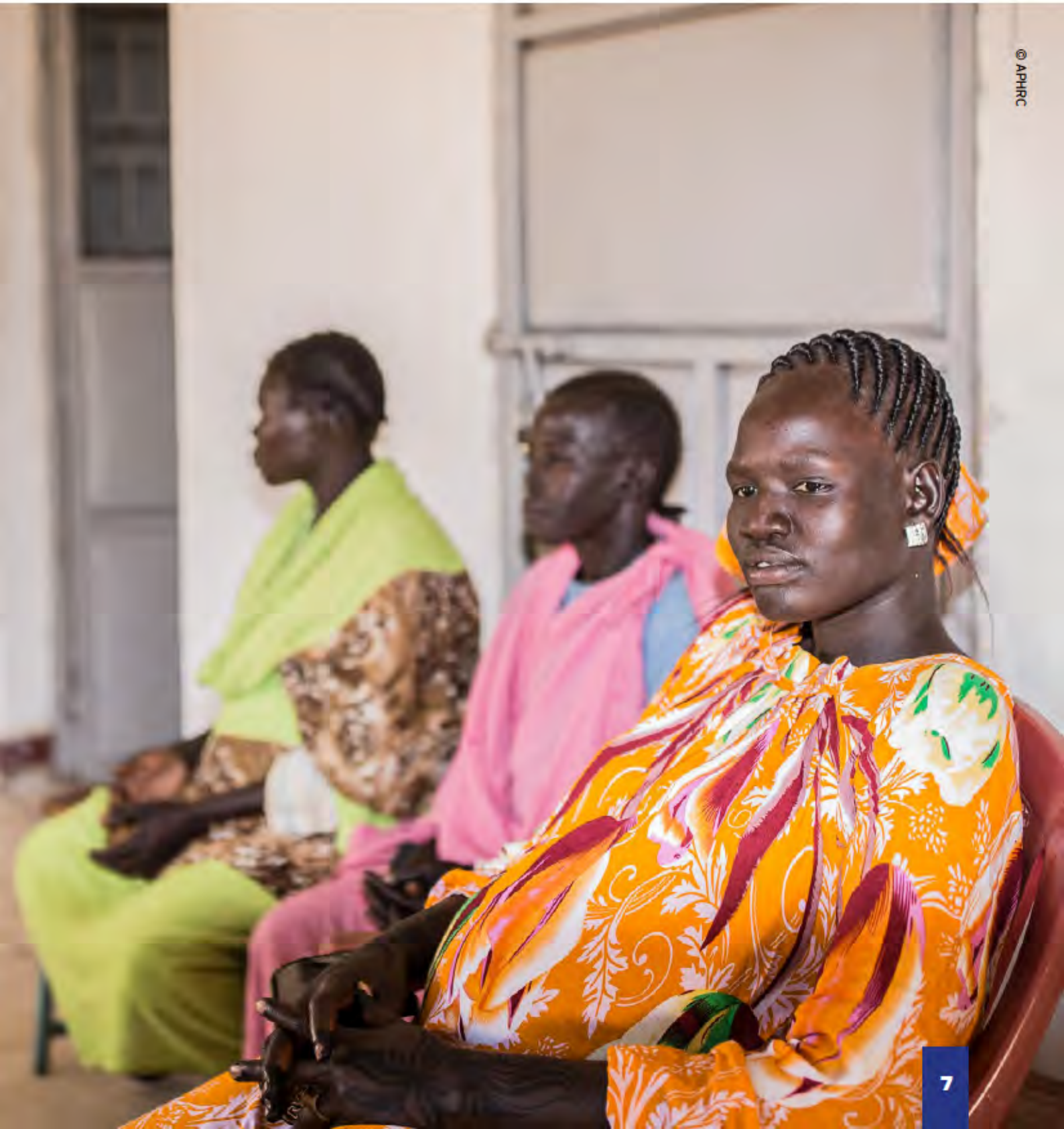
"I know of a nurse who was on duty and alone during her shift. She had two patients, a child needing CPAP and a woman with severe bleeding. She had to choose who to attend to and went to save the woman who was bleeding."

To mitigate staffing problems, participants in the study recommend the designation of nurseries as wards in their own right and for nurses trained in the use of the bubble CPAP equipment to be dedicated to the nurseries.

In addition to staffing shortages, infrastructure problems, specifically frequent power outages, lead to delays in initiating bubble CPAP treatment in neonates suffering from respiratory distress. The lack of appropriately-sized accessories for the CPAP equipment, such as infant-sized nasal prongs, is also harmful to newborns.

These factors together undermine the effective implementation of the Pumani bubble CPAP. Mitigating measures, including those that have proved effective in other African countries, can and should be tried in the Malawian context to improve CPAP implementation.

To read more about this study, click here



© APHRC

Research tool reveals state of care for mothers, newborns in Malawi hospitals

According to a study, the standard of care for newborns in Malawi's district hospitals needs significant improvement if the country aims to reduce its neonatal death rate. Malawi has committed to reducing its neonatal mortality rates from 27 to 15 deaths for every 1,000 live births by 2035.

Malawi already enjoys the distinction of being one of the few countries in Sub-Saharan Africa to have achieved the Millennium Development Goal of reducing under-5 mortality by two-thirds between 1990 and 2015. However, the rate of death of the country's neonates born in hospitals remains high. This warrants a closer look at what is happening in district hospitals, where most births take place.

The study used the WHO's Integrated Maternal Neonatal and Child Quality of care Assessment and Improvement Tool to examine conditions in four district hospitals in southern Malawi. The study found all the hospitals struggling with staffing shortages, poor infection control, infrastructure, and management of respiratory complications in newborns. These had disastrous consequences for the newborns.

Findings

None of the hospitals assessed had a full-time obstetrician-gynecologist or a pediatrician on staff. Instead, births, including Caesarian deliveries, were conducted by clinical officers or by general doctors with on-the-job training. A gynecologist or a pediatrician visited the hospitals approximately once a month, sometimes less frequently. The unavailability of specialists meant that infections in newborns went undiagnosed.

Further, **the key facilities at the hospitals assessed did not meet WHO standards**. Some of the hospitals did not have a consistent supply of electricity or water. Further, researchers found that the labor and delivery wards lack adequate space and lighting. There was also no heating equipment for neonates, neither did any of the hospitals have an infusion pump for newborns.

Alarmingly, there was **inadequate prevention of infection at all four hospitals, despite there being infection control policies in place.** Infrequent hand hygiene, irregular disinfection of the facilities, and a lack of sterile gloves and soap also contributed to the hospitals' inability to control infection effectively.

Also concerning, the study found that clinicians **and nursing staff could not recognize or treat jaundice effectively.** Management of jaundice is key since high bilirubin levels in newborns can lead to irreversible brain damage. The diagnosis and management of convulsions were poor.

The **monitoring of sick neonates was found to be inconsistent.** Nurses reassessed sick neonates daily and effectively. However, doctors reassessed patients irregularly in the week and not at all on weekends and public holidays. This meant that complications were not being attended to by a specialist on time.

All the district hospitals assessed had the equipment to manage respiratory problems in newborns, **but the staff was not always trained to use it.** Essential antimicrobials and anticonvulsants were available but in minimal stock and not within easy reach of the nurseries.

Overall, the study found the hospitals examined were effective at promoting early and exclusive breastfeeding. Activities such as carrying out neonatal resuscitation, screening, preventing and managing transmission of infectious diseases from mother to child, and providing counselling for mothers met WHO standards. However, **the monitoring of newborns' breathing and body temperature was not done regularly.** There were no records for breastfeeding or of mothers' health in all four facilities. While staff knew how to manage preterm labor, little was being done to prevent it.

All the district hospitals assessed kept well-stocked and efficiently-run laboratories that met WHO standards of care. Most essential tests were available in the labs at all four facilities. All test results were available within 45 minutes to an hour. However, **none of the labs had the necessary tests to manage sick newborns, such as blood gas analysis, urine, or blood cultures.** This meant there was a poor diagnosis of neonatal sepsis.

The **WHO tool is not perfect in that it did not provide a complete picture of the conditions at the four district hospitals.** It did not, for example, consider delays caused by power outages, the rate of ordering tests, nor did it take into account whether or not there was effective coordination between the staff from ward to lab.

Even so, the WHO research tool revealed the areas where more effort is needed to raise the standard of care at Malawi's district hospitals for mothers and newborns.

To read more about this study, click here

Media campaign on family planning wins hearts and minds in northern Mozambique

A media campaign created as part of the IMCHA supported study has increased knowledge of and changed attitudes towards family planning (FP) and sexual and reproductive health (SRH) services among teenagers in a community in northern Mozambique.

Mozambique has a high incidence of maternal and infant mortality. This is due, in part, to insufficient knowledge about available SRH services and the low use of family planning. The campaign pointed to the value of the media as a tool that can help Mozambique's government achieve its goal of enhancing access to family planning and sexual and reproductive health services.

According to the study, low literacy levels and poor communication between health care professionals and the community highlighted the need for a different approach to disseminating quality, comprehensive information about contraceptive methods.

The eight-month media campaign targeted Macua-speaking communities in Natikiri district, Nampula province, northern Mozambique, living in suburban and rural areas. It consisted of the following:

Two weekly 3-minute radio broadcasts (spots) and discussions. Distributed twenty portable radios and USB sticks with the spots to six local health committees (LHC).

Three 15-minute theatre performances about maternal and child health messages, performed in village centers.

In addition, for three months, **60 volunteer family health champions visited families in their homes**, spreading key messages on sexual and reproductive health and family planning.

In addition to these interventions, the ministry of health sponsored TV spots that ran throughout the above media campaign.

The radio broadcasts reached an estimated 200,000 people, the theatre performances about 1,750, and the volunteer family health champions reached 1,340 people in Nampula city.

→ Results

- **A survey carried out in Natikiri after the media campaign revealed that teenagers aged 15-17, most of whom were not using FP methods, indicated that they were motivated to start using FP.** The 15-19 age group demonstrated greater awareness of SRH concepts.
- **Young people's understanding of family planning expanded as a result of the media campaign.** They understood it not just as a means of avoiding pregnancy but also as a means of delaying having children and as a way to "have fewer kids."
- **The community's knowledge about the SRH services offered at hospitals also expanded.** These include FP, sexual health services, prenatal consultations, delivery, and newborn visits.

Hope for the long-term

Some positive developments for the long-term have emerged from the study. The first is the validation of radio as an effective tool for spreading information on FP and SRH services and, eventually, changing behavior on SRH services. The second is the critical role that volunteer family health champions can play in changing attitudes towards SRH services in hospitals. Local health centers are empowered by policy and mandated by law to conduct outreach on FP and SRH to communities, but they are not doing so effectively. This study shows that family health champions can solve this problem and bring the public health system and patients closer together.

Mozambique is still far from achieving its goal of enhancing access to family planning and sexual and reproductive health services. However, this short-term study reveals a model that, can be used to make that goal a reality.

The radio broadcasts reached an estimated

200,000 people

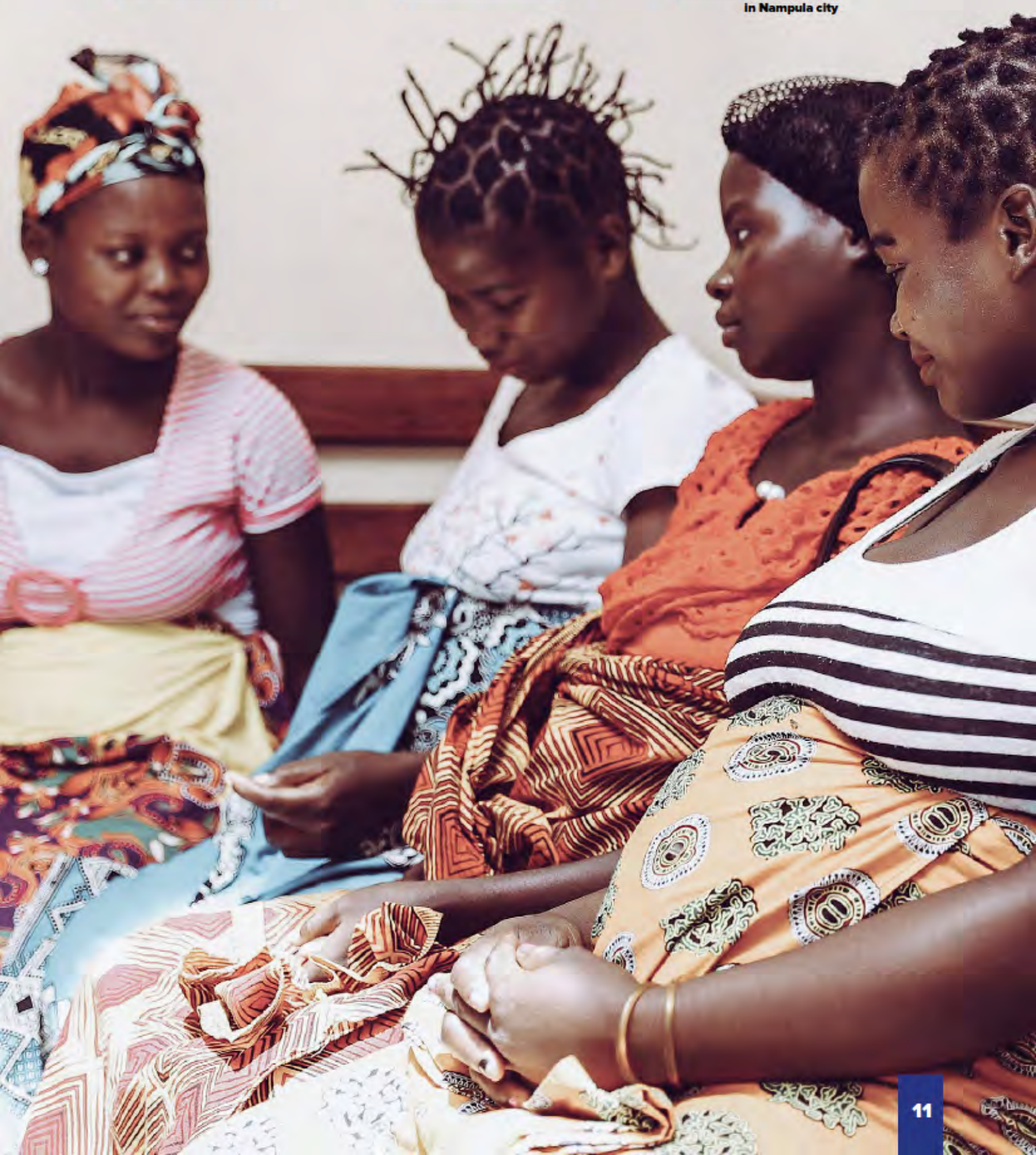
The theatre performances about

1,750 people

the volunteer family health champions reached

1,340 people

in Nampula city



Barriers to the provision of quality healthcare services for mothers, children, and adolescents in South Sudan

Since gaining its independence in 2011, South Sudan has made reproductive, maternal, newborn, child, and adolescent health (RMNCAH) a priority. The government of South Sudan has put in place the Basic Package of Health and Nutrition Services (BPHNS), prioritizing safe motherhood, essential obstetric care, family planning, and essential child health. However, this policy is not being effectively implemented, and a study sought to find out why.

The study examined 39 official documents and held interviews with staff from the South Sudan Ministry of Health (MoH) and implementing partners. Data was analyzed according to the World Health Organisation (WHO) health system building blocks. The building blocks are service delivery, health workforce, information, medical products, vaccines and technologies, financing, and leadership and governance (stewardship).

The study found multiple barriers that prevent the effective implementation of the BPHNS policy.

Findings

The suspension, in 2012, of South Sudan's oil production, cost the country its primary source of income. That loss was felt acutely in the health sector. **The government can only allocate 2-3% of its total annual budget to healthcare, compared to the 15% recommended by the Abuja Declaration.** Even those allocations are difficult to access. As an employee of the MoH put it:

"... [the government authorities] do allocate, but when it comes to getting the funds, it becomes very difficult. Each time you request from the Ministry of Finance, they say the funds are not there. Last year, we were able to access only 30% of the total budget allocated. They allocate, but the physical money, they do not give it."

The international community has been funding the MoH efforts to supply primary health care facilities with essential vaccines and medicines needed to manage childhood illnesses for antenatal and obstetric care. Even so, **there are frequent shortages due to insecurity and stock outs at the central store.**

Other barriers to RMNCAH services are logistical, such as **a lack of transport to hospitals located a long way from patients' homes.** One interviewee was quoted as saying:

"Meen hospital [primary healthcare unit (PHCU)] and Maper hospital [primary healthcare center (PHCC)] are very far from us. We are actually in the middle between Rumbek and Maper hospitals. If you want to go to the hospital, you can spend one day to reach there."

The target groups for RMNCAH are often unable to pay for the hospital services. One interviewee said:

"I only attended one antenatal care service during my pregnancy. Everything here (at the hospital) is at a cost, and we are suffering financially. The little (money) we have is for buying some food."

Conflict is a barrier to accessing RMNCAH services, where hospitals are located in enemy territory.

"Our place is also in the middle of enemies who frequently attack us. Some of us fear that if we go to deliver in the hospital and the enemy comes to attack in our absence, there will be nobody to lead our children to a hiding place."

The study found that in some contexts, there is cultural pressure on women to increase the size of their families so that few women are interested in family planning services:

"If you are married and already living with your husband and do not have a child, the husband can leave you and tell you to go back to your family."

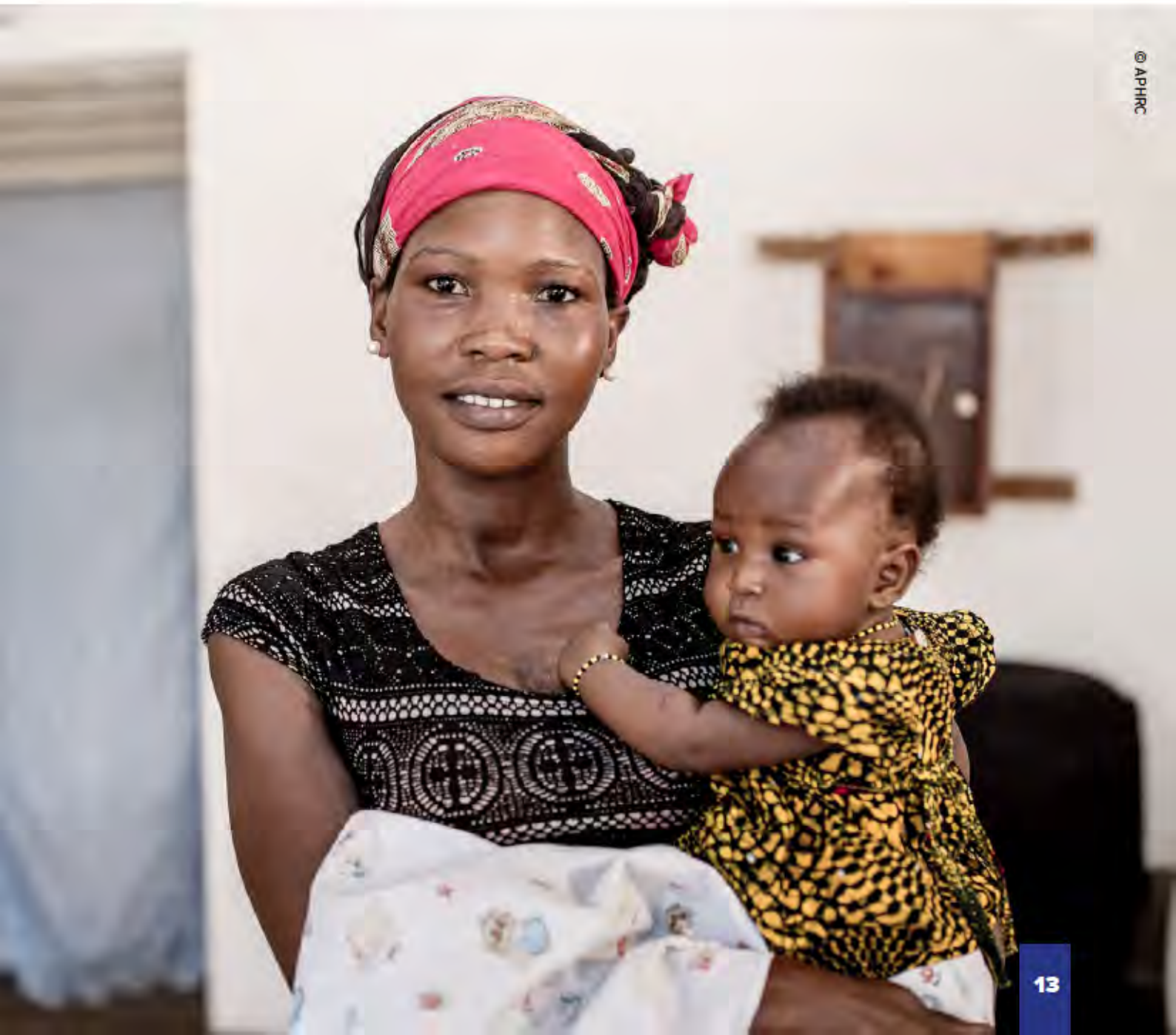
Pregnant women may expect high standards of services at primary health care facilities. However, in reality, the study found, **less than 9% have the essential equipment to identify and manage childhood diseases like ultrasound machines and ambulances, all requirements of the WHO health system building blocks**.

The country faces a critical shortage of skilled health workers such as clinical officers, nurses, and midwives. Health facilities rely on traditional birth attendants and community health workers who do not have the training to provide RMNCAH services effectively. They cannot identify or manage serious obstetric problems, neither can they offer young people sexual and reproductive health services. At the government level, the lack of skilled healthcare manifests as a lack of technical staff able to develop, implement or monitor health programs around RMNCAH policies such as the BPHNS.

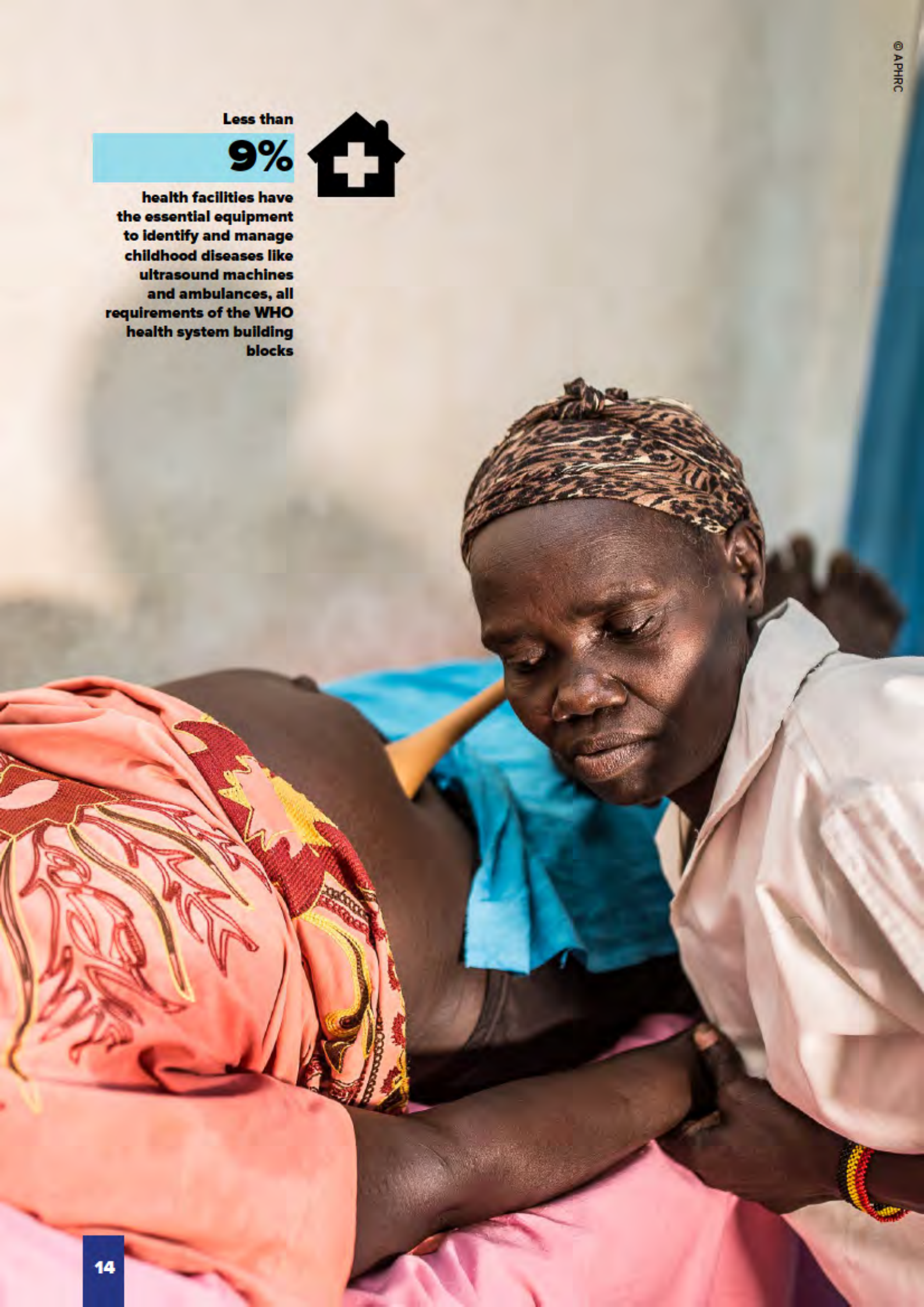
Recommendations

The study concluded that addressing South Sudan's capacity and leadership challenges in providing RMNCAH will require creative home grown solutions such as increasing donor aid so that government allocations for health can adequately address the shortage of medical supplies and essential medicines. Closely related to this, government funds must be streamlined to support the RMNCAH priorities. The recruitment of skilled medical staff from the South Sudanese diaspora or neighboring countries to deliver RMNCAH services is vital. The government could provide financial and non-financial incentives to encourage private players to develop local training facilities for medical staff.

To read more about this study, click here



© APHRC



© APHRC

Less than

9%

health facilities have the essential equipment to identify and manage childhood diseases like ultrasound machines and ambulances, all requirements of the WHO health system building blocks

How Tanzania's spousal escort policy frustrates antenatal health care

Good care during pregnancy is important for the health of mothers and the development of unborn babies. Antenatal care contributes to a woman's overall good health, links her and her family to the health system, and increases her chances of using a skilled attendant at birth. The World Health Organisation (WHO) puts great store on care during pregnancy because, by its own estimates, 25% of maternal deaths occur during pregnancy.

But antenatal care isn't the norm for millions of women across Africa. In Tanzania, for example, the numbers are low. Even though over 90% of pregnant women attend at least once, only 51% make four or more visits during their entire pregnancy, according to the Tanzania Demographic and Health Survey. Only 24% of women make their first antenatal care attendance before the fourth month of pregnancy.

WHO and the Tanzanian Ministry of Health's guidelines recommend that a woman attends her first antenatal care clinic as soon as she conceives and no later than the 12th week of her pregnancy.

There are several reasons why women don't go for antenatal check-ups. These range from lack of knowledge and past experience with safe delivery, traditional gender roles, shame and stigma, superstitions, rude language from health care workers, and shortage of health workers in health facilities.

But our recently published research identifies an important additional barrier preventing women in rural areas from accessing and using antenatal care services: a new government policy that requires male partners to accompany pregnant women for their first antenatal visit. Our research, which the Innovating for Maternal and Child Health in Africa, shows that this is a major deterrent, exacerbating an already bad situation.

Findings

Tanzania requires that **male partners accompany pregnant women for their first antenatal care visit**. The policy has been implemented since 2004 as part of the National Guidelines for the Prevention of Mother to Child HIV Transmission by the then Ministry of Health and Social Welfare. It was put in place to ensure that men get more involved in maternal health issues and ensure couples undergo HIV testing to prevent mother-to-child transmission of HIV/AIDS.

Even though the policy carries good intentions, we found during our study that it constituted a barrier to care in numerous ways. These include additional costs making return visits, delayed care, or outright withdrawal of care seekers.

As part of the study, researchers held 40 group discussions with men and women in 20 villages in Kilolo and Mufindi – rural districts in Iringa Region, Tanzania. In addition, they conducted interviews with healthcare workers, members of health facility committees, and community health workers. Broader stakeholder engagements were also done at the ward level, where 450 people participated.

We found that **pregnant women who were not accompanied by a male partner on her first antenatal care were asked to provide an introductory letter from a village leader**. Those who did not have the letter were turned away and unable to access services. As one woman said in the interviews:

"I was sent back home two times because I did not come with my partner."

Women incur travel costs for every visit to the health facility. Being sent away means that they will incur additional costs. As a result, some give up on antenatal care services altogether. In addition, the researchers found that pregnant women who were not accompanied by their male partners for various reasons delay their first antenatal care attendance. And in a bid to circumvent the escort policy, the researchers noted that some women resorted to "hiring" spouses to access care. One female participant in the study narrated:

"My friend and I wanted to start the antenatal care clinic together. Unfortunately, she was dating a married man who refused to escort her to the clinic. After some months, she decided to hire a person to accompany her to the clinic."

The researchers also sought to know why some men were not available to accompany their partners. They found the following reasons: the fear and stigma around HIV testing, pregnancies born out of the formal union of marriage, and distance as some men work in different towns away from their partners. **A male participant in the study said candidly:**

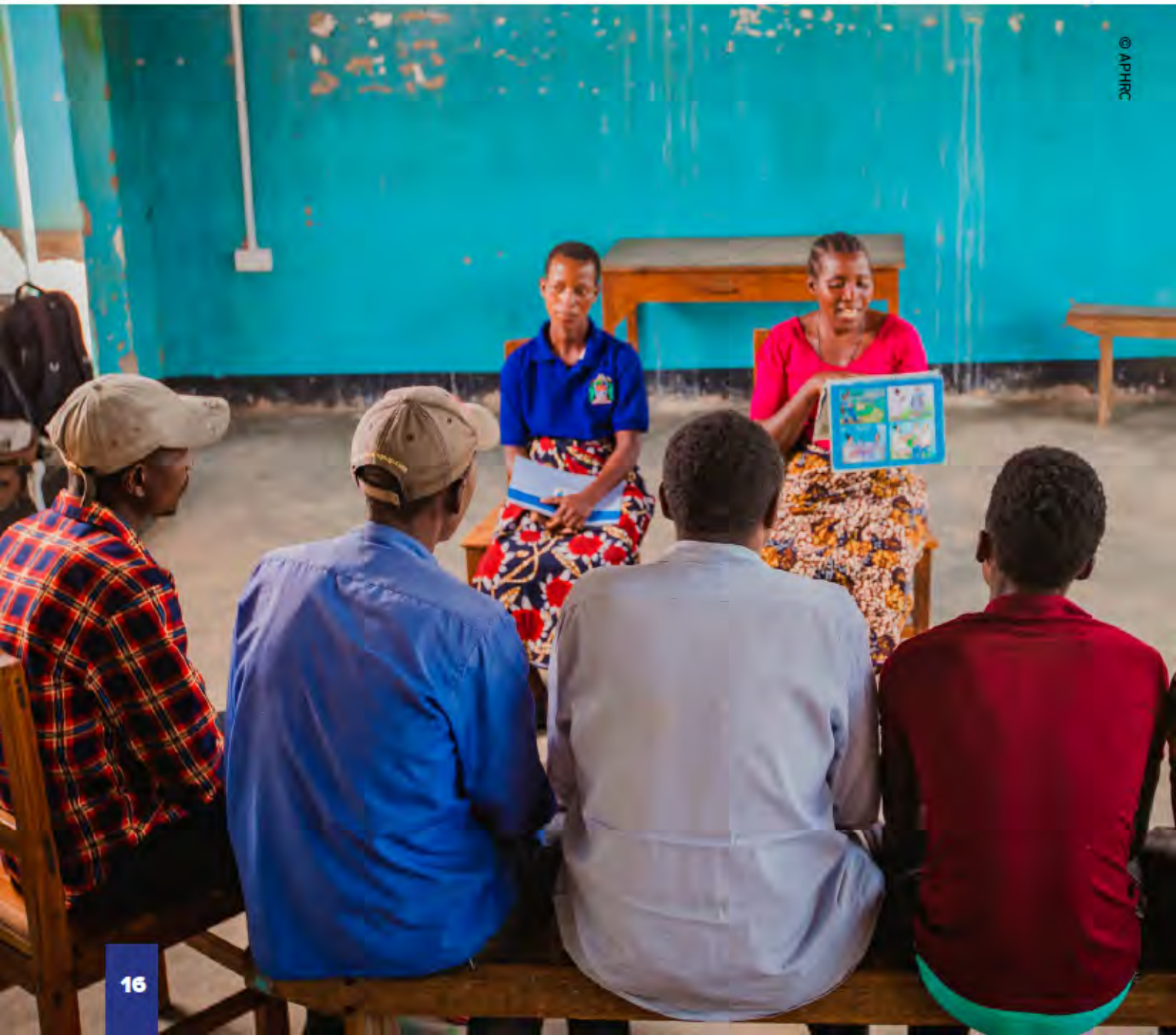
"Men do not escort their partners mainly due to fear of HIV testing. When you go to the clinics, you are required to take a HIV test as part of the antenatal care services."

Conclusions

The study recommends that the government engage the community effectively to identify other ways to improve male involvement in maternal health. We also recommended that the government clarify the implementation of the spouse escort policy to ensure that it doesn't act as a barrier to women's access to lifesaving antenatal care services.

Researchers are engaging the communities to design culturally acceptable strategies to encourage antenatal clinic attendance and male participation in maternal and child health.

This article was first published by The Conversation




Only 24%
of women make their first antenatal care attendance before the fourth month of pregnancy.
© APHRC

The number of children who die before their fifth birthday in Tanzania has dropped by nearly

60%

since 2000

© APHRC

Mothers embrace group farming to fight malnutrition

While Uganda is considered as the food basket of East Africa, some families are still going hungry, many children are malnourished, and diet-related non-communicable diseases are on the rise.

For some children in Omoro district, nutritious foods are not accessible to their families while for others, a lack of access to essential health services lead to illnesses that prevent children from absorbing food nutrients.

As such mothers in Omoro district have resorted to group farming to fight malnutrition that is common among children and pregnant women in the district.

According to health Officials from Lacor hospital, malnutrition in the district is a key health challenge but through these groups, mothers now grow nutritious foods such as vegetables, beans, millet, soya bean, sorghum among others to improve the health condition in their homes.

With the support of Mother and Child Health Lacor and South Sudan (MOCHELASS) in partnership with Lacor hospital, communities in Gulu, Amuru and Omoro districts have reached a milestone in fighting poor child spacing, adolescence pregnancy and malnutrition in the region.

Miriam Akello, from Hima village, Lakwana Sub-county in Omoro district, is among those whose families have been battling with malnutrition for over 5 years.

Akello said crop growing was the only option to fight malnutrition and other child health related diseases in their families.

"We were lacking mineral foods in the body. Our children were dying, pregnant women were facing a lot of challenges but now we have got some training through capacity building. We were taught how we can fight malnutrition in our homes through this kind of initiative," she said.

Janet Arach, a mother of four from Opit village in Omoro district said that they face a serious challenge of poor feeding in their area, something that could not be ignored.

"We didn't know that we can prevent some of these child health related illnesses. We were taken to Lacor hospital and trained on how we can fight malnutrition in our families," she said.

Morris Ogwang,the senior clinical officer in charge of Lacor Health Centre III Opit in Omoro district, told The Nile Post that setting up kitchen gardens in homesteads have helped to reduce the cases of malnutrition in the district.

"We really had this challenge of malnutrition. At least on average we were getting up to about 30 children who are under five with malnutrition. One of our interventions was to empower community sensitisation in relation to malnutrition," Ogwang said.

He said children suffering from malnutrition may not grow tall, their brains will be incapable of performing tasks of their age and they stand higher chances of dying while young.

Emmanuel Ochola, epidemiologist from St Mary's hospital Lacor who doubles as Principal investigator in Uganda for Mothers and Child Health Lacor and South Sudan project, attributed the increasing level of malnutrition in the region to post conflict in the area.

"We noted the problem of child spacing, we noted malaria, we noted HIV/AIDS, we noted diarrhoea diseases which were still killing many children and we also noted that adolescent pregnancy in certain locations was a terrible challenge in the region. Our approach as the hospital was to let the group take the lead," he said.

Agnes Kirabo, the executive director of Food Rights Alliance, a coalition of civil social organisations working in the field of sustainable agriculture and food security said there is a double burden of malnutrition in Uganda.

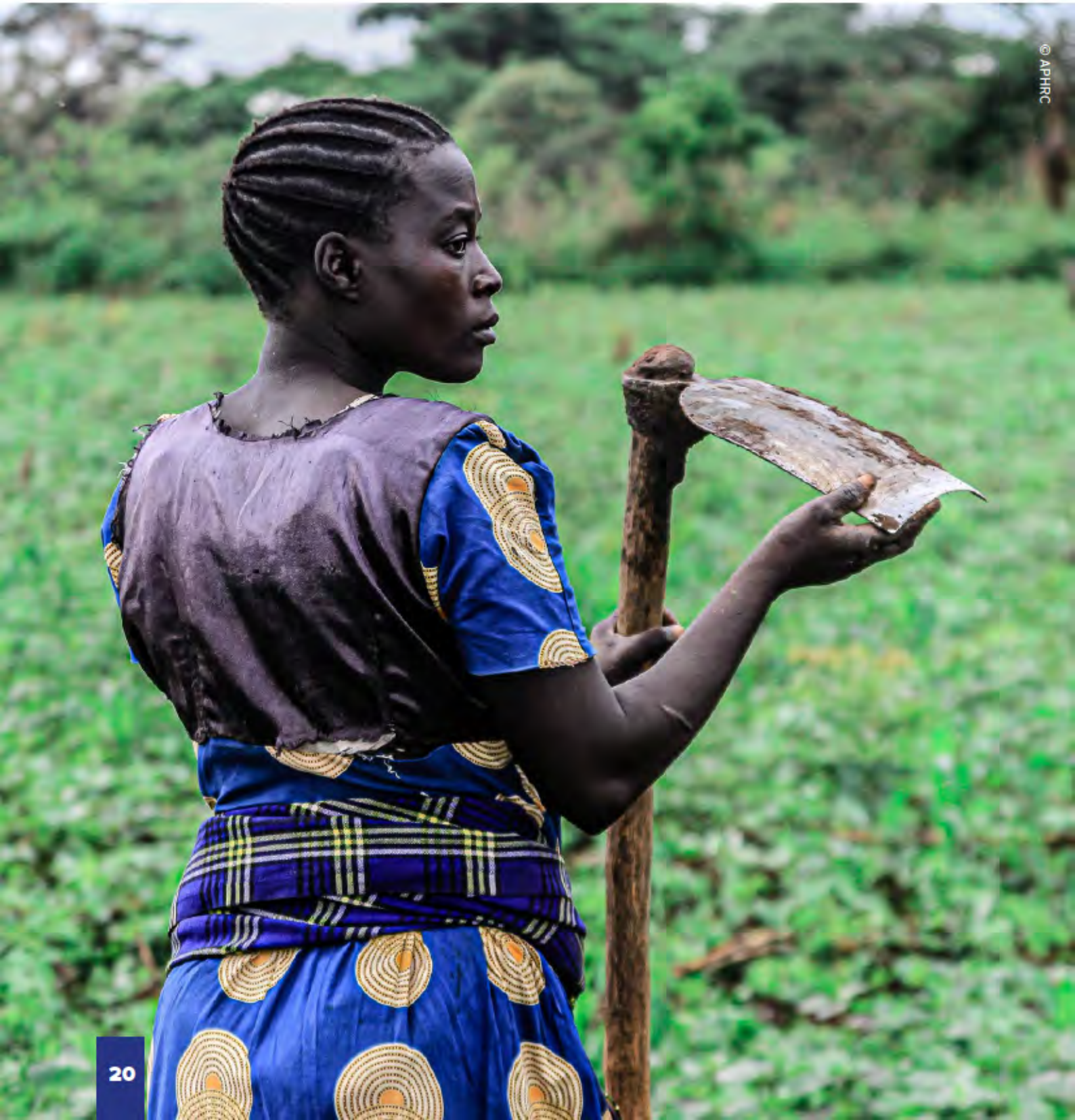
She said the children of the rich are overweight and contract non communicable diseases while those of the poor are underweight and stunted.

Dr Joyce Moriku Kaducu, the minister of state for Primary Healthcare, said we need to put a lot of emphasis on the food which is produced for the children.

"The amount of food, the quantity and the quality that is needed for the body to build and to grow matters a lot in feeding. Stunted growth is still a problem in the country as opposed to underweight. We are talking about age for height, it is not an overnight issue to deal with," she said.

Research conducted by Integrated Food Security classification in August 2020, indicates that 23% of Ugandans face high levels of acute food insecurity.

This article was first published by The Nile Post



The HPRO Model, enhancing collaboration between health researchers and decision-makers

Finding a solution to poor maternal health services remains a challenge. Improving maternal health relies on addressing the entire health system in any given country – from staffing and access to essential medicines to financing and leadership.

Interventions must also be based on robust evidence and appropriately tailored to their particular country context to be sustainable and scalable.

High-quality African-led research is therefore critical in identifying gaps in maternal health services. This research is useful to policymakers in health and finance ministries, as well as to hospital administrators. They need evidence to understand barriers to service delivery and knowledge on where to allocate resources. But research in Sub-Saharan Africa faces a range of issues. One of the most critical is meaningfully linking the evidence that researchers produce to national and subnational policy processes.

The IMCHA initiative developed a unique model - two health policy and research organizations (HPROs), one in East and another in West Africa (West Africa Health Organization), to achieve this. The ultimate goal of this unique model was to complement research teams' efforts to integrate the evidence they generate into policies and practices in maternal and child health in the targeted countries.

The East Africa- HPRO has been working with 13 research teams implementing 19 projects across Ethiopia, Malawi, Mozambique, South Sudan, Tanzania, and Uganda. The EA-HPRO has facilitated mutual learning among researchers and policymakers and strengthened individual and institutional capacities for research.

"Our work has been to ensure that research teams have an impact," explains Lynette Kamau, senior policy and communications officer at the African Population and Health Research Center – one of three organizations that make up the EA-HPRO consortium. ***"We maximize the use of evidence by facilitating early and sustained contact between decision-makers and researchers."***

The EA-HPRO also conducted training to sharpen and further develop research capacity and the translation of evidence into policy-friendly formats such as fact sheets and policy briefs. Additionally, it also conducted a political economy analysis to map relevant policies, stakeholders, and forums to understand better maternal, newborn and child health challenges in the six countries. The analysis facilitated the development of effective country policy engagement strategies. The EA-HPRO also facilitated the engagement of researchers with high-level Ministry of Health decision makers through in-person meetings, stakeholder forums, and technical working groups. These forums enhanced the national ownership of research and enabled the researchers to share evidence emerging from their projects.

One of the achievements resulting from bridging the gap between researchers and policymakers/decision makers is through one project in Tanzania. The project tackled gaps in service delivery and quality through a combination of training and skills development for health care providers.

Initial analysis by the research team on the project revealed a particular lack of medical staff qualified in emergency obstetrics care. In fact, for some providers at primary clinics, their on-the-job training was sometimes just three weeks long – and training on the safe delivery of babies was done only once. In addition, researchers found that health facility managers lacked the skills to provide supportive supervision to staff or keep adequate medical procedures records – a process called clinical auditing.

As part of the implementation research, specific training for managers made them better mentors to their staff and enabled them to track key clinical trends in their facilities. Learning materials were availed offline on computers at health facilities, as they lacked amenities such as an internet connection. What resulted was something efficient and sustainable, incorporating many hands-on simulation sessions, along with e-learning modules to allow staff to refresh their skills when they needed to.

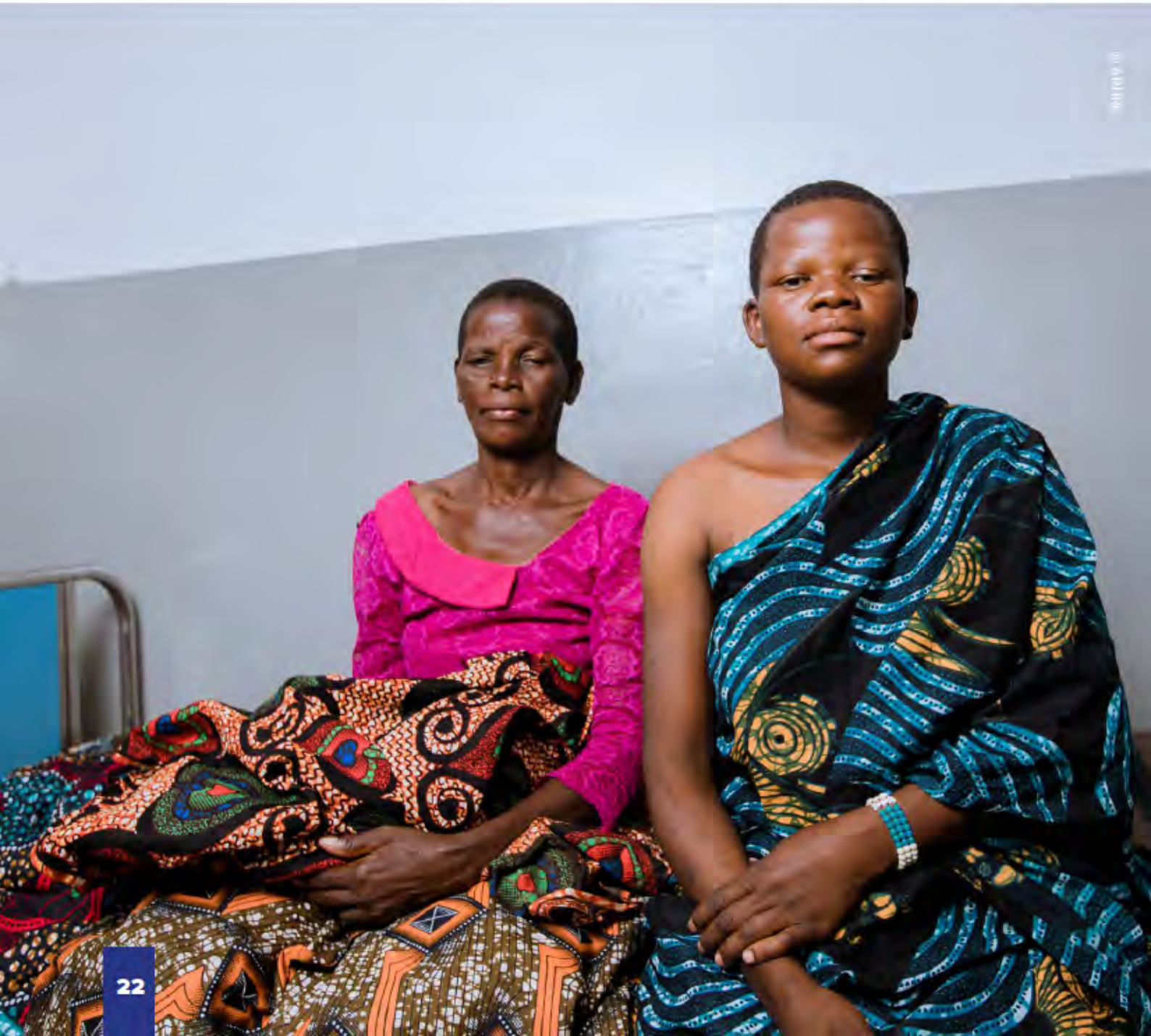
Through several engagements with decision makers at the national and sub-regional level, the research team shared evidence emerging from their work. In the process, Tanzania's Ministry of Health saw the need to refresh its curriculum on emergency obstetrics and newborn care. Tackling these issues means expectant mothers can now access health services closer to their homes, with no need for travel. This example demonstrates how the implementation of the HPRO model is enhancing collaboration between health researchers and decision-makers.

In 2020, the EA-HPRO implemented a monitoring and evaluation process to reflect on the lessons learned from its work. One of the reflections was that the HPRO model effectively weaves together policy engagement and communications activities, convenings, and bespoke training that facilitates access to timely, relevant, and robust evidence.

The HPRO model is worth investing in, and as we have learned, it bridges the gap between research and policy relevance through tailored interventions.

To read more about the EA-HPRO evaluation , click here.

EA-HPRO is made up of three organizations, African Population and Health Research Center (APHRC - Lead), based in Kenya, the East, Central and Southern Africa Health Community (ECSA-HC), in Tanzania; and Partners in Population and Development Africa Regional Office (PPD–ARO) – based in Uganda.



Publisher African Population and Health Research Center as part of the EA-HPRO
Publication date May 2021
Editorial team Lynette Kamau, Moreen Nkonge, Jane Mangwana from APHRC and Eva Nakimuli from Partners in Population and Development Africa Region (PPD-ARO)
Cover Image ©APHRC

Acknowledgement
This work was carried out with the aid of a grant from the Innovating for Maternal and Child Health in Africa initiative - a partnership of Global Affairs Canada (GAC), the Canadian Institutes of Health Research (CIHR) and Canada's International Development Research Centre (IDRC).

@imcha_ismea

http://ea-imcha.com/

African Population and Health Research Center

Canadian Institutes of Health Research | Instituts de recherche en santé du Canada

Government of Canada | Gouvernement du Canada

IDRC · CRDI

Canada

www.ea-imcha.com