# SAFE MOTHERHOOD PROGRAM

## MINISTRY OF HEALTH AND POPULATION

**Proceedings of a**
**SAFE MOTHERHOOD**
**consultative workshop on**

## INTERVENTIONS THAT PROMOTE MATERNAL AND NEONATAL SURVIVAL

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Edited by:
Ann M. Maureen Phoya, D. N. Sc; RNM, PHN
National Safe Motherhood Initiative Coordinator
Ministry of Health & Population

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## 1. INTRODUCTION

A two day consultative workshop was organised by the National Safe Motherhood Program in the Ministry of Health and Population to disseminate information learnt from the participation of Malawi in the Africa Safe Motherhood Initiative (ASAMI). The ASAMI was a data gathering exercise organised by Mothercare International and funded by USAID to assist African countries document information on interventions or strategies that seem to promote maternal and neonatal survival and making a positive contribution to the global Safe Motherhood Goal. Through the ASAMI, Ghana, Malawi and Uganda collected information on interventions that are being implemented as part of National Safe Motherhood Programs. Analysis of the data from the three countries showed that interventions that promote maternal and neonatal survival include among other things empowering communities with information to recognise maternal and neonatal problems and make timely decisions to seek care; making maternal and neonatal health care services accessible to communities, providing quality maternal and neonatal health services and ensuring an enabling policy environment. The workshop was therefore aimed at providing a forum for stakeholders in the Safe Motherhood Initiative to share information on interventions implemented by District health management Teams, Non-Governmental Organisations (NGOs) projects in the country. Secondly the workshop also aimed at creating a forum for the Safe Motherhood Stakeholders to discuss and come up with recommendations on interventions that should be implemented throughout the country to accelerate achievement of the Safe Motherhood Initiative Goal in Malawi

## 1. SPECIFIC OBJECTIVES

Specific objectives of the workshop were to:

2.1 Share experiences on interventions which promote Maternal and Neonatal Survival in Malawi.

2.2 Identify gaps hindering the achievement of the Safe Motherhood Initiative goals.

2.3 Make appropriate recommendations which would promote Maternal and Neonatal Survival on:

a) Issues of policy that would promote implementation of SMI activities.
b) Interventions that should be implemented at community level.
c) Interventions that should be implemented at facility level
d) Indicators for monitoring Maternal and Neonatal Health, and
e) Mechanisms for maintenance of quality of maternal and neonatal care.

## 2. WORKSHOP PARTICIPANTS

The workshop was attended by 110 people composed of District Health officers, (DHO), District Nursing Officers (DNO), District Safe Motherhood Trainers/Co-ordinators, Regional Health Officers, Regional Safe Motherhood Co-ordinators, representatives of health training institutions, regulatory bodies for the Medical and Nursing Profession, Health Donor Agencies, Christian Hospital Association of Malawi (CHAM) and NGOs who are implementing Safe Motherhood projects. The Ministry of Health and Population Headquarters was represented by the Controllers (Directors) for the six technical units of the Ministry, the National Safe Motherhood Advisor/Coordinator, Program Managers from the Reproductive Health, Preventive Health and Health Planning Departments of the Ministry. The names of the participants and their designations are on Annex XVII.

## 3. WORKSHOP PROCEEDINGS

### 3.1 Official Opening

The workshop was officially opened by the Principal Secretary for Health and Population Mr. George Mkondiwa responsible for Administration and Finance. In the official address the Principal Secretary reminded the participants on the poor maternal and neonatal health indicators in the country and the need for multisectoral collaboration in the provision of maternal and neonatal health care. He further informed the participants that the Ministry of health and Population view the Safe Motherhood Program as one of its priority programs and that the coming forth national Health Plan which will become operational in 1999 will provide guidelines on interventions that need to be implemented to address the issue of high maternal mortality. Annex I provides a copy of the opening speech as presented by Principal Secretary.

### 3.2 PAPER PRESENTATIONS

#### 3.2.1 MATERNAL AND NEONATAL SURVIVAL PATHWAY: by Dr. Ron Mataya; MD/FRCOG, MEDICAL DIRECTOR, Blantyre Seventh Day Adventist Hospital)

The presenter described the Maternal and neonatal Survival Pathway as comprising of the following:

a) An enabling policy environment

b) Ability of the community to recognise a problem, make correct decisions and seek care in a timely manner.

c) **Access to emergency obstetric care**
This is a problem in the country. Even where access in improved, the decision made by the health personnel also affects quality of care.

d) **Provision and monitoring of quality care**
Providing quality care even to a few women can make a difference inspite of the difficult circumstances we are working under.

e) **Feed back to the community.**
This can be done at under-fives clinic, postnatal clinic, community meetings and outreach clinics. The complete paper describing the themes of the survival pathway is on Annex II.

### 4.2.2 COMMUNITY-BASED SAFE MOTHERHOOD INFORMATION, EDUCATION AND COMMUNICATION by Mrs. M. Kambewa; RNM, RCHN –District Public Health Nurse & Safe Motherhood Trainer: Lilongwe

The community-Based SMI is implemented as part of the Malawi-Penn Women for Women's Health Project which started in 1990. The IEC component started in Chiwamba, Lilongwe district in 1996. The process included five components:-

1) Knowledge, Attitude and Practice (KAP) Survey

2) Development of training and IEC materials

3) Training of community based SMI advisors

4) Dissemination of messages by the Community-Based SMI Advisors

- 60 women (young and Elderly) have been trained. They attended 3 sessions each comprising of 6 days. After training the 60 women disseminate IEC messages in their own villages.

- Initially they were supervised by Community Nurses but this was not successful due to transport problems. Health center personnel were then given the responsibility of supervision.

- More than 12,000 people (TBAs, adult men and women in and out of school youths) have been reached with IEC messages.

- Utilization of health services has improved since the introduction of these community advisors.

- The following incentives have been given to the advisors to motivate them:
  Umbrellas
  Bags
  6 meters 'chitenje' cloth

Annex III provides detailed information on the implementation of the community based SMI-IEC.

### 4.2.3 COMMUNTY MOBILIZATION AND UTILIZATION OF COMMUNITY MATERNAL DEATH AUDIT by Mrs. Chisenga; RNM, Field Manager, Monkey-Bay Safe Motherhood Project

AIM: To involve the community and promote ownership of Safe Motherhood Interventions.

**a) Community Mobilization**

**STRATEGIES**

1. Patch based care which involves paying a certain amount of money for the resources needed.

2. Utilizing cost sharing principles

3. Training of local leaders; local drama/band groups and community based Safe Motherhood Advisors.

4. Regular meetings with influential leaders.
   The Area Development Committee (ADC) is the focal point and after sensitisation the committee now realises that maternal death is a problem of the community.

5. Provision of SMI-IEC through trained band groups and community based advisors.

6. Improving access to maternal health care through provision of bicycle ambulances and training of TBAs and construction of TBA huts.

7. Introduction of Community Maternal Death Audit.

**OUTCOMES OF COMMUNITY MOBILIZATION**

- TA organises advocacy meetings and ensures that measures agreed on a maternal death audit are carried.
- The ADC now includes SMI on their agenda
- Less deliveries by untrained personnel.

## b. COMMUNITY MATERNAL DEATH AUDIT

This is a strategy to address avoidable factors that contribute to high maternal mortality.

- The Area Development Committee is used as a focal point to organise meetings for a community maternal death audit meeting.
- The TA (Chief) informs the health workers when there is a maternal death in the community. The community and health workers agree on a date to meet and discuss the possible causes of the maternal death and what needs to be done to avoid other deaths.
- Actions agreed upon at the meeting are implemented by the community and health workers as a joint venture.

**Constraint:** Poor leadership skills hinder the M.D. audit process. Annex IV provides information on the implementation of community maternal death audit and community mobilization by the Monkey-Bay SMI Project.

## 5. IMPROVING ACCESS TO MATERNAL AND NEONATAL CARE

### 5.1 Utilization of Maternity Waiting Homes at Ekwendeni Hospital by Mr. B. Kamanga – Chief Clinical Officer and Medical Superintendent

**Rationale:** Ekwendeni was experiencing a lot of maternal deaths in their catchment area due to deliveries attended by untrained TBAs or relatives.

- Previously women who decided to wait for labor, were housed in a guardian shelter which was uncomfortable. To improve this situation two waiting rooms were constructed at the hospital where women are admitted at 38 weeks gestation to wait for delivery.
- Mothers clean the rooms and take care of their nutritional needs.
- Nurse-Midwives do physical examination every week and give iron supplements daily.
- The women pay K100.00 if they attended ANC with other providers and K30.00 if they were attending antenatal clinic at Ekwendeni hospital and its outreach clinics. This payment is for the entire stay including delivery.
- Not less than 700 women stay in this home every month.

- There is a need now for expansion and the community will mould the bricks.

Full details of the utilization of the Maternity Waiting Home are on Annex V.

## 5.2 Utilization of Bicycle Ambulance By Dr. Ratsma – DHO Kasungu District Hospital

- Several health centres in Kasungu have been and are using bicycle ambulances for transporting maternity patients as well as dead bodies.

- Bicycle ambulances are favoured as compared to ox-carts because of the problem of cattle diseases.

- The impact of using bicycle ambulance has not been realised but all the same with shortage of vehicles the bicycle ambulances reduce delays in referring patients.

### Constraints

1. Some belts are not comfortable to pregnant women

2. Irregular supply of spare parts which demotivates the community.

3. Initially the bicycle ambulances were being kept at the district hospital therefore causing more delays.

### Recommendations

- The districts to ensure regular supply of spare parts and also to keep the bicycle ambulances at the community.

- The districts to purchase comfortable reclining or adjustable ones.

Annex VI provides information on the experiences of Kasungu Hospital on the utilization of Bicycle Ambulance to improve access to maternal health care.

**5.3a Utilization of Radio Communication in Mulanje by Mr. Eliya RNM and District Safe Motherhood Trainer – Mulanje Hospital**

There are 9 health facilities with radio communication and 8 with a telephone in the district.

**Constraints**

1. Power failure at the district at times.
2. Communication to some health centres not direct due to mountainous area.
3. Ambulance sometimes not available when needed.

**5.4b Utilization of Radio Communication in Thyolo: (By Ms D. Kachoka – RNM, District Safe Motherhood Trainer, Thyolo Hospital**

- This has improved the referral system.
- 3 health centres have telephones, 2 vehicles, have radio communication and all 9 health centres have radio communication system.
- Major constraint is power failure and sometimes bad weather.

5.5c **Experience of Embangweni Hospital on Radio Communication by Ms J. Ng'oma**

**Rationale:** To improve the referral system and reduce delays in referring the patient.

- Embangweni hospital has installed radio communication in its 2 health centres.
- 6 months training of laboratory aides was done so that grouping and crossing is done at health centre level and donors accompany the referred severely anaemic patients.
- The impact is that the number of referrals to the hospital has increased, and the use of radio communication in this area which is coupled with community participation has improved access to essential obstetric care to women from rural underserved areas.
- The constraint is that they cannot communicate to one health centre because of its location in mountainous area. Secondly the other radio which communicates over long distances is very costly.

Annex VII provides extra information on experiences with radio communication at Embangweni Hospital in the Northern Region.

### 5.6 Utilization of TBAs By Ms Thundu: ENM – TBA Supervisor, Kabudula Rural Hospital - Lilongwe

- TBA training started in Kabudula areas as part of a Child Survival Project which trained 15 TBAs. The project has now been extended to a Micah Project – a micro-nutrient project.
- The Micah project is concentrating in four areas where there are 3 TBAs who are supplied with all basic requirements. The TBAs also stress on IEC related to micro-nutrients.
- Supervision is done once or twice a month.

Annex VIII is a description of how World Vision Micah Project is utilizing TBAs for Child Survival activities.

### 5.7 Levels of care and Interventions for Maternal and Neonatal Survival By. Dr. Ebanyat

Maternal and Neonatal care is provided at the following levels: community, health centre and hospital. The interventions to reduce mortality are done at different periods as follows:-

1. Pre-conceptional period
2. During pregnancy
3. During delivery
4. Immediate postpartum
5. Late postpartum up to 6 weeks

Annex IX provides information on major causes of maternal mortality in Malawi and interventions that can be done during the pregnancy cycle.

## 6. MAINTAINING QUALITY OF ESSENTIAL OBSTETRIC CARE

### 6.1 IMPLEMENTATION OF QUALITY ASSURANCE PROGRAM IN MALAWI By Mr. Nalikungwi, Medical Council of Malawi

- Medical Council started Quality Assurance exercises by training few people from pilot districts. It is now planning to introduce QA exercises in all districts. The pilot districts have carried out a few QA exercises.

- Quality Assurance will now begin in all districts. Each district will initiate QA activities with 3 health facilities beginning with the district hospital, one health centre and one CHAM health facility. After 6 months another set of 3 health facilities will be targeted in each district.

- Each district will have a Quality Assurance committee and networking will be one of its major activities.

- District Health management Teams will identify a District Quality Assurance Facilitator.

- Experience from the pilot district show that CHAM units are doing better in Quality Assurance evidenced by Ekwendeni as compared to government units therefore the need for commitment by government institutions
  Experiences of Ekwendeni Hospital is initially a quality assurance as on Annex X.

## 6.2 ASSESSING REQUIRED INPUTS FOR ENSURNG ACCESS TO QUALITY ESSENTIAL OBSTETRIC CARE BY THE SOUTHERN REGION SAFE MOTHERHOOD PROJECT

The goal of the project is to reduce maternal mortality and morbidity in the Southern Region of Malawi. The following are the outputs:

- Increased awareness of SMI issues

- Improved availability and accessibility. Of essential obstetric care

- Improved quality of care

- Improved referral systems

- Effective monitoring systems

The project will be implemented in a phased approach i.e. selected districts per year over 6 years with a major focus on community participation. In each district, a needs assessment will be done with district plans made based on the information gathered and the target is 3 districts per year during the project life. Currently Needs Assessment done in the first two districts show that there is need for continuing education of personnel, provision of essential equipment and supplies, improving communication and counseling for clients, reducing clients walking time to health facilities; as well as waiting time and improving health facility infrastructure including communication system will ensure delivery of quality essential care. Detailed results of the needs assessment are on Annex XI.

6.3 **ASSISTING DISTRICT HEALTH MANAGEMENT TEAM TO PROVIDE QUALITY BASIC OBSTETRIC CARE: CESTAS SAFE MOTHERHOOD PROJECT BY E. Kari – Midwifery Consultant– CESTAS Project.**

- C.E.S.T.A.S. is an Italian NGO working with Lilongwe District Health Management Team to improve the quality of basic obstetric care in the health centers of the district.
- The project was designed by C.E.S.T.A.S. in collaboration with MOHP and Lilongwe DHMT. It is funded by EU.
- To determine Safe Motherhood Interventions for implementation, DHMT, Health Center personnel and Project personnel went through problem identification exercise.
- Major problem identified was poor quality of MCH services in all health centers due to low morale of staff; inadequate essential equipment and supplies; inadequate continuing education, and supervision of personnel and poor working conditions.
- To address these problems C.E.S.T.A.S and DHMT decided to provide essential equipment and supplies, training of DHMT in supervision, provision of continuous supervision, monitoring of services and provision of radio communication as major components of the project. Detailed explanation of the project design and implementation are on Annex XIII.

6.4 **CONTROL OF STANDARDS IN PRIVATE MATERNITY PRACTICE: Presented by Ms R.C. Mbvundula – Nurses & Midwives Council**

The presenter started by defining standards as "measure for quality or required degree of excellence". The following were some of the reasons for the need to introduce standards in midwifery practice:

- They guide the midwives into purposeful, safe and effective midwifery care.

- They promote universal level of performance which enhance a broad and uniform development of midwifery and increases the mobility of midwives just to mention a few.

Standards put in place for private maternity practice by Nurses and Midwives Council were described and that continuos monitoring is done for control purposes.

The Nurses and Midwives Council want to maintain the standard of midwifery care in order to safeguard the public who are recipients of such care.

**Recommendation:**

It was recommended that Nurses and Midwives Council should also monitor government institutions apart from private practitioners to ensure standards in such institutions.

Annex XII gives a detailed description of the standards which the Nurses and Midwives Council follow in order to safeguard the mothers who receive care from private maternity units.

6.5. **NATIONAL OBSTETRIC/MIDWIFERY MANAGEMENT PROTOCOLS: BY DR. H.W. VOLLERT – CHIEF OBSTETRICIAN, LCH AND CHAIRMAN OF THE NATIONAL SAFE MOTHERHOOD TASKFORCE.**

Commenting of the need for maintaining quality of maternal and neonatal care, the Chairman of the National Safe Motherhood Task Force informed the participants that the Malawi Safe Motherhood Program has developed guidelines or protocols for the management of common obstetric emergencies and complications. There are different guidelines for health centers and district hospitals, and they provide information on the management of haemorrhage, obstructed/delayed labor, genital sepsis, anemia, hypertensive disorders of pregnancy, cord prolapse, intra-uterine death etc. The protocols are now under print and will become available before end of the year. When the protocols become operational, they will also assist supervisors to assess if health workers are managing obstetrical complications properly. The protocols will also assist District Health Management Teams stock appropriate essential obstetrical equipment and supplies.

6.6. Two presentations were not made as the presenters who had indicated willingness to present failed to show up due to unforseable circumstances.

As indicated on the program schedule (Annex XVI), these presentations were on ambulatory post-arbotal care implemented by Queen Elizabeth Central Hospital and Trends in Maternal and Neonatal Health as recorded by the Ministry of Health – Community Health Services Unit. As information on these two issues is critical to the implementation of SMI interventions, the national SMI Co-ordinator/Advisor requested the presenters to provide their papers for inclusion in the report for reference. The papers are therefore on Annex XIV and Annex XV.

## 7. DAY TWO: TASKS FOR GROUP WORK

The second day of the workshop was spent on group discussions whereby participants were divided into four groups to discuss and make recommendations that would assist Malawi enhance implementation of the Safe Motherhood Initiative and reduce the high maternal mortality in the country. Specific tasks for the groups were as follows:

### 7.1.1 POLICY GROUP: To identify existing policy tat inhibit or facilitate implementation of SMI activities

a) THOSE THAT FACILITATE

- Use of contraceptives allowed to adolescents.
- Maternity leave i.e. encourages EBF
- Restriction on registration of Nurses and Midwives and maternity units.
- Existence of government policies on Safe Motherhood Program.
- Free Primary Education.
- Staffing i.e. services made available
- TBA training
- Provision of iron supplement to all antenatal mothers.

**b)** THOSE THAT HINDER

- Legality of abortion
- Age of marriage > 18 years
- Family Planning (non prescriptive nature of it).
- Educational policy
- Staffing (activities are too many for one person).
- Restriction of distance between health centres.
- K5,500 fee for the private practitioner.

**RECOMMENDATIONS**

- There should be specific ratio for staff and patients e.g. one nurse for 10 patients (1:10).
- First aid training for drivers for transfer of obstetric cases
- Each unit to have different room for each activity e.g. labor, delivery, ANC, FP.
- Should have Safe Motherhood policy document which should comprise the 4 pillars.
- Family Planning policy should limit number of children e.g. 4.

- Maternity leave – 90 days mothers + 30 days fathers – EBF.
- Staffing for health centre
  - 4 nurses –1 CO – 1 MA 1 H/Insp. 1 Lab. Ass.
  - 1 Pharmacy. Ass
- Need for national assessment of MMR e.g. at ten years interval so that there is one figure to work on.

### 7.1.2 COMMUNITY INTERVENTIONS GROUP

**a) Interventions**

i) Community empowerment
ii) IEC
iii) Training
Bottom up approach in planning health activities (Participatory Rural Apprisal)

**b) Recommendations**

i) Resource – Human, Maternal, Financial.
ii) District initiatives.

### 7.1.3 FACILITY BASED INTERVENTIONS

**a) Gaps at health center level**

- Lack of motivation and recognition of the professionals.
- Shortage of nursing staff and Medical Assistants.
- Lack or shortage of basic equipment e.g. BP machine/resuscitation machine.
- Shortage of essential drugs e.g. ergometrine and supplies e.g. syringes, gloves – stationery e.g. labour graphs, ANC.
- Lack of knowledge on use of labour graphs, ANC.
- Lack of refresher courses for staff due to funding problems.
- Transport problems e.g. bad roads, impassable roads, rainy season.
- Communication problems e.g. no telephones, no radio messages.
- Inadequate infrastructure e.g one room for ANC/Labour Ward/FP.
- Maintenance problems e.g. falling buildings, water problems.

**At district hospital level**

- Lack of motivation and recognition.
- Shortage of nursing staff.
- Lack of sharing of information and no team work.
- Shortage of basic equipment, supplies e.g. reagents for VDRL/Hb. Drugs due to lack of fund and unavailability at Medical Stores.
- No refresher courses due to lack of funds.
- Lack of supplies for infection prevention.
- Shortage of Doctors in some districts and specialists in Central Hospitals e.g. Northern Region.
- No transport to collect staff on call.
- Negligency of some staff in managing cases.
- Lack of supervision at all levels.

**RECOMMENDATIONS ON APPROPRIATE INTERVENTIONS**

1. To build up strong professional associations who can motivate their members and monitored standards of care.
2. To train more staff and increase number of training schools.
3. Improve working conditions e.g. by increasing salaries, introducing risk allowances and standardise promotional courses e.g. a MA goes for training comes back as a CO while a Nurse goes for training comes back as an STA.
4. Increase monthly funding and prioritise accordingly.
5. Improve interpersonal communication – there should be team spirit.
6. Supportive supervision at all levels.

**Basic equipment**

- Weighing scale
- Delivery beds
- BP machines
- Forceps
- Stationery.

### 7.1.4 GAPS IN INDICATORS FOR MONITORING MATERNAL AND NEONATAL HEALTH

- Lack of registration of vital statistics.
- Shortage of stationery to send vital information to CHSU.
- Lack of transport/communication.
- No proper data collection, analysis, interpretation and feedback at all levels.
- Lack of skill and knowledge for data analysis
- Lack of commitment/prioritisation.
- No basic investigation in antenatal mothers e.g. HB, serology due to lack of staff and equipment.
- No multisectoral collaboration in health education.
- Lack of processing data and to give feedback at all levels.
- Lack of government/political commitment on vital registration register.

**RECOMMENDATIONS**

- Registration of vital statistics (put mechanism to sustainability) e.g. traditional leaders can have a register of births, deaths with assistance of HAS.
- Government should be committed on National Registration.
- Capacity building on HIS (training on data collection analysis).
- Strengthen the feedback giving system for the concerned to take appropriate action at all levels.
- To develop mechanism for data interpretation by holding regular meetings.
- Feedback on referred cases to personnel
- To have someone trained on HIS (for central hospital).
- Health personnel to be committed on their job by data collection health service data appropriately
- The buying system of the government needs to be reviewed.
- Need to develop and strengthen district technical committee to share ideas at least quarterly.

## 8. RECOMMENDATIONS MADE AT THE SAFE MOTHERHOOD CONSULTATIVE WORKSHOP

After lengthy discussions on the recommendations made by the different groups, the participants made the following recommendations for the inistry of Health and its partners to consider:

1. The MOHP should train more health workers such as Nurse-Midwives, Clinical Officers, Specialists in obstetrics to improve access and quality of care with proper incentives and improved working conditions to retain a motivate cadre of maternal and neonatal health workers.

2. The MOHP and other health care organisations should ensure adequate provision of basic equipment and supplies and infrastructure including communication systems to all facilities providing maternal and neonatal care.

3. The MOHP should advocate for the establishment of a system for vital registration with annual assessment of maternal and neonatal indicators.

4. The MOHP should reinforce regular supervision and monitoring of maternal and neonatal services at all levels with feedback given to the supervisors.

5. Communities should be involved in the planning and implementation of Safe Motherhood activities e.g. Maternal Death Auditing; monitoring of health centre and other community based activities.

6. MOHP should train all health workers in Interpersonal Communication and Counseling skills.

7. MOHP should provide adequate monthly funding to the districts and district teams should be able to prioritise their activities.

8. MOHP should train District and Health Centre teams in HIS so that they should be able to use data collected.

9. All technical committees at central, regional and district levels should meet quarterly to share ideas and experiences in implementation of Safe Motherhood activities.

10. MOHP and other organizations should ensure in-service trainings at regular intervals for all health workers providing maternal and neonatal care.

11. Nursing Schools in collaboration with the Nurses and Midwives Council should award Diplomas to Enrolled Nurse/Midwives undergoing postgraduates courses e.g. Community Nursing as part of incentives.

12. The Nurses and Midwives Council should reduce the amount of fee for registration of private maternity homes to enable more Midwives open such facilities and increase accessibility of maternal and neonatal services.

## ANNEX I

## SPEECH BY DR. W.O .O. SANGALA, SECRETARY FOR HEALTH AND POPULATION AT THE NATIONAL SAFE MOTHERHOOD CONSULTATIVE WORKSHOP AT KALIKUTI HOTEL, ON 13TH OCTOBER, 1998.

Mr. Chairman,

Distinguished participants,

Invited Guests,

Ladies and Gentlemen.

I feel greatly honoured and privileged to be here this morning to officially open this workshop for Policy Makers and Implementers of the Safe Motherhood Initiative. Over the next two days, you will discuss Malawi's experience in the implementation of the Safe Motherhood Initiative, ten years after Nairobi. The Safe Motherhood programme is one of the key programmes in Malawi's quest for a better quality of life for all Malawians.

As you are all aware, available statistics on mortality point a disturbing picture. Every year 500,000 women die during pregnancy or child birth world wide especially in developing countries. Here in Malawi our socio indicators are among the worst in the world. For example, infant mortality rate stands at 134 per 1000 live births, while the child mortality is 234 per 1000 live births. According to the Demographic and Health Survey 1992, maternal mortality is estimated at 620 per 100,000 live birth having risen from 170 in 1987. * These indicators are typical of developing countries. It is against this background that the United Nations and other International donor agencies organised an International Safe Motherhood Conference in Nairobi, Kenya in 1987. The purpose of the Conference was to provide information to participating countries on the magnitude of maternal mortality, the immediate and underlying causes of maternal mortality and also to provide a forum for health care workers to come up with strategies to reduce the problem of pregnancy related deaths in

developing countries. Safe Motherhood Initiative therefore implies that efforts to reduce maternal mortality should focus on making family planning, antenatal care, clear and safe delivery and essential obstetric care available to all women of child bearing age.

* The major factors contributing to the gloomy picture are, among others, high illiteracy rates, especially among women, a high total fertility rate of 6.7 and a low contraceptive prevalence rate of 14 per cent.

Mr. Chairman, distinguished participants, ladies and gentlemen, I am delighted to note that since the Safe Motherhood Initiative was launched more than ten years ago, the government has taken measures to readdress the situation. The previous National Health Plans have been addressing these issues by strengthening maternal and child health services. More recently, the health Policy Framework, a precursor to the forth National Health Plan identified Safe Motherhood Initiative as a priority health strategy for addressing the high maternal mortality rate. Consequently the forth National health Plan which will become operational by the end of the year outlines strategies to be implemented within the framework of the National Safe Motherhood Programme, whose goal is to reduce the high maternal morbidity and mortality rate in Malawi by ensuring a safe pregnancy and child birth for all women of child bearing age. This will be achieved by, among other things: creating awareness at the community level on the risk of pregnancy and the need for utilization of health services; improving quality of maternal and natal care; improving communication and transport systems at community, health center and district levels for easy referral of patients. Strategies for realising the objectives are well articulated in several key policy documents including the National Population Policy, Safe Motherhood strategic Plan, National Health Plan. These policy documents provide a solid framework within which to address Safe Motherhood issues holistically.

The workshop is important because it has brought together policy makers and implementers from both the government and Non governmental organisations to share experiences on the implementation of the Safe Motherhood Strategic Plan. It is necessary that this workshop should review the implementation of these strategies and formulate action oriented recommendations which will be easily implemented by all Malawians at the village, community and national levels. It is against this background that this workshop has been organised with the following objectives in mind:

- to share experiences on interventions that promote maternal and neonatal survival

- to identify gaps/constraints hindering the achievement of Safe Motherhood Initiative goals and;

- to formulate action oriented recommendations which would promote maternal and neonatal survival.

With the assistance from USAID through JSI- Mother Care International, a Safe motherhood Africa Initiative was launched by three African countries of Ghana, Uganda and Malawi to identify and document an appropriate model of maternal and neonatal health care that addresses the needs of pregnant women and neonates. This exercise was achieved by collecting and analysing data on the existing safe motherhood programme interventions implemented in the three countries using the survival pathway. Data collected by these three

countries clearly show that there are definite interventions that promote maternal and neonatal survival.

Mr. Chairman, distinguished participants, ladies and gentlemen, the government is committed to the implementation of the SMI programme and it will do everything possible at its disposal to ensure that interventions recommended by the Africa Safe Motherhood Initiative are implemented by all stakeholders in the health sector.

Finally, Mr. Chairman, distinguished participants, ladies and gentlemen, I would like to take this opportunity to thank USAID through JSI - Mother Care International for providing assistance for this workshop. I would also like to thank the Safe Motherhood Initiative Program Coordinator in the Ministry of health and Population for organising this workshop.

I wish you all fruitful deliberation during the two days you will be here. I hope you will come up with action oriented recommendations and resolve to see them put into effect for the successful implementation of the Safe Motherhood Initiative Malawi.

It is my honor and privilege to declare this workshop officially open.

I thank you all for your attention.

## ANNEX II

## MATERNAL AND NEONATAL SURVIVAL PATHWAY BY DR. ANN M. MATEKWE PHOYA, NATIONAL SAFE MOTHERHOOD INITIATIVE COORDINATOR/ADVISOR

1. According to literature collected during the Safe Motherhood decade there seems to be a definite pathway of interventions that contribute to maternal and neonatal survival. The survival pathway is a continuum that starts at community level with two major interventions which include:

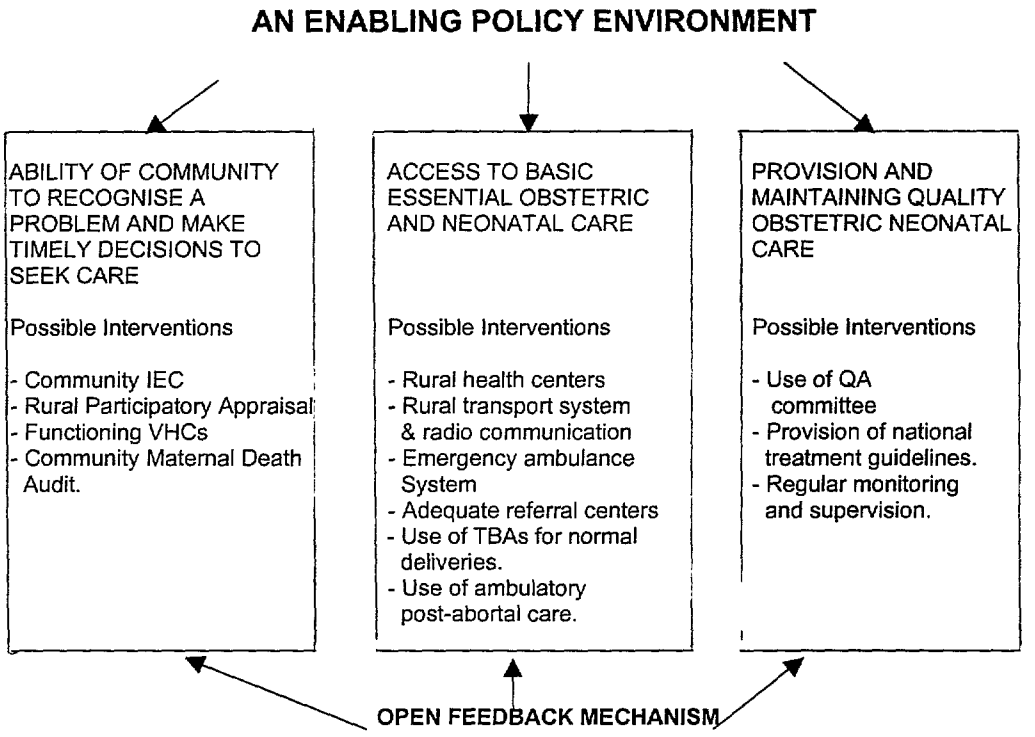
   - Empowering communities with appropriate information to recognize a problem or a risk that may threaten life of a pregnant woman and the neonate.

   - Once the community is able to identify a problem, it should be able to make an appropriate decision to seek care in a timely manner to address the problem or risk identified.

2. The second part of the survival pathway consists of the availability and accessibility of health services to meet the needs and demand from the community for maternal and neonatal survival to be realised. Communities must have access for care during pregnancy, labor, delivery and the puerperium as well as prevention and management of complications that may arise. Services must also address preconceptional care such as family planning and needs of the neonate and the under-five child. Once communities have recognised a health problem affecting the pregnancy cycle and have decided to seek care in a timely manner, health services should be within reach of their homes.

3. The third part of the maternal survival pathway addresses obstacles that may prevent the community from utilizing services that are within reach of one's home. Most of these obstacles relate to quality of the available care; consequently, for mothers and neonate to survive, available and accessible services should be of desired standards or quality. Services that are of low quality often contribute to low utilization, therefore mechanisms should be put in place to set appropriate standards and a continuous system of monitoring to ensure availability of quality care at all times. An enabling policy environment and an open feedback mechanism between the health care system and the community is an important aspect of quality assurance system. The diagram below provides a scheme of the determinants of maternal and neonatal survival and possible interventions.

## DETERMINANTS OF MATERNAL AND NEONATAL SURVIVAL




VHC = Village Health Committee

IEC = Information, Education and Communication

QA = Quality Assurance

ANNEX III

# IMPLEMENTATION OF CHIWAMBA COMMUNITY BASED SAFE MOTHERHOOD IEC INTERVENTION – PENNSLAVANIA MALAWI WOMEN FOR WOMEN'S HEALTH PROJECT

BY

MRS. MARY KAMBEWA, RNM, RCHN,DISTRICT COMMUNITY HEALTH NURSE AND SAFE MOTHERHOOD TRAINER

## BACK GROUND INFORMATION TO THE PROJECT

The Penn-Malawi Women for Women's Health Project is aimed at participating in the reduction of Malawi's High Maternal Mortality Rate (MMR of 620).

The project started in 1990 to 1995 whereby two Penn Nurse/Midwives and two Malawian Nurse/Midwives trained 45 Malawian Nurse/Midwives on advanced midwifery practice aiming at reduction of maternal and infant mortality.

In turn the Nurse/Midwives trained 940 Health Workers through orientation seminars, and 850 community members, village health committees, women's group and TBAs.

In 1994, the project was evaluated. The following were some recommendations from Nurse/Midwives who participated in this project.

- To pass on information to the community members at the grass root level.
- To improve services and infrastructure, buildings, roads, transport, telephones, supplies etc.

Therefore the first recommendation was chosen for a follow up by the project. In agreement with MOHP, Penn initiated the 2nd project which concentrates on disseminating SMI messages to the community members at the village level using women from the village at the community.

## IMPLEMENTATION AND DEVELOPMENT

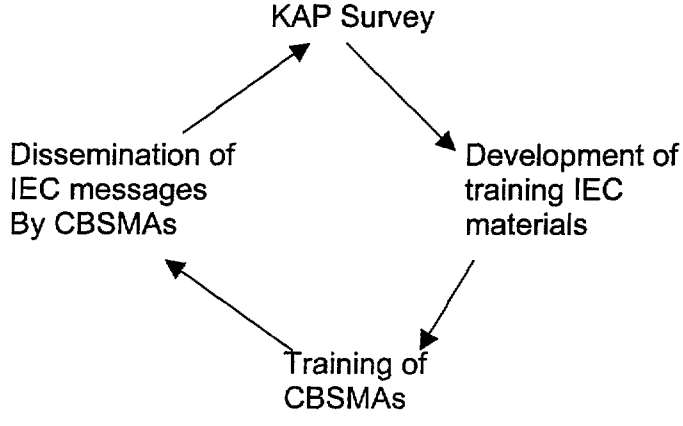
Lilongwe District was chosen by the MOHP as a pilot district for implementing the community based SMI IEC interventions, as it is one of the districts whose health indicators are among the worst in the country. For example data collected by the District health Office in 1996 shows the following figures which are above the national figures:

| | | |
|---|---|---|
| ♦ Infant mortality | 157 ---------- | 134 |
| ♦ Maternal mortality | 662 ---------- | 620 |
| ♦ Fertility rate | 6.9 ---------- | 6.7 |
| ♦ CPR | 7% ---------- | 14% |

The intervention area consists of 135 villages with an estimated population of 30,000 people. The area is Chiwamba Traditional Authority Chimutu (which covers the whole area). Chiwamba is situated at the North-East of Lilongwe on Lilongwe Salima road. The area is rural most parts are remote. The geographical features are hilly with rough roads, impassable during the rainy season. There is one Local Government Health centre with one Nurse/Midwife, a Medical Assistant, Environmental Assistant and 23 Health Surveillance Assistants (HSAs) allocated all over the area.

## THE IMPLEMENTATION OF IEC INTERVENTION

The Community-Based IEC Intervention commenced in 1996 and it involved four main activities namely a survey on the maternal health care knowledge, attitude and practice, (KAP). Development of training materials and IEC messages, training of community based Safe Motherhood Advisors (CBSMAs) and the dissemination of SMI IEC messages at the community by the CBSMAs. Below are the four activities and how they relate to one another:




The KAP Survey was done to determine current attitudes, beliefs and practices that may act as obstacles to appropriate maternal and neonatal health care behaviour. The sample for the survey included 189 men and women from 15 randomly selected villages. The questionnaire for the survey helped to obtain information on health care during pregnancy; labour delivery; beliefs pertaining to the role of antenatal; postnatal care and health facility delivery; how decisions are made to seek health facility care during pregnancy, labour, delivery and postnatal period; use of traditional herbs during pregnancy and delivery, obstacles for complying with advice from health providers; incidences of maternal and neonatal deaths in the villages and causes of the deaths as well as measures taken by family members to prevent such deaths.

## ANALYSIS OF THE DATA

Analysis of the survey data indicated that most women and men value antenatal care (90.5%), but there were a number of beliefs and practices that placed the women at risk of maternal morbidity and mortality. Some of these beliefs are as follows:

- Women wait to be told by the husband to go to the health facility for ANC and for delivery.

- Women are afraid to go to hospital to deliver because people die there and they get sold into slavery.

- There is no need to go for health care during pregnancy and delivery as there are herbal medicines which can prevent miscarriage or speed up delivery when labour starts.

- Women who die of obstructed labour are those that have been or their husbands have been unfaithful.

- Mineral drinks such as cocacola, fanta and orange rinks can improve heamoglobin level.

- If a woman has minimal blood loss after delivery she should be given herbal medicines to increase the blood flow for the body to be cleared from all impurities of conception.

- There is no reason to go for a postnatal check-up if the mother and baby are not experiencing any problems. PHC was mostly unknown

- Witch craft is the main cause of most obstetrical problems and maternal deaths.

The information obtained during the survey helped to develop the curricular for the training of CBSMAs. The contents are as follows:

- Role and status of women in the community

- Role of men and community leaders in Safe Motherhood.

- Women who should deliver at a health facility without failure (women at risk).

- Common causes of maternal deaths in Malawi and how to prevent them.

- Role of a TBA.

- Dangers of herbal medicines.

- Environment and its effects on the fetus.

- Care of the new born in the home (selected aspects connected with delivery).

- Role of family planing in Safe Motherhood.

- Simple methods of disseminating SMI IEC messages at community level. Songs, role play, story telling and drama.

- Teaching practice.

## TRAINING OF COMMUNITY BASED SAFE MOTHERHOOD ADVISORS

Women were chosen from a number of villages of the intervention area. To get support for the intervention, meetings were held with the Traditional Authority and group village headmen to discuss the outcome of the survey and the proposed intervention. The chiefs agreed to the proposed intervention and they were given the responsibility of selecting 60 women to undergo a 12 day training program. To assist the chiefs with the selection, criteria was designed in agreement between the programme team and chiefs. The agreed upon selection criteria were:

- The women should be willing to perform the role of a community based Safe Motherhood Initiative on a voluntary basis without pay.
- Able to speak to groups.
- Willing to learn about SMI and sharing information with others
- At least able to read and write.

The group 60 women was too large to teach therefore, it was divided into 15 persons per session. Each group had two sessions of 6 days training, and a two and half day refresher course.

## THE OBJECTIVE OF THE TRAINING

The overall objective of the training was to provide opportunity for women to participate in the implementation of the Malawi National Safe Motherhood Program through dissemination of SMI messages to members of their own families and communities. And the specific objectives are as follows:

### 1. FIRST TRAINING SESSION

- Demonstrate awareness of self as a person and importance of women in society.
- Demonstrate knowledge of the concept of Safe Motherhood.
- Identify major reasons why women are dying from pregnancy related causes.
- Describe specific interventions that can be taken at the community level to keep women off the road to maternal death.
- Demonstrate ability to impart Safe Motherhood messages to women, adolescents and men in their local communities.
- Develop plan of action on how the knowledge learned would be shared with other members of the community members.

## 2. SECOND SESSION

- Demonstrate adequate Safe Motherhood awareness.
- Evaluate each others Safe Motherhood IEC activities.
- Demonstrate improved knowledge and practice that contribute to high maternal mortality.
- Propose possible income generating activity to be implemented by women.
- Utilize additional appropriate teaching methods for groups.
- Develop an IEC plan of action for their own communities.

The first training provided information to the participants on SMI issues such as:

- Underlying and direct causes of maternal death in Malawi.
- High risk pregnancies
- Women who should deliver in hospital
- Importance of early prenatal care
- Intrapartum care and normal birthing process
- Importance of postnatal care
- Preventing neonatal tetanus, septicaemia and puerperal sepsis in a home delivery
- Dangers of using home medicines to prevent miscarriage, induce abortion or speed labour.

## 3. DISSEMINATION OF SMI IEC MESSAGES

After completion of each training session, the women return to their villages and start to disseminate SMI messages. The second session is done after 3 months practicals. The messages are disseminated in a variety of forums such as schools, churches, outreach clinics, health centres, TBAs birthing centres.

The women feel quite comfortable to disseminate messages, supervisors provide moral support during the meetings as well as clarifying issues which the women can not handle very well.

## SUPERVISION

Supervision preliminary was done by the community Health Nurse and the In-country Coordinator for the Penn-Malawi Women for Women's Health project alone. Owing to problems with transport it was decided to involve Chiwamba Health Centre staff such as Health Surveillance Assistants and Health Assistants after being oriented to the project.

## THE OUTCOME OF THE COMMUNITY BASED IEC

Post intervention survey was carried out in April this year – data is being analysed. However, the reports provided by the women during the second and third training sessions including supervisory reports and data from the health centre serving the intervention area, give an insight into the effect of the training program; and the community based SMI IEC program.

Reports from the women show that if given the right information and authority they are willing to actively participate in the implementation of health programs designed for their own benefit i.e. out of 60 women, only 2 reported to have not carried out their activities as planned. Most of them feel confident and satisfied with their work. Some of them have designed poems which are meaningful.

Information has been disseminated to group of men, women adolescents, youths up to more than 12,000 people by December 1997.

During the IEC sessions some community groups show interest by requesting the advisor to go back with more information. For example the women would report that "PEOPLE ARE CHANGING".

- Many women are now attending antenatal
- When the people have illness or any problems they come to ask for advise.
- Attending family planning
- Many women are delivering at health facility

Through supervision and supervisory reports, the women show having mastered the important and useful information on the prevention of maternal mortality and are able to disseminate this information properly.

Data for the Health centre indicate that since the inception of the community based IEC on Safe Motherhood more women are now utilizing health services, as indicated on the table below.

## DATA FROM CHIWAMBA HEALTH CENTER

| | 1995 | 1996 | 1997 |
|---|---|---|---|
| ANC clients | 780 | 840 | 850 |
| Deliveries | 416 | 453 | 500 |
| Live births | 405 | 427 | 490 |
| Fresh SB | 5 | 3 | 2 |
| Macerated SB | 13 | 17 | 8 |
| Referred cases | 11 | 25 | 34 |
| FP clients | 216 | 356 | 371 |
| Postnatal | 1 | 1 | 1 |
| Waiting mother | 9 | 15 | 24 |
| Maternal death | 3 | 1 | 1 |

- Causes of the maternal deaths: Antepartum hemorrhage, eclampsia and obstructed labour. With delayed transport for referral as an underlying cause of death.

## INCENTIVES FOR COMMUNITY-BASED SAFE MOTHERHOOD ADVISORS

Although the women were informed during the selection process that there would be no payment for their work even during the training, some of them felt they should be given something to compensate for their time and for the government to show appreciation for their work. They suggested the following:

- Bags to carry the file when going to work.
- Umbrellas and shoes to protect them from the sun and during the rainy season.
- To have a good outfit especially to put on during the dissemination sessions, some said as uniforms T-shirts etc.
- To have some money to buy some soap during the training
- Bikes to enable them move around.

All these requests were considered to be reasonable. Therefore to avoid a high dropout of the advisors some of their requests were granted. For example:

1. Public certification ceremony was done for the 1st group.

2. Bag and umbrellas having National SMI Logo have already been provided to the 1st and the 3rd group of women.
3. Six meters of cloth to make a complete attire i.e. a blouse, two wraps and a head scaff.

During the training each trainer is given K100; two bars of washing soap, two tablets of bathing soap, a jar of skin moisturizer.

**PROBLEMS AND POSSIBLE SOLUTION**

A number of problems were encountered that threatened the smooth running of the training program as well as the operations of CBSMA.

- Inadequate application of the selection criteria by the chiefs. Some chiefs selected their own relatives who could not read and write as a result these women had to be paired up with other women who could read and write. Somehow this caused some delays during training sessions, we had to go on their pace.

- Most of the women related to the chief are clustered in one village. There are some villages that do not have adequate advisors, therefore some had to walk long distances. To remedy this some more trainers had to be trained this year in may 1998 adding to a total of 75.

- With numerous household chores, some household activities (chores), some husbands and relatives prevent the women from carrying out all scheduled IEC sessions.

- Peer group pressure discouraged the women named them as women who can talk obscene language in public.

- A few advisors were challenged by their fellow women during IEC session regarding how much knowledge they have on prevention of maternal death.

- Some health workers (HSA) felt it was wrong to train the advisors before they were trained because these women seemed as having a lot of knowledge as a result they never supported them.

- The health centre can not cope with the increased demand for services because of inadequate space, personnel, drugs, equipment.

- No vehicle for supervision

- Poor infrastructure – roads impassable during rainy season.

- Not much IEC materials related to Safe Motherhood.

- Men and some women think this is for women only. For example men should not know issues about labour, delivery etc.

**FUTURE PLANS**

- Continuously encouraging the advisors through regular supervision until the whole community is reached.

- Possibility of expanding such intervention to other areas of the district if funds will be available.

ANNEX IV

# COMMUNITY MATERNAL DEATH AUDIT AND COMMUNITY MOBILIZATION

## PAPER PRESENTED AT THE SAFE MOTHERHOOD CONSULTATIVE WORKSHOP – KALIKUTI HOTEL 28TH – 29TH SEPTEMBER, 1998.

BY

BEATRICE CHISENGA
FIELD MANAGER
SAFE MOTHERHOOD PROJECT
MONKEY-BAY

## INTRODUCTION

The Monkey Bay Safe Motherhood Project was undertaken jointly by the MOHP, Mangochi District Health Management Team and the Department of the college of Medicine sponsored by Canada Fund. The Project started in August, 1995 and covered villages from the catchment area of Monkey Bay Health Center with a total population of about 17,000 people. This project phased out in July 31$^{st}$, 1998. An evaluation of the end of the year of activities found the impact of the programme to be very positive. Final results by external auditor from Canada are Still being worked out.

In august 1996, Nankumba ADC requested that the SM activities be extended to Nankumba area and a similar request was received from the staff of Nankhwali Health Center. UNFPA positively responded to the two proposals till December, 1998. The total population for Nankumba and Nankhwali is about 60,000 people. The place is quite remote with very poor infrastructure. Based on funding, further extension would be made to Malembo areas from January, 1999.

## COMMUNITY MATERNAL DEATH AUDIT

### 2.0 WHY MATERNAL DEATH AUDIT

2.1 One of the strategies identified by the project assist in the reduction of the unacceptable high maternal mortality rate of 620/100 000 (DHS 1992).

2.2 To assist communities to participate in identifying the local Causes of maternal deaths, local interventions to be carried out to Prevent future recurrence.

## 3.0 MOBILIZING COMMUNITY PARTICIPATION FOR MATERNAL DEATH AUDIT

### 3.1 UTILISATION OF EXISTING STRUCTURES

Community leaders were organised into a maternal death committee. The leaders included the traditional authority (T.A) Nankumba, members of Parliament (MP) of the two areas, village headmen (VH) and other influential leaders.

All the above mentioned leaders convene during monthly Area Development Committees (ADC). This forum also includes representatives of line ministries in the local areas, NGO leaders, local businessmen and religious leaders. Both Nankumba and Monkey Bay ADC were oriented to S. M. Monthly project reports are tabled in the meetings and possible solutions to problems are made with contributions from the local leaders. Other line ministries equally utilize the quorum to sort out irregularities.

It should be noted that the two ADC`s are among the eleven Mangochi District ADC`s. These ADC`s came into existence in 1995 as part of government decentralization process. Mangochi happens to be one of the local IMPACT District in Malawi for the 5$^{th}$ Country UNDP Program in promoting decentralization. The terms of reference for ADC`s is promote developmental activities in the area across the sectors (thus including health/SM.). Actually ADC`s present their proposals to DDC for funding after District Executive Committees (DEC) appraises them.

## 4.0 COMMUNITY MOBILISATION

Each village was visited. Project activities were spelled out including Maternal mortality audit on each IEC activity, the importance of carrying A maternal death audit was explained.

## 4.1 TRAINING

Training was conducted for VH, TA, MP, and other influential leaders. VHCs also received one day training and yearly refresher courses. After training among other thing, their terms of reference included participation in maternal mortality audit.

## 4.2 FEEDBACK TO COMMUNITY AFTER INQUIRY

The trend has been that the inquiry team (health workers and VHC) goes to the deceased house to find more information about the deceased mother. After inquiry the VH organizes a large community gathering where issues surrounding the maternal death are discussed. Usually before discussions start, an SMI band plays IEC messages. The band acts as an ice breaker before the audit discussion which usually is in a form of questions like:

Has anybody heard of any pregnancy related death in his life?

Is pregnancy related death a problem to us as well? Following the discussion the village is positively reinforced for contributions made towards proposed solutions to avert other maternal deaths.

## 5.0 HOW THE COMMUNITY ACCEPTED THE MATERNAL MORTALITY AUDIT

5.1 The main objective of introducing a community maternal death audit was to promote project activities ownership. In Monkey Bay, community mobilization was slowly accepted

and its performance in most villages has not been up to standards set. However the project was advertised during monthly ADC meetings since it was ` Top Down` idea. This was to let the community realize, high maternal mortality rate as a problem in their setting. Most times this ADC viewed development in a form of infrastructure e.g. building school block, clinic, bridges and not women`s health. In Nankumba, the project activities were requested by Nankumba ADC, typical of ` Bottom Up approach since it was the community need. Community participation including material mortality audit has been more encouraging.

5.2 During training, communities develop implementation plan in relation:

- to implementing activities decided upon following an audit.
- channel of communication for maternal death in the village include:

VHC/VH ⟶ HSA ⟶ H/C ⟶ TA.

- Community maternal death for auditing committee includes TA or his representative, one member of community health committee (CHC) HAS TBA VHC members(s) and midwife.

**IMPACT**

Difficult to measure MMR reduction, however we can look at some indicators which could project results e.g.

i. community participation as input almost all auditing involved midwife, VHC, VH, and HSA.

ii. TA imposed penalty on every unsupervised deliveries, to pay to the headman in a form of a chicken or money. The couple is also to explain to the VH their reason for going to untrained attendant for delivery.

iii. most inquiry recommendations are implemented e.g Sokole TBA who used to deliver high risk cases before MD and inquiry have reduced by 70%.

iv. at the district hospital, monthly maternal mortality meetings are held. Prioritization is on blood bank.

v. IEC Intensified. TA had had 3 large meetings and has talked about SM nurse, local SM supervisor was invited as guest of honour. Maternal mortality audit was one of the issues highlighted.

vi. After inquiry of Binali/Sokole villages, the made meetings in their villages alerting at risk cases to deliver in hospital.

**REASONS CONTRIBUTING TO POSITIVE RESULTS**

- Intensive community mobilisation
  ~ selling the problem to the community to realise or recognise it as a problem in the community. This promoted participation.

- Frequent contacts with community through ADC meetings, VHC visits by HAS through those contact MME has been reinforced.

- The TA with a reasonable educational background is very much intensified in development work. This TA is chairman of both involved ADC,s

## 6. SUSTAINABILITY

- Program incorporated within MOHP Structure
- The problem of high MMR is at least viewed as community problem. The spirit of ownership should drive them to continue.
- Utilizing the already existing structures i.e. TA, ADC etc.

## 7. CONTRAINTS

a. Minimal support for TBAs in most villages. Paraffin, soap and matches are scarcely given. Most women have a misconception that TBAs are on government pay roll.

b. Some VH have misused the contributed resources e.g. utilizing bicycle or moneys for personal interests.

c. Poor leadership skills primarily due to illiteracy and cultural beliefs by some village headmen especially in Monkey-Bay area. This makes them to have less input as communication is a problem.

d. Induced abortion have been difficult to trace or it would be even difficult to conduct inquiry, feedback would go to a wrong target group.

e. Hospital deaths are viewed as negligence by health personnel especially if the community did all their part.

## SUMMARY

The maternal mortality audit is stressed not to be viewed as 'fault finding'. If a maternal death occurs it is the system which has failed and not as an individual.

## B. COMMUNITY MOBILIZATION

### 1.0 AIM

To promote community ownership of project activities

### 2.0 STRATEGIES USED TO PROMOTE COMMUNITY OWNERSHIP

#### 2.1 Utilization Patch Based Care

Villages which were not active in Monkey-Bay were isolated, and if such a village had TBA trained, a push ambulance could not be given to such villages. The isolation served as a motivator for accepting a project aimed at improving access.

#### 2.2 Utilization Cost Sharing Principle

- Fixed amount of money for villages to come up with, so as to be given push ambulance. This would be used for maintenance. Money is kept by VHC treasurer.
- If a village wanted a bicycle to attach to the push ambulance they are given at half the cost.
- HAS bicycle also at half the cost.

2.3 Regular meetings with community influential leaders.
Monthly meetings with ADC, VHC visits by HAS. Selling the problem to the ADC to realize or recognise maternal death as a problem in their community (promoting bottom up approach).

#### 2.4 Training

- **For local leaders VH, MP in SM.**
  Local leaders involved in developing their terms of reference during training of Terms of Reference included:

  a) Community to raise funds to provide paraffin, soap, matches to be given to TBA as a token.
  **b)** Build birthing huts for active TBAs.
  **c)** Assist prompt transportation of women and babies referred by TBA.
  **d)** Documentation of deliveries by a non trained attendant, and outcome.
  **e)** Maintain push ambulance.

**2.5 Intensifying IEC**

IEC intensified by VHC, community based SMI advisors (CBSMA), band groups and HSAs. It is stressed that Safe Motherhood is everybody's responsibility.

2.6 TA Nankumba authorised VH to fine every unsupervised delivery.

## 3.0 OUTCOME

- About 30 push ambulances distributed. This is after communities had made contributions ranging from K100.00 to K500.00. 10 villages procured bicycles to attach to push ambulance at half the cost.

- 1 birthing hut is constructed, two are being constructed and five have bricks ready to start construction. The project only assist provision of cement.

- In most meetings organised by the VH the CBSMA is invited to talk about SM. The TA also organised their three large advocacy meetings.

- Active participation in maternal mortality audit. VH ensures that measures agreed upon are implemented to avoid future deaths.

- Reduced unsupervised deliveries as the women fear to be fined by the VH.

- The ADCs do not only discuss infrastructure projects, Safe Motherhood is presently one of the items on the agenda. Nankumba SM project was born as an outcome of a community proposal.

# ANNEX V

# IMPROVING ACCESS TO SAFE MATERNAL HEALTH SERVICES THROUGH MATERNITY WAITING HOMES

## PAPER PRESENTED AT THE MALAWI SAFE MOTHERHOOD CONSULTATIVE WORKSHOP – KALIKUTI HOTEL: 28 – 29TH SEPTEMBER, 1998

*BY*

*MR. BRIGHTWEL KAMANGA*
*MEDICAL SUPERINTENDENT*
*EKWENDENI HOSPITAL*
*MALAWI*

## 1. INTRODUCTION

The paper presents experiences of Ekwendeni Mission Hospital which has implemented services of a maternity home as part of its Safe Motherhood Program. Ekwendeni Hospital is in the Northern Region of Malawi, in Mzimba, the largest district in Malawi. The hospital is run by the Synod of Livingstonia which is under the Church of Central Africa Presbyterian. The hospital is a member of the Christian Health Association of Malawi (CHAM) in which patients pay a contribution fee. The catchment area is basically rural with a population of 45,000 people. Women of child bearing age are estimated at 9,000. However, the hospital serves as a referral area for approximately 120,000 people from other neighbouring catchment areas that are only served by health centers or dispensaries. There are 230 hospital beds for the hospital of which 70 are for maternity care.

## 2. RATIONALE FOR INTRODUCING A MATERNITY WAITING HOME

Utilization of a Maternity Waiting Home was introduced at Ekwendeni hospital in 1986 as a consequence of a large number of women who were admitted into the maternity unit with obstetrical complications. Common obstetrical complications observed among the women included obstructed labour, ruptured uterus, eclampsia and vesico vaginal fistulae. These women were either seeking delivery services from untrained TBA or family member because the hospital was very away from their homes. Construction of the Maternity Waiting Home was therefore done as part of a Safe Motherhood Initiative for the hospital which focused on improving maternity care through the training of TBAs, upgrading the maternity unit which was handling more than two thousand deliveries a year as well as improving access to maternal and neonatal care.

## 3. MOBILIZATION OF THE COMMUNITY FOR PROPER USE OF THE MATERNITY WAITING HOME

The idea of introducing a maternal waiting home was first shared with the PHC advisory board composed of village health volunteers for various programs elected by the community. This was done at a number of meetings organized by chiefs and held at community level. During these meetings the contributing factors of maternal morbidity and mortality were discussed including possible solutions such as use of maternity waiting home to reduce delay in obtaining emergency obstetric care. The idea of the maternity waiting home was accepted and the volunteers played a major role of motivating pregnant women from the community to come to the hospital and await for labor at the waiting home. In addition to the village meetings, information pertaining to use of the maternity waiting home was disseminated at every static and mobile clinic, whereby community nurses informed the people and encouraged them to pass the information to others. Pregnant women are encouraged to come to the hospital to wait for labor at 38 weeks gestation. The home was constructed with donor funds given to the hospital for expansion of the maternity unit, and it is located about 100 meters from the maternity ward.

## 4. PROCEDURE FOR ADMISSION AND CARE IN THE HOME

When mothers decide to await for labor in the home, they are required to bring their own food and beddings. Most mothers are usually accompanied by a female relative who helps them with chores like cooking. Every pregnant woman who comes to await labor, first reports to the delivery room where there is always a midwife in attendance. A thorough examination is done by the midwife in attendance to exclude complications. Only those women

without obvious complications are allowed to stay at the home, while any woman with a complication is admitted in the high risk antenatal ward. During the awaiting period, the mothers receive weekly antenatal care on Mondays. An elected leader at the home is assigned responsibility to ensure that all women attend the weekly antenatal clinic. To determine compliance with the weekly antenatal care, the midwife compares the attendance list with the available antenatal cards kept in the labor ward as well as statistical data collected at midnight when the mothers are all sleeping. Headcount is done at midnight because this is the most convenient time as the mothers spend most of their daytime outside and are scattered within the hospital premises. The leader also ensures that all women remain in the home and do not abscond to deliver at home. While in the waiting home, the mothers are oriented to the labor and delivery rooms to make sure that all fears and misconceptions of health facility delivery are dispelled.

## 5. COST OF SERVICES

There are no specific charges for use of the home, instead the mothers pay a flat fee of thirty Malawi Kwacha (1USD) for the use of the home as well as labor and delivery services if she registered with the hospital or its outreach clinics for antenatal care. Mothers who register for antenatal care with other institutions, pay one hundred Malawi Kwacha (3.5USD). Cleaning at the home is done by the mothers themselves and the hospital personnel only provide supervision.

## 6. IMPACT

The waiting home has increased women's access to maternal health services without extra cost. In addition to improving access, the waiting home has also increased the number of women who report early in labor

to be attended by qualified staff. Consequently, health personnel have a chance to identify any complication in early labor and take appropriate action. Due to early utilization of labor and delivery services, there has been a reduction in complications of first and second stages of labor. The introduction of the home has also increased the number of hospital deliveries and reduced the number of deliveries attended by untrained TBAs in the community.

The number of complicated cases from home or TBAs has also reduced. Currently the home keeps an average of 720 mothers per month or about 24 mothers per day. Most of these mothers come from areas that are about 10 to 60 kilometers outside the Ekwendeni catchment area In addition to the reduction of maternal morbidity, the home is also appreciated by the mothers. A few mothers that had been interviewed on the benefits of the home had this to say:

" It helps us to be near the hospital for delivery"
" You don't need to hire a vehicle in case of problems since you are already at the
hospital".
" It may prevent you from dying if you have complications since you are near and
you will be attended to quickly".
"Blood is checked on arrival to find out if you have enough, or any diseases that
need to be taken care of before the baby comes"

Because of the value attached to the waiting home by the mothers and the patronage from the community, there are plans to extend the waiting home to ensure that no woman is turned away.

## 7. SUSTAINABILITY

The building was funded together with the hospital by the German Government. There are no extra expenses incurred in the running of the waiting home. However, community participation promotes ownership and utilization of the facility. Hence, the community is expected to mould bricks for the proposed extension of the home and a donor funding will only be sought to assist with other roofing materials needed. The positive experience of Ekwendeni has prompted the Malawi Safe Motherhood program to include utilization of waiting homes as one of its strategies. District Development Committees are therefore encouraged to include maternity waiting homes as one of their development activities.

## ANNEX VI

### UTILIZATION OF BICYCLE AMBULANCE – KASUNGU DISTRICT By Dr. Ester Ratsma – DHO, Kasungu Hospital

The use of bicycle ambulances is not a "new" idea. Many years ago when I worked for Phalombe Mission Hospital we had already a bicycle ambulance in use for transport of maternity and general cases and of dead bodies. Similarly Mulanje Mission Hospital used them for transport of maternity cases.

In Kasungu district Newa Health Centre which is a CHAM unit, has been using a bicycle ambulance for some time. It is used for patient transport from the village to the health centre and also for referrals from the health centre to Nkhamenya Mission Hospital. A small fee is charged for maintenance but it is cheaper than hiring an ox-cart.

UNICEF donated 6 bicycle ambulances to government health centres in Kasungu district. The stretcher part is produced locally in Malawi. The idea was introduced to the Officers-In-Charge of the health centres during a meeting in December, 1995. They were advised to design control measures together with their health centre management teams and with representatives of their community.

As a result, a logbook is kept at each health centre which indicates date, time in/out, name, village, diagnosis and remarks from the user. The borrower is required to carry a letter from his village headman or the chairperson of the village health committee or Health Surveillance Assistant authorising him to borrow the bicycle ambulance in order to prevent theft.

In Kawamba in 1996, 136 patients used the bicycle ambulance of which 42 were maternity cases. In Simlemba and Chulu the bike ambulance is also used for the transport of dead bodies.

In Chulu they mentioned that ox-carts are scarce because it is near Kasungu National park and people fear trypanosomiasis. So the bicycle ambulance is a welcome alternative for transport of ill patients.

**Problems Encountered**

Chief Simlemba decided he wanted to have a trip on the stretcher himself prior to exposing the members of his community to this new invention. His son was peddling so fast that the chief and the stretcher overturned. Fortunately the chief was not harmed but only got a fright. So there is some concern about the stability of the stretcher during speedy transport.

From Mkhota came the concern that the community takes it for granted that if one is picked on the bicycle ambulance, it is too serious. This is so because according to beliefs, people fear to be taken like a dead body on a stretcher while they are still alive.

From Kawamba came the concern that most expectant mothers do not use the ambulance because they believe that when one has started labour this should not be known by many people since they are afraid of being bewitched.

The roads are fairly bad, especially in the rainy season, and there have been cases of people requesting just the stretcher portion as the bike may be heavy to peddle.

The way the stretcher is connected to the bicycle makes it difficult to turn around a corner.

We have noted some manufacturing faults of types and tubes and the saddle gets loose easily.

Some users have complained that the strapping is uncomfortable over the belly of a pregnant woman.

At times poor supply of spare parts has demotivated the community. If one comes and finds it off the road, that person spreads the news that the ambulance is no longer moving.

The bicycle ambulance serves only nearly villages.

**Recommendations**

- There is a need for health education in order to change unfavourable beliefs.
- The handle of the stretcher should be suitable for pushing
- The trailor should be connected to the bicycle in such a way that it is easy to turn around a corner.
- Some suggest that the stretcher should be in the shape of a reclining chair. The stretcher should have side railings.
- The bicycle should be of a sturdy make e.g. raleigh.
- There should be an adequate supply of spare parts for health centre based bicycle ambulances, so that the ambulance should be ever on the road.

**Recent Development**

In October, 1997 we received another 11 bicycle ambulances from UNICEF which were meant to be community based. It was decided that the community will be responsible for maintenance and safe keeping. These bicycle ambulances have been issued to traditional birth attendants through

village Health Committees. They sign a special form of agreement that they will take care of the ambulance.

By the end of this month an evaluation will be done of the community based bicycle ambulances. We expect that this evaluation will teach us the way forward.

ANNEX VII

# EMBANGWENI HOSPITALS INITIATIVE TO IMPROVE ACCESS TO SAFE MATERNAL HEALTH SERVICES THROUGH RADIO COMMUNICATION WITH HEALTH CENTERS

PAPER PRESENTED AT A CONSULTATIVE WORKSHOP
KALIKUTI HOTEL – LILONGWE 28 – 29TH SEPTEMBER, 1998

SUBMITTED BY:

MS. JOYCE NGO'MA
PRIMARY HEALTH CARE COORDINATOR
EMBANGWENI HOSPITAL
P.O. BOX 7
EMBNGWENI
MZIMBA, MALAWI

## INTRODUCTION

The paper presents the experiences of Embangweni Mission Hospital which has implemented radio communication between the hospital and two of its health centers as part of the Safe Motherhood Initiative. Embangweni hospital is situated in the northern region of Malawi, south eastern Mzimba District. It is 30 km from the Zambian border to the west and 31 km from Jenda at M1. The proprietor of the hospital is the Synod of Livingstonia which is under the Church of Central Africa Presbyterian. The hospital is a Fee-For-Service hospital and it is a member of the Christian Health Association of Malawi (CHAM) in which the hospital pays a contribution fee. Embangweni hospital serves a rural population of about 90,000 people and is 120 bed hospital of which 30 are for maternity care. Kalikumbi Health centre is 27 km from the hospital and Mabiri is 15 km from Embangweni. There is no telephone service available to either of the health centres. The roads are dirt, not graded, and often difficult to pass through the rainy season.

### Rationale

Utilization of radio communication was initiated at Embangweni hospital in 1994 in order to improve the referral system and decrease the time needed for a patient to be transported to the hospital. Prior to installation of the radios if a Nurse/Midwife would encounter obstetrical problems requiring referral to the hospital, a guardian would have to cycle to the hospital for an ambulance to collect the patient. This could take up to 2 hours from Kalikumbi and 1 hour from Mabiri. It could also take longer if the patient arrived at the health centre with only one guardian and someone had to be found who would cycle to the hospital. By ambulance it takes 45 minutes to get to Kalikumbi one way and 25 minutes to Mabiri one-way. This means that prior to radio communication it could take as long as 4 hours for a patient to arrive at Embangweni Hospital for treatment. With radio communication, we have been able to more than halve that time.

### Mobilization of the Community

Radio communication was facilitated by meetings between the hospital's maintenance Officer, hospital and health centre workers, village chiefs, and villagers from the health centres' service areas. Since road conditions and transport time are co-factors in maternal deaths, there was a Food-For-Work Program which improved the road between the health centres and the hospital. Maintenance of the roads is continued by the local communities.

### Other Factors

Other factors implemented to improve maternal health was the 6 months training of laboratory aides to do blood grouping and cross-matching so blood donors could accompany the referred severely anaemic patients.

## Procedure

The radios are located in the maternity units of the health centers and the hospital and are on 24 hours each day. Once the Nurse/Midwife at a health centre identifies an obstetrical problem, she radios a message to the Midwives in the maternity at the hospital who alert the doctor and prepare to receive the patient. One Midwife accompanies the driver to the health centre with a delivery kit. The driver delivers the patient directly to the maternity unit and the referred patient receives immediate attention as soon as she arrives at the hospital.

## Impact

The impact has been great in the community and at the health centre. The number of referrals from Mabiri Health Center doubled after the radios were installed in 1994. Kalikumbi Health Center's maternity unit was not opened until 1996 so comparison data on the impact of the radio is not possible. Below is a table giving Mabiri Health Centre's number of deliveries, maternal deaths, and number of referrals for two years prior to radio installation and two years following radio communication.

| DELIVERIES | | | | | MATERNAL DEATHS | | | | | REFERRALS | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1992 | 93 | 94 | 95 | 96 | 1992 | 93 | 94 | 95 | 96 | 1992 | 93 | 94 | 95 | 96 |
| 240 | 270 | Radio | 243 | 232 | 0 | 0 | Radio | 0 | 0 | 14 | 19 | Radio | 36 | 36 |

Although still not a simple issue, staffing the health centres with midwives has become easier because the midwives do not feel so isolated as they know they have daily communication with the hospital and can have the medical support they need.

A retired midwife who worked in the health centres for 20 years commented that prior to radio communication, it was difficult to refer a patient to the hospital especially during the night. Guardians would wait till dawn to look for either an ox-cart to carry the patient or a bicycle to call for an ambulance from the hospital.

She also commented that community members have said, "Now they can freely go to the health centres for deliveries because they know they can have immediate attention if problems arise".

**Limitations**

The radio which we use to communicate with Kalikumbi and Mabiri is an VHF radio with a "Line of Sight" broadcasting range which means if the radio is in a valley it is unable to go over mountains. This is why we are unable to communicate with our third health centre at Mpasazi. The radios that we use cost US$400 and is run by solar power.

We do have another radio system which is an HF System and can communicate much longer distances. We use it to communicate with Lilongwe, Livingstonia, Mzuzu etc. It costs much more, about US$1300 without Antenna and also runs off of 12v DC, in our case solar power. An Antenna is about US$300.

**UTILIZATION OF RADIO COMMUNICATION – MULANJE (Presented by Mr. Eliya)**

Mulanje and Phalombe has a population of over 850,000 people.

There are 50 Health Institutions in Mulanje and Phalombe. Mulanje has 36 Health Institutions. 18 are private, 4 CHAM, 9 MOH/Local Government and 5 MOH. There are 4 Health Centres that have radio communication and 5 Health Centres with telephones. The two centre with telephones are nearby Post Office.

Mulanje district has two big hospitals which are Mulanje District Hospital (MOH) and Mulanje Mission Hospital. The hospitals have telephones and fax. The centre of radio communication for both Mulanje and Phalombe is at Mulanje District Hospital.

Phalombe has 14 Health Institutions. 5 are MOH, 5 MOH/LOG and 4 CHAM. Out of these health centres 5 has radio communication and one centre has a telephone.

Mulanje and Phalombe district have a total of 24 maternity units, 13 in Mulanje and 11 in Phalombe. The total radio communication for Mulanje and Phalombe is 9 and 8 telephones.

**Problems**

- Frequent power cuts
- Lack of priority on which maternity case to pick first.
- Most ambulances are expensive to run therefore at times are off the road.

# IMPROVING ACCESS TO MATERNAL AND NEONATAL CARE

## UTILIZATION OF RADIO COMMUNICATION (THYOLO DISTRICT HOSPITAL)

Thyolo District is in the Southern Region of Malawi and shares boundaries with Mozambique, Chikwawa, Mulanje, Blantyre and Chiradzulu.

It has: 9 Government Health Centres
6 Council Maternity Units
6 CHAM Unit + 1 CHAM hospital
10 Tea Association Units

Radio communication has improved the maternal and neonatal care in the sense that it has improved the referral system from Health Centres to the mother hospital.

A telephone system is only available in 3 Health Centres

Radio communication started in 1994. We have 2 radio communication installed in 2 vehicles, and nine (9).

Health Centres (Government) which include:

- Thomas (out of order)
- ZOA
- Khonjeni
- Bvumbwe Research + telephone
- Bvumbwe (Makungwa)
- Mikolongwe
- Changata
- Thekerani + telephone
- Chipho

The hospital bought 2 of the radios and the rest were bought and installed by UNHCR and funds from the Dutch Government.

Maintenance is done by a government electrician based in the maintenance department of the district hospital.

**PROBLEMS**

- Electricity (power failure)
- Bad weather – heavy rains

ANNEX VIII

TRADITIONAL BIRTH ATTENDANTS UTILIZATION

BY

WORLD VISION INTERNATIONAL

# KABUDULA MICAH PROJECT PRESENTATION PAPER

SAFE MOTHERHOOD INITIATIVE
SHARING EXPERIENCES THAT
MAKE A DIFFERENCE

# TRADITIONAL BIRTH ATTENDANTS UTILIZATION

World Vision is a Christian humanitarian international non governmental organization with its headquarters in Washington DC in the United States of America. World Vision has its mission statement which is to follow our Lord and Saviour Jesus Christ in working with the poor and oppressed, to promote human transformation, seek justice and bear witness to the Good news of the Kingdom of God. We pursue this mission through integrated, holistic commitments.

World Vision as an international organization has support offices throughout the world, Africa inclusive. In Malawi the field operations support office is in Blantyre. There are three Regional Operations Offices in Malawi thus South, Centre and North.

Kabudula MICAH Project is located in T/A Kabudula, Lilongwe district in the Central Region of Malawi. It is situated 55 kilometers west of Lilongwe city, its nearest commercial center. The area is served with dusty roads which are almost impassable during rainy season. There is no telephone communication.

The project area has a population of 16,936 people and 3342 households. The target population is 4223 women of child bearing age and 1541 under five children (this was by December, 1997).

## TRADITIONAL BIRTH ATTENDANTS (TBAs)

### INTRODUCTION

These are trained middle and aged women who assist antenatal, postnatal mothers and new born babies (neonates) at village or community level.

Usually these TBAs are women who have the knowledge of assisting pregnant women from their grand parents. The Ministry of Health and Population does the active ones (already practicing) from the known TBAs within the community. For the one already in practicing, it is very easy for her to continue after training because the community already knows her work. The TBA is regarded to be active when she assists 3 or more normal deliveries per month.

### GOAL OF HAVING TBAs IN THE COMMUNITY

To help the nation have health live mothers and new born babies, hence the health status for the community is improved.

### BRIEF BACKGROUND

The Child Survival project to start with, had 15 TBAs active in its 14 centres that was from 1990 to 1997 when it completely phased out in the 10 centres.

Now the project is having 3 TBAs in its 4 centres where it is implementing micronutrient project activities. For proper running of the project activities TBAs inclusive, the project gave an initial training to those who were not trained (4 weeks duration) and made sure that these TBAs were being refreshed once a year for effective performance.

The project was making sure that the TBAs were getting all the necessary support from the office like equipment, spirit, cotton wool, cord ligatures, and treatment for minor diseases like ORS, eye ointment and iron for pregnant women.

**TRAINING**

The TBA initially undergoes a 4 week training then to be refreshed at least once a year. There are several topics which are covered during their training to help them assist the expectant, postnatal mothers and their new born babies accordingly. The topics which are covered during the training are as follows:

1. Management of a woman during antenatal period
2. Physical examination
3. Identification of mothers at risk
4. Examination and management of minor pregnancy disorders
5. Management of a woman during labour
6. Management of first stage of labour
7. Management of second stage of labour
8. Management of third stage of labour
9. Management of abnormal labour
10. Postpartum care
11. Management of engorged breast
12. Care of the new born baby
13. Physical examination of the new born baby
14. Management of common diseases associated with pregnancy like anaemia, malaria etc.
15. HIV/AIDS prevention
16. Management of a child with diarrhoea
17. Management of a child with neonatal tetanus
18. Management of a child with malnutrition
19. Primary Health Care (PHC)
20. Nutrition
    - Exclusive breast feeding
    - Weaning food
    - Mother
21. Care of equipment
22. Immunization
23. Family Planning
24. Information, Education and Communication (IEC) etc

On the above mentioned topics TBAs are taught in details on how to identify and manage problem when it arises.

## MICRO-NUTRIENT PROJECT FOCUS

The micro-nutrient project in Kabudula area is now focusing on 4 centers out of the initial 14 centers and in these 4 centers there are 3 TBAs active and already trained. The project staff make sure that they visit the TBAs once or twice a month, to trace their needs as they continue the good work. The project gives them iron for the pregnant mothers, cord ligatures etc, when we have them in stock.

The project is also constructing TBAs huts for these TBAs to create a clean and roomy environment for a TBA to perform her job as expected to end up with a healthy live mother and a healthy live infant.

The project will make sure that all amenities which are necessary for a TBA to perform well are built during construction of the hut like placenta pits, pit latrines, bathrooms etc.

TBAs are more influential in the community. They help in many ways for proper project activity implementation. They educate mothers on importance of family planning, vitamin A, growth monitoring, how to combat iron deficiency anaemia like educating the community on growing and utilizing dark green vegetables at household level.

## RECOMMENDATIONS

1. **Supervision**

   Frequent supervision is one of the most important tool to make our TBAs more active and through supervision the cleanliness and sanitary amenities can be improved. If the cleanliness can be maintained then there will be reduction of infection like tetanus, puerperal sepsis hence death is reduced. Supervision be done once or twice a month.

2. **Refresher Trainings**

   As we all very know that a TBA usually an elderly person, it is very easy for them to forget what they have been taught. I would recommend at least to have a refresher course twice a year. (CBD Agents twice a year more literate than TBAs).

3. **Criteria for Selecting TBAs**

   The selection should be done by the local community together with the health personnel and guidelines for choice should be clearly known by the community. This is to avoid high drop out rate if they are chosen by local influential , local leaders who tend to choose their relatives thinking the issue is money related and in the end after discovering that they are not getting anything, they stop and then the community suffers.

## SUMMARY/CONCLUSION

In brief this is what World Vision is doing in utilizing TBAs in Malawi in the local communities where it is having its projects throughout the country. TBAs provide basic maternity care which in most cases is inaccessible to the underserved areas of the country. There is however, a need to ensure that TBAs limit their practice to normal pregnancies and risk identification for timely referral.

**Annex ix**

**INTERVENTIONS FOR MATERNAL AND NEONATAL SURVIVAL (By Dr. Ebanyat - WHO Technical Advisor)**

Major causes of maternal mortality in Malawi:

- Puerperal sepsis
- Haemorrhage/anaemia
- Hypertensive disease of pregnancy
- Obstructed labour (rapture/haemorrhage/sepsis)
- Abortion (haemorrhage/sepsis)

Major causes of perinatal/neonatal mortality

- Birth asphyxia
- Low birth weight
- Sepsis
- Hypothermia
- Haemorrhage
- Congenital abnormalities

Major underlying factors

- Socio-cultural
- Economic
- Education
- Fertility
- Health service factors
    - poor access
    - low quality of services
    - inadequate equipment, supplies
    - lack of trained staff
    - poor referral system

**Levels of care**

- Community
- Health Centre
- Hospital

**Interventions/activities to reduce mortality:**

**Pre-conceptional period**

For young girls, adolescent and lactating mothers

1. Social mobilization
   Sensitization on perinatal and maternal mortality

Sensitisation on risk factors associated with pregnancy e.g. age, close births, many births, reduction of workload for girls and women.

2. Nutrition:
   Good nutritional habits
   Strengthening food security
   Use of iodised salt, vit A supplement
   Growth monitoring
   Encourage/promote breastfeeding

3. Anaemia
   Promote proper nutrition, iron folic acid supplements and antihelminths.

4. Basic education for girls
5. Family life education
6. Family planning services
7. Immunization for U5 and mothers with TT
8. Screening for STDs/HIV, breast and Cx cancer

**During Pregnancy**

- Community mobilization including education on high risk factors
- Provision of ANC/counsel for assisted delivery
- Nutrition including breastfeeding
- Immunization
- Abortion care and counseling for FP
- Management of ectopic pregnancy/antepartum haemorrhage
- Management of STDs

**During Delivery**

- Identify high risk births and major cases of mortality and refer early
- Clean safe delivery at all levels to reduce sepsis
- Foetal monitoring for foetal distress, malpresentation, fever.

**Immediate Postpartum**

Mother – routine surveillance, PPH
Care for newborn – resuscitation, cord care, thermal control, eye care, breastfeeding, examination for weight, congenital abnormalities.

**Late Postpartum up to 6 weeks**

PPH, eclampsia, sepsis
Routine PNC
Care of the newborn.

ANNEX x

# MEDICAL COUNCIL OF MALAWI

# INSTITUTIONALISATION OF QUALITY ASSURANCE IN MALAWI

## KALIKUTI HOTEL – LILONGWE
## 28 – 29 SEPTEMBER, 1998

## INSTITUTIONALISATION OF QUALITY ASSURANCE IN THE DISTRICT HOSPITALS

Institutionalisation of quality assurance in the district hospitals will begin with identification of a District Quality Assurance Facilitator (DQAF) in each district. Individuals will be selected by the District Health Management Teams (DHMT). Those chosen shall ideally be members of the DHMT. If not he/she shall report to the DHMT.

District Quality Assurance Facilitators must have:

- Initiative
- Commitment
- Motivation
- Ability to communicate and teach
- Sense of responsibility.

He/she will need to commit most of his/her time to quality assurance activities especially in the initial period.

Selected individuals will initially receive an initial five day training in QA skills. After 3 months, the QAFs will be called back for a two week training in coaching skills.

Districts with larger number of health facilities can request to train more than one DQAF to cover the district within 5 years. CHAM institutions wishing to have in-house QAFs will have to apply for their candidates to attend QA courses organised by Medical Council of Malawi until establishment of the national QA Unit.

## RESPONSIBILITIES OF THE DISTRICT QUALITY ASSURANCE FACILITATORS

- Facilitating QA activities at services delivery level including all private facilities in the districts.
- Provide just-in-time training in QA methods and tools
- Monitoring and evaluating QA activities at service delivery level by visiting facilities at least once every month.
- Conducting an inventory of the existence and knowledge of standards at service delivery level.
- Net working at all levels
- Organising QA forums at district level
- Communicating QA activities to the region.

## INITIATION OF QUALITY ASSURANCE AT SERVICE DELIVERY LEVEL

Quality Assurance will initially begin in all districts. *Each district will initiate QA activities with 3 health facilities beginning with the district hospital, one health centre and one CHAM health facility.* After six months another set of three health facilities will be targeted in each district. The six months period is needed to develop health facility capacity to independently conduct QA activities. This pace will be maintained until all health facilities in each district in the country are covered.

## DISTRICT QUALITY ASSURANCE COMMITTEE

Every district hospital will have a District Quality Assurance Committee (DQAC). This committee will comprise of the following members:

- District Quality Assurance Facilitator
- Selected members from the district QA team (including management).
- Community members
- Co-opted members

## RESPONSIBILITIES OF THE DISTRICT QUALITY ASSURANCE COMMITTEE

- Setting and adopting standards in line with set standards at national level.
- Communicating new or revised standards to service delivery level
- Implementation of problem identification, problem prevention, and problem solving at district level.
- Develop annual workplan for QA activities at district level.

## NET WORKING IN QUALITY ASSURANCE

At district level, Quality Assurance forums will be organised quarterly by the District QA Facilitators. These forums will bring together staff from:

- Health facilities
- NGOs working in the health sector
- Representatives from the community
- Local leaders.

At these forums participants will exchange experiences, advocate for quality assurance and create linkages. Similar forums will be organised by the Regional QA Facilitators twice a year at regional level and by National QA Unit annually at national level.

## QUALITY ASSURANCE – EKWENDENI (Presented by Mr. Kamanga)

### Utilization of staff on Quality Assurance at Ekwendeni Hospital.

Three people who came back from Lunzu Quality Assurance workshop, briefed the hospital staff before formation of the committee.

Nine people were chosen to look at the long waiting time at antenatal clinic. One member deferred, the eight people continued as committee members. The team comprised of one team leader, record keeper and time keeper. The committee at the beginning used to meet two times a month for one hour and half. The people chosen were four from the management one Medical Superintendent, the Matron, one Medical Officer, one Dr PHC Directory involved with research, two Community Nurses, one Sister from Maternity and Accountant.

The group has been maintained intact due to the co-operation that exists at the hospital. The management support was also favourable. Fellow members of staff gave us their support although not as members of the team.

Impact of the program has been that the numbers of hours taken have been reduced from 5 hours seeing 200-300 clients to $2/^{1/2}$ hours as evaluated in September, 1998. The time recorded starts at the time the client enters the gate up to the time the client walks out at the gate. The improvement has been made with the additional rooms for examination, additional nurses, Laboratory Assistants taking blood at the start of antenatal clinic. Drugs are pre-packed, results of VDRL, HB written on chart before hand. With the above solutions more time is given to the woman's examination rather than haste examinations.

ANNEX XI

# ASSESSING REQUIRED INPUTS FOR ENSURING ACCESS TO QUALITY ESSENTIAL OBSTETRIC CARE THROUGH THE SOUTHERN REGION SAFE MOTHERHOOD PROJECT.

## GOAL:

**To reduce maternal mortality and morbidity in the Southern Region.**

# Outputs

- Increased awareness
- Improved availability & accessibility
- Improved quality of care
- Improved referral systems
- Effective monitoring systems

# Strategy

**A phased approach over 6 years, with a major focus on community participation**

- infrastructure
- equipment
- transport & communication
- training
- drugs
- IEC
- monitoring

# SAFE MOTHERHOOD PROJECT
# Needs assessment: Why was it done?

- Project Implementation will focus on the development of Safe Motherhood Plans for each of the districts in the Southern Region
- The development of these district plans will be based on the information gathered from the needs assessment
- The needs assessment:
  - obtained information on the seven components of the Project
  - was carried out between the months of July to September 1998
  - was specific to the districts of Blantye and Nsanje
  - will culminate in the development of district Safe Motherhood Plans for Blantyre and Nsanje
  - will also assist in the development of operations research
- Will be repeated in other target districts (3 per year) during the project life

# *Participatory Needs Assessment*

## *Main Objectives*

***Overall Aim: To provide necessary information for the refinement of the implementation strategy as defined by the 7 major project components***

1.0 To ascertain (1) How obstetric complications are recognised
(2) The actions subsequently taken (from village to tertiary level)

2.0 To determine cultural, physical, financial and/or social barriers to health service utilisation

3.0 To analyse current IEC strategies, identifying gaps and potential channels for effective communications in order to develop district-specific IEC campaigns

4.0 To assess the quality of obstetric care offered at obstetric care facilities by:

- *Identification of important quality of care factors as perceived by users/providers*
- *Satisfaction level of users, providers and managers with services offered*
- *Community and health staff's perceptions of the status of physical infrastructure, obstetric skills level, and drugs and equipment*

5.0 To assess the role of policy makers, politicians, government and non-government organisations (at operational levels) regarding issues pertaining to Safe Motherhood

# SAFE MOTHERHOOD NEEDS ASSSESSMENT
## Methodology, sample size, target

- Qualitative
  - FGDs
  - Key informant interviews
  - Role Plays
  - Critical Incidents
  - PLA: Venn diagrams, mapping, ranking
- Over 100 exercises performed
- Target population: users, non users, service providers and managers

- Quantitative
  - Questionnaire surveys
- Sample size up to 2000 individuals
- Target population: users, non users, service providers and managers

## The Elements of Quality of Care

1. Promotion and protection of health.
2. Accessibility an availability of services.
3. Acceptability of services.
4. Technical Competence of health care providers.
5. Essential supplies and equipment.
6. Quality of client/provider interaction.
7. Information and counselling for the client.
8. Involvement of clients in decision making.
9. Comprehensiveness of care and linkages to other reproductive health services.
10. Continuity of Care and follow-up.
11. Support to health care providers.

Mother Baby Package, WHO, 1996

*'their daughter had been in labour for two days. ... and the mother-in-law kept saying 'Push! Push!' ... she refused to take the woman to hospital because she had delivered babies before. I left them alone. ... the woman was referred to hospital on the seventh day after the onset of active labour.*

Rural TBA, Nsanje

***What do you think caused this bleeding?***

*'She was 7 months pregnant. At first I thought she was bewitched. The parents of my wife think that even now. I don't think so though, but I can't tell you the cause.'*

Husband, Blantyre, following wife's death

## Promotion and Protection of Health.

- No IEC materials on dangers signs in pregnancy
- 50% of women and 89% of men report receiving health information on the radio however only 3% of women and 2% of men recalled receiving information on safe motherhood or dangers in pregnancy by this route
- 22% of women report receiving information on danger signs and complications in pregnancy
- Low community awareness of danger signs
- bleeding was mentioned by 19% of women and 13% of men
- fever or sepsis were not mentioned by anyone

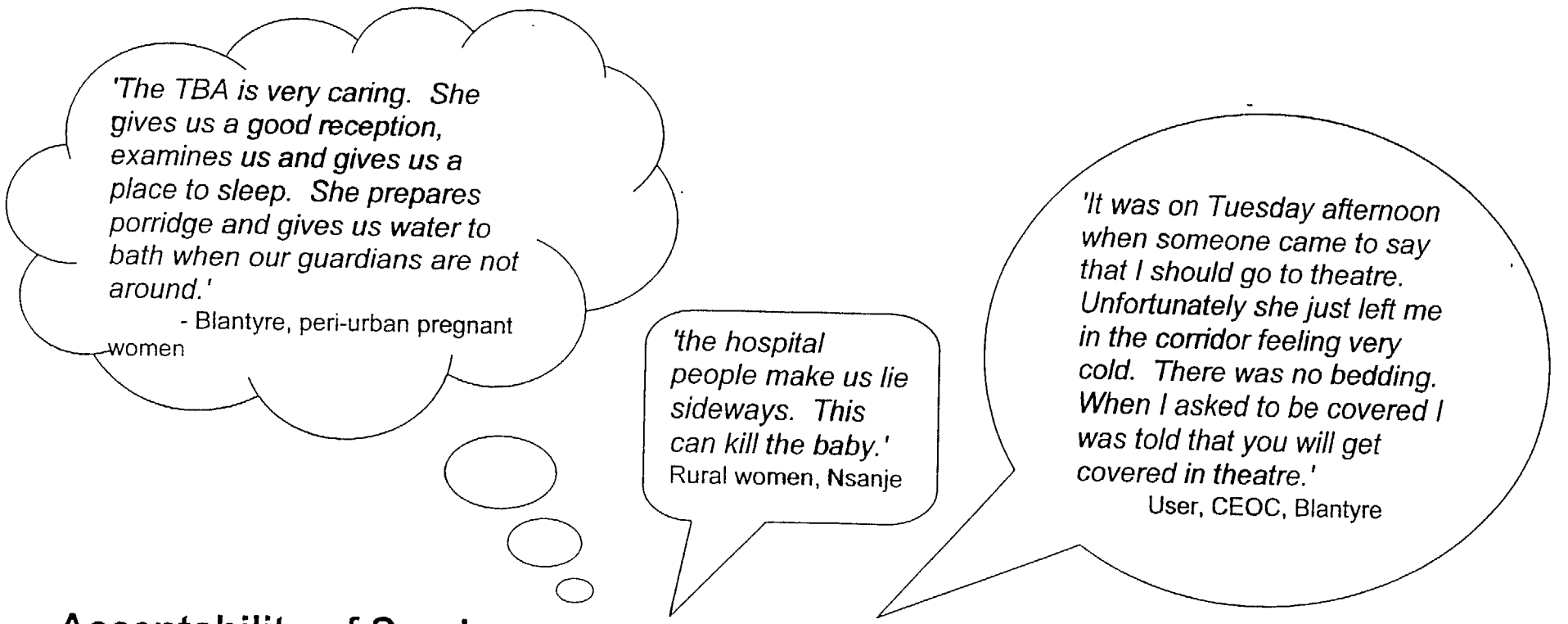
The doctor *'was in a meeting and told us to wait until it had finished. The meeting was almost 2 hours…. The nurse put a tube down … and blood* (came) *up from her stomach into a bottle. By the time the doctor came to us from the meeting she had died.'*
Husband, Nsanje, following wife's death post c-section.

*'Both times I started labour suddenly and ended delivering at home'*
Rural woman, Nsanje

*Also she was sent away two times* (from the health centre) *over 3 weeks and when she finally got to the hospital the staff were angry we had waited so long, when we didn't wait at all, but trusted the doctor and he let us down.'*
Huband, Nsanje, following wife's death

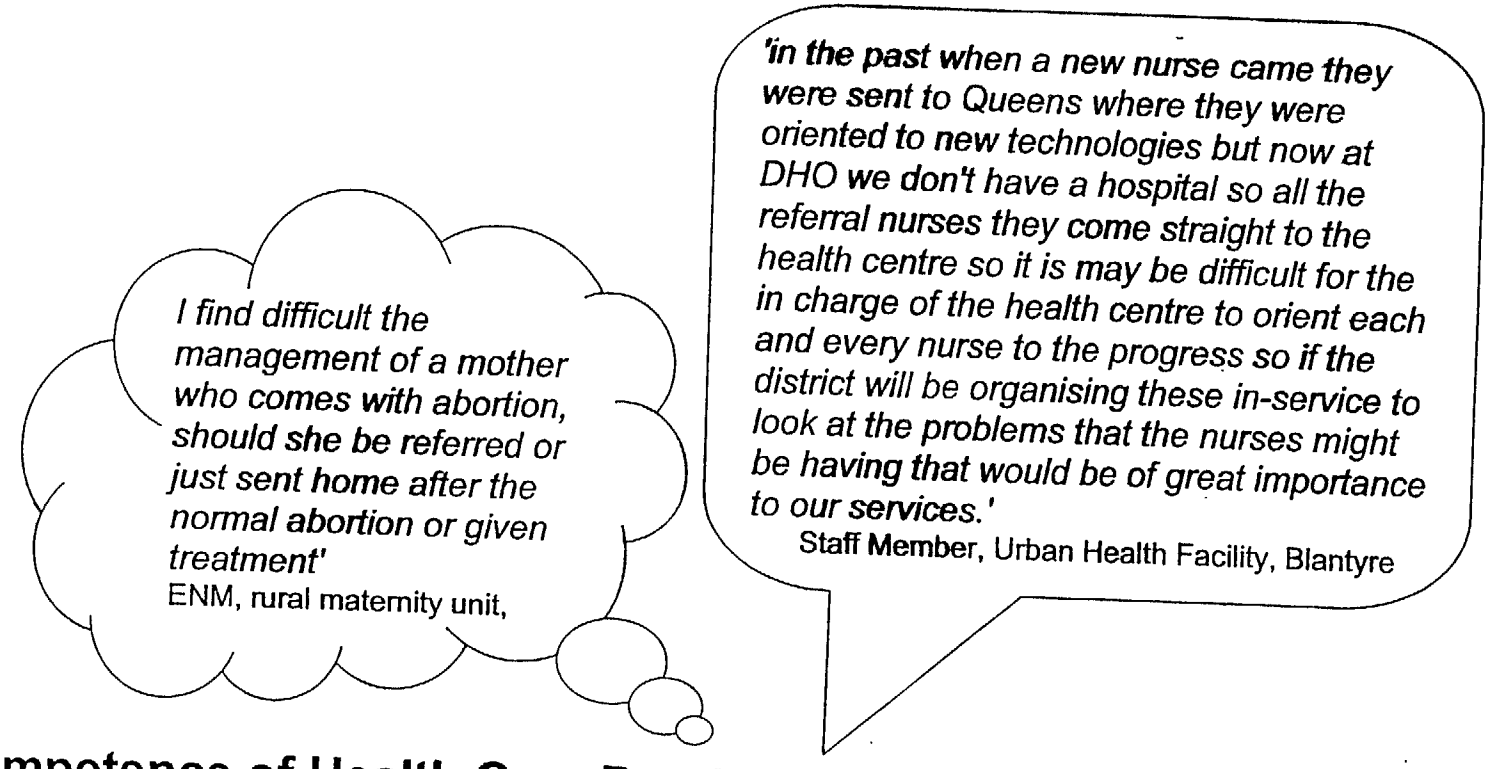
## Accessibility and availability of services.

- The majority of women walk, even if suffering from complications
- Women are afraid to walk at night
- The majority of women report travelling 2-5 km to their nearest maternity unit
- 23% of people in Nsanje and 9% in Blantyre reported travelling more than 5 km to their nearest maternity unit (23% did not know)
- 90% of users with out access to a maternity hut wanted one.
- 28% of users with access to a maternity unit used it one this visit.



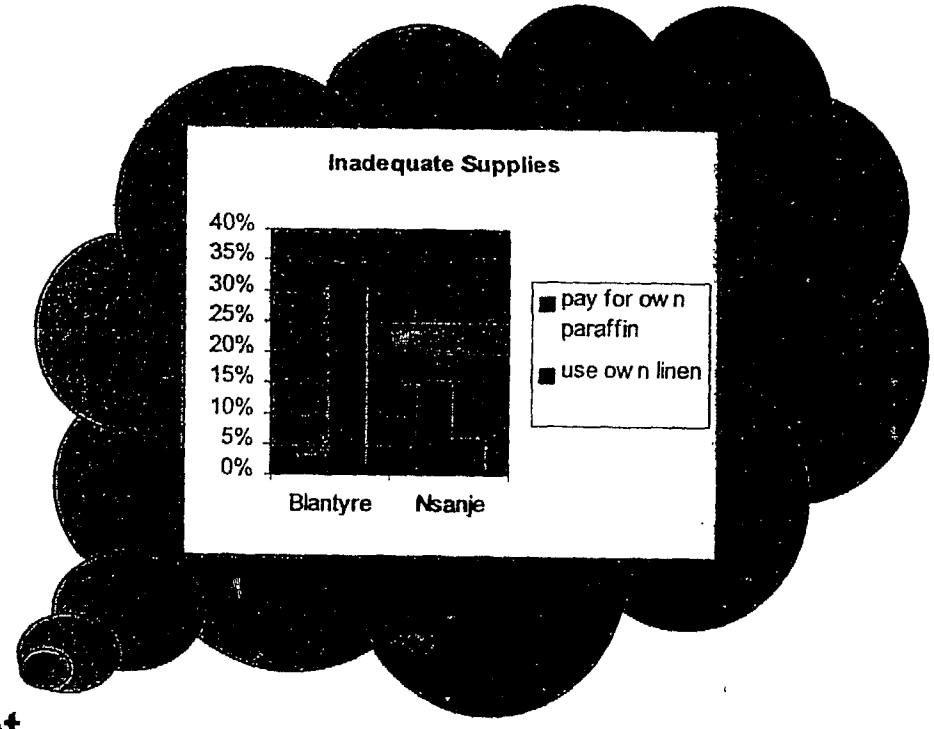

## Acceptability of Services

- Maternity service use may be constrained by cultural believes regarding causes of complications, hygiene, delivery position and disposal of placenta.
- 20% of women would not attend if buildings were poor
- 24% of users ranked infrastructure and facilities as the most important factor in the provision of quality obstetric care
- Inability to wash before and after labour strongly discourages 45% of users from attending for delivery




## Technical Competence of Health Care Providers.

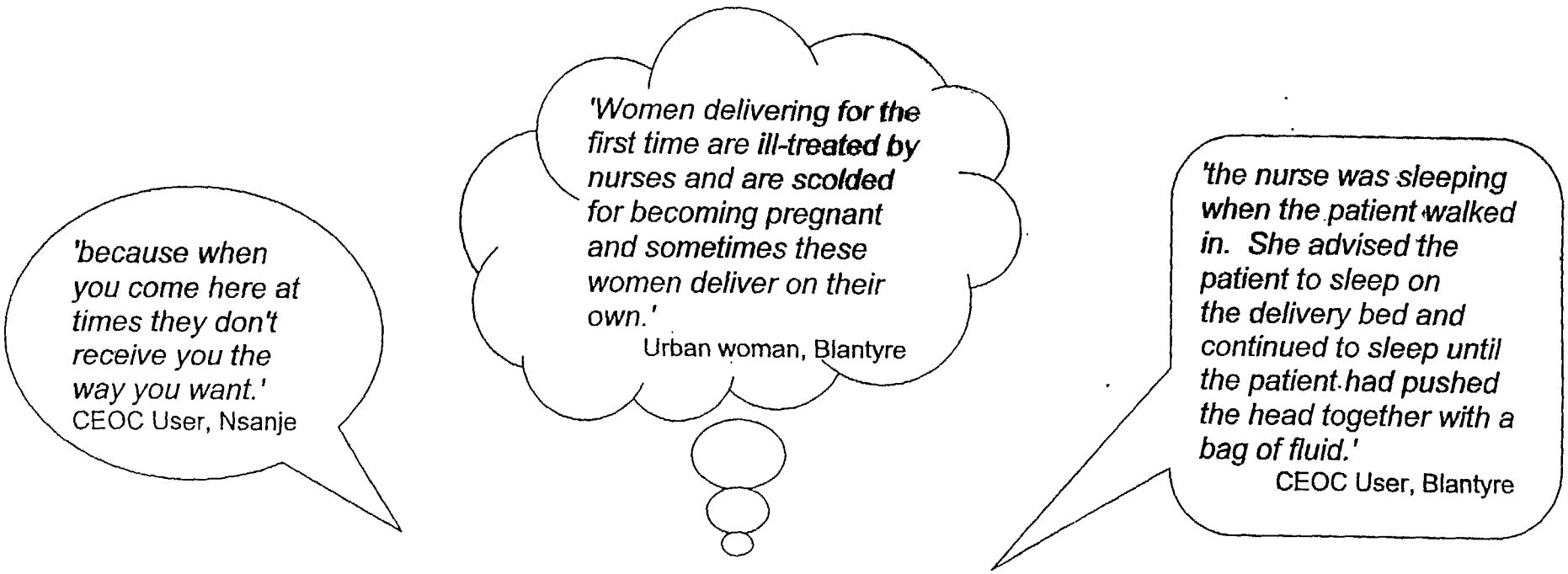
- No member of health staff named all five of the main obstetric complications (APH/PPH, obstructed labour, (pre)/eclampsia, sepsis, ruptured uterus)
- 45% named only one
- Low level of self-rated competency in handling obstetric complications
- High level of self-rated competency in technical skills




# Essential Supplies and Equipment

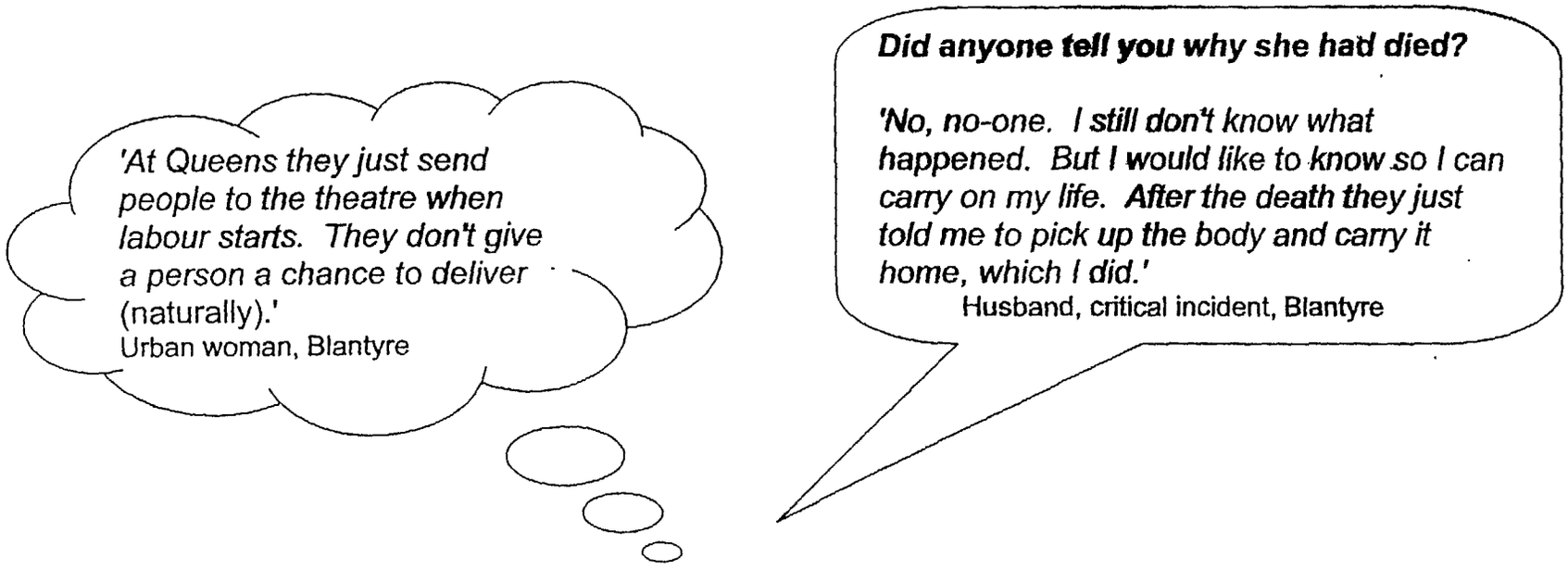
14% of users rated equipment and drug availability as the most important factor for quality obstetric care

- 85% of maternity units suffer drug shortages
- inadequate drugs and equipment was cited by staff as their main reason for dissatisfaction with obstetric service provision and as a major de-motivating factor
- 4 -15 % of users pay for their own paraffin
- 6 - 34% of users provide their own linen



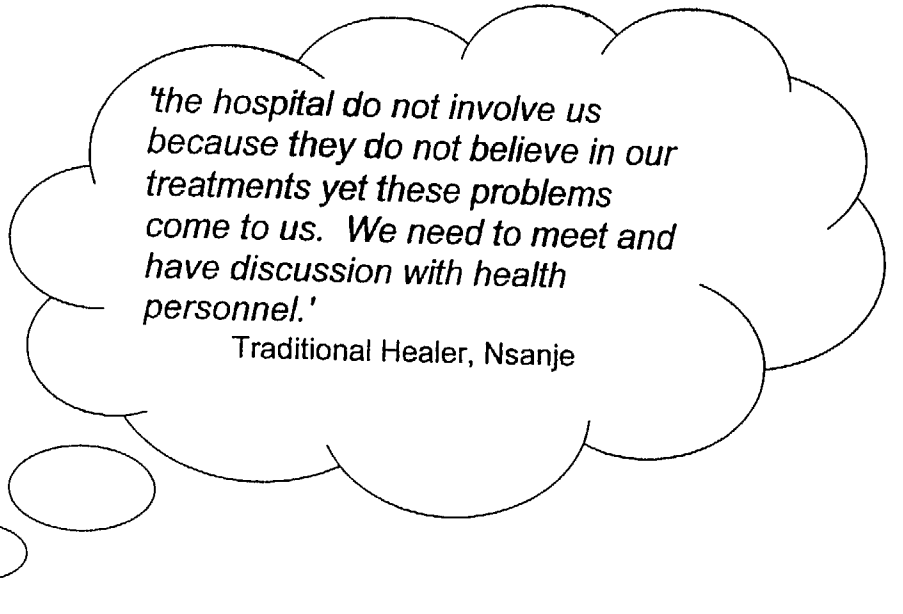

## Quality of client/provider interaction.

- Good reception and staff behaviour and prompt, appropriate care were cited by users as the most important factors for quality obstetric care
- Reception is often perceived as poor
- 23% of users are dissatisfied with waiting time before delivery and 18% with waiting time during delivery.




## Information and counselling for the client and involvement of clients in decision-making

- Only 6% of users reported receiving discharge advice on bleeding and less than 1% on fever
- In all the critical incidents explored the family did not know the cause of death




## Comprehensiveness of care and linkages to other reproductive health services.

- High level of awareness of family planning and HIV/AIDS
- Possible confusion between malaria and sepsis
- 32% of health personnel feel there should be more co-ordination with traditional healers.
- 15% of users think it would be beneficial if health staff involved traditional healers in women's care sometimes.

*'since we don't do antenatal clinics here - antenatal clinics are done by the city clinics - yet they just come here for delivery and we don't know if they have been having problems during antenatal care so want if we could be examining pregnant women also here.'*

Staff Member, Urban Maternity Unit, Blantyre

## Continuity of Care and Follow-up

- Antenatal, peri-natal and post-natal care are frequently carried out in different locations
- 29% of Users in Blantyre and 56% of those in Nsanje reported that they were not asked to attend for any type of follow-up visit post-natally

(To improve quality of care we need) *'proper and frequent supervision of those in charge and follow-up of any blunders made.'*

ENM, CEOC, Blantyre

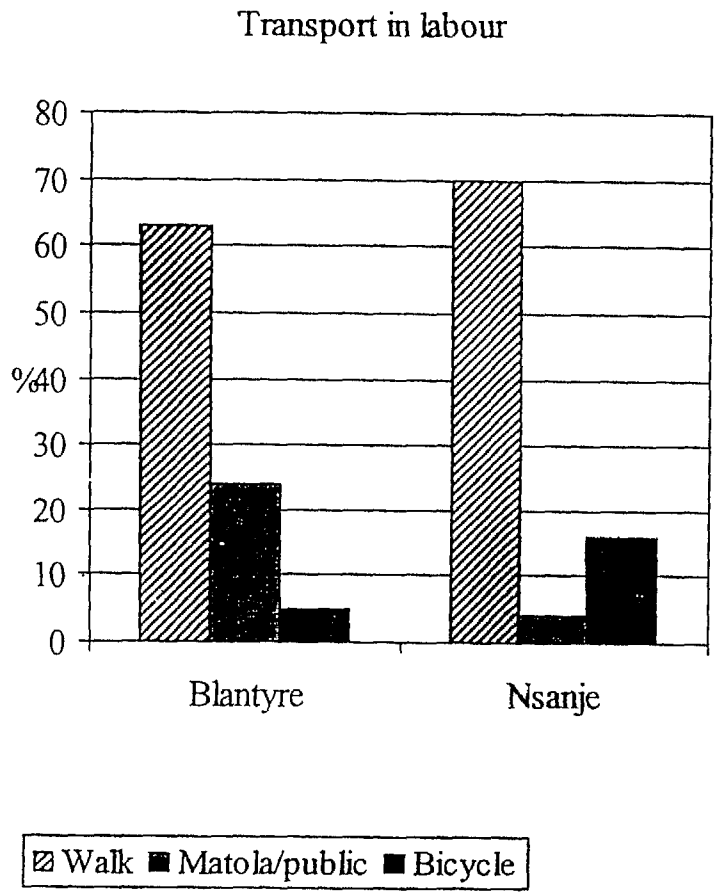
*'working conditions of midwives should be improved in terms of staffing, promotions and some incentives. Whenever some good activities are happening at the hospital such as workshops the midwives should also be considered not only the same people. One becomes lazy due to some disappointments from management.'*

Nurse Midwife, CEOC, Nsanje.

## Support to health care providers.

- The majority of staff feel only moderately or not motivated.
- Staff rank salary increase, inservice training and more staff as their top three motivating factors.
- 7-17% of health personnel are not satisfied with the obstetric care they provide. 19% (18-21%) are very satisfied
- too few staff and inadequate equipment and drugs were the most frequently mentioned reasons for staff dissatisfaction.
- 68%(57-71%) of health personnel rank the emergency obstetric care they provide as good or very good.

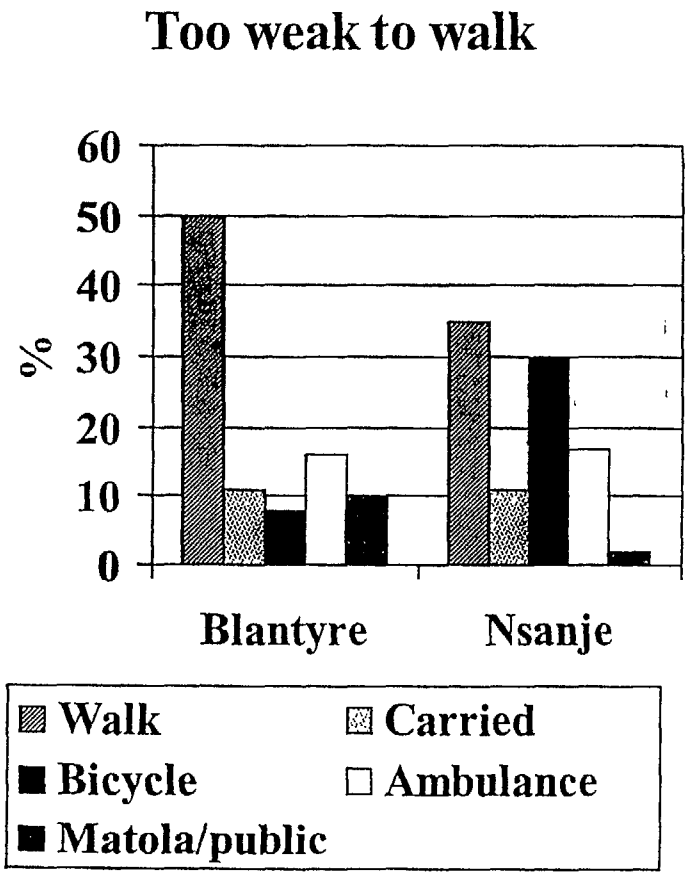
# Transport - the community




- The majority of women in labour walk to delivery site
- Use of bicycles is not very common: (reasons cited are that women fall off easily, difficult to cycle in some terrain, must have accompanying elder woman to help deliver, so not much faster than walking)
- Use of matola/public transport and bicycle notably different in both districts

## Transport - the community

- Still a large majority who have to walk
- Interesting differences in the use of bicycles and matola in the two districts remain
- May have implications on the appropriate village transport mechanisms to be put into place
- Operations research



## Transport

- **85%** (45/53) of Health Personnel in Blantyre and **79%** (14/19) in Nsanje felt that the time between a referral call and the arrival of the ambulance was unacceptable.

- 12/13 Health Managers concurred with this view.

Health Managers suggested the following solutions

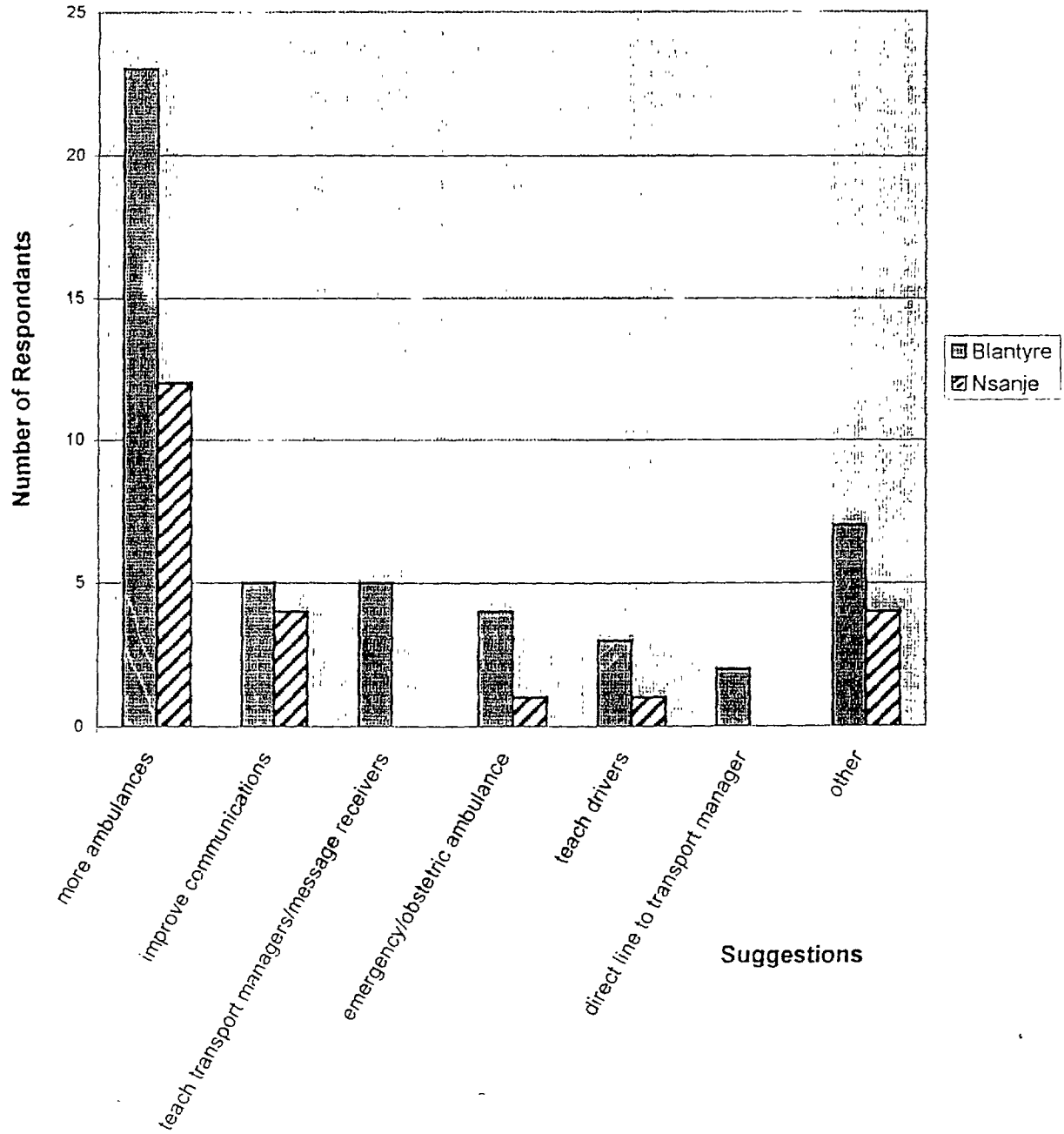
- provision of more vehicles some of which could be placed at distant health facilities,
- implementation of better control mechanisms including a record book to monitor the use of the ambulance,
- regular servicing,
- allocation of one driver to each car,
- allocation of one ambulance especially for emergencies and
- training of transport officers and drivers.

Lack of Transport is also Perceived to Cause other delays in Delivery of Emergency Care:

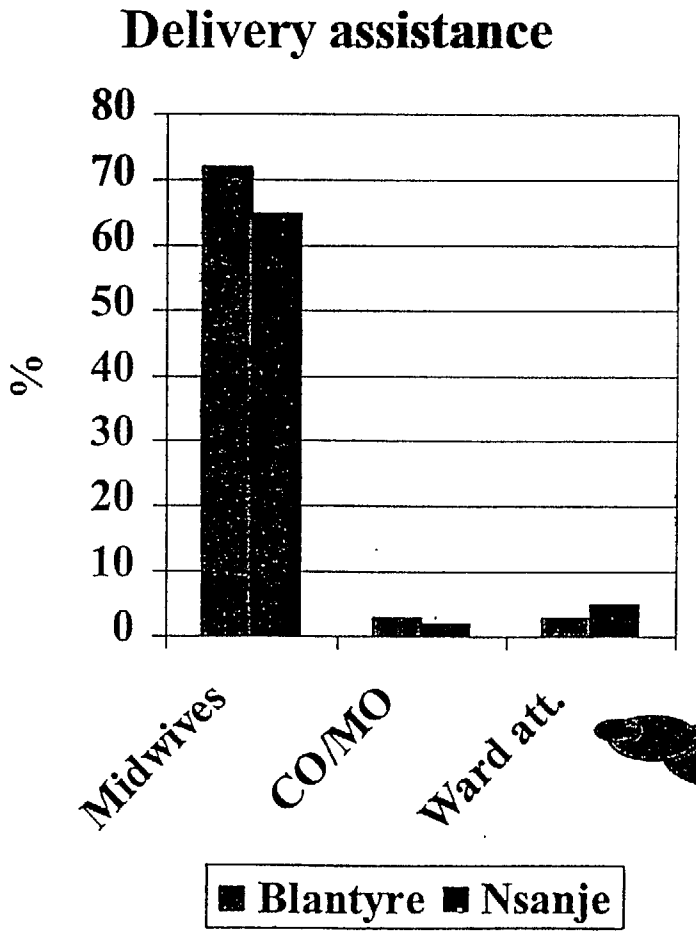
*'there is no emergency here. It's difficult to collect theatre staff when there's no vehicle as a result we have seen patients waiting a long time before a caesarian section is done.'*

- District Health Manager's Questionnaire, Blanytre

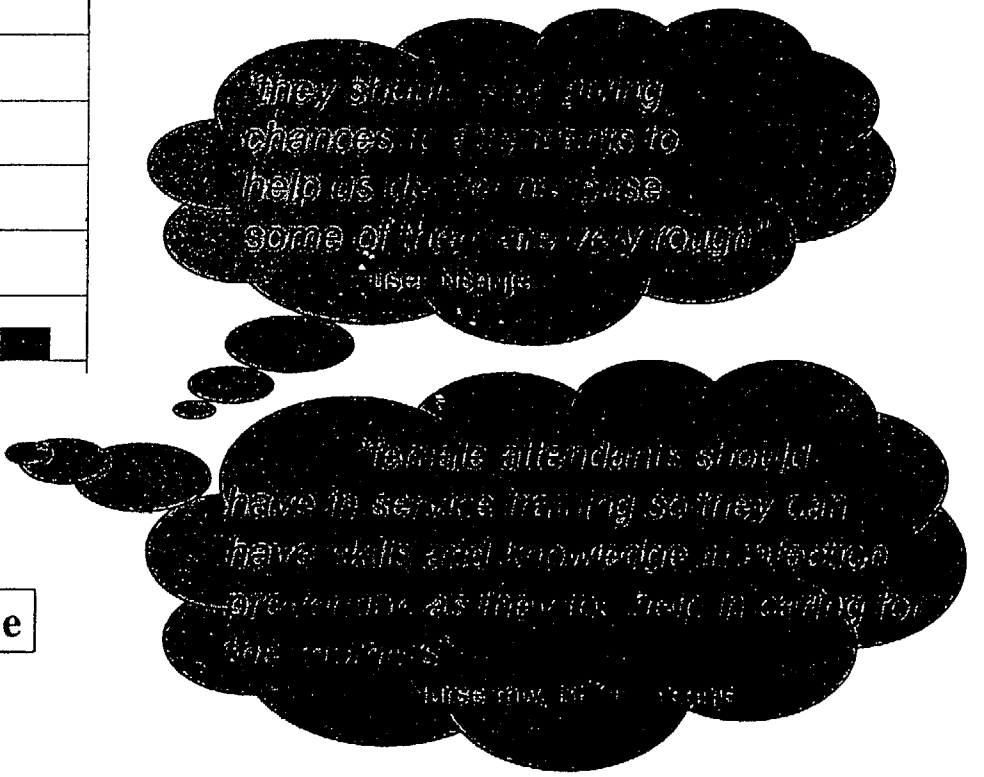
## Health Personnels Suggested Solutions to the Transport Difficulties (n=59)



# Training of para medical staff




- 5% of deliveries are conducted by ward attendants/cleaners
- This has important implications on training



## Transport and para-medical staff training
## Conclusions

- Transport
  - Most people walk
  - interesting differences in choice and availability of transport in Blantyre and Nsanje
  - alternative solutions to resolution of difficulties have been suggested by hospital personnel, e.g. training of para-medical staff
- Training
  - may need to include para medical staff like ambulance drivers, ward attendants and message receiver
  - impact and appropriateness of this training is uncertain: potential for operations research

## SAFE MOTHERHOOD NEEDS ASSESSMENT
## What next?

Much of the data confirms what is already known but gives more information on how to find solutions.

We will use the data:

- to develop safe motherhood district plans based on district specific needs
- to verify the appropriateness of project activities already in place and correct inputs if necessary
- as a baseline to measure the impact of the project
- to compare between districts
- to develop appropriate interventions for implementation
- to develop ideas for operations research
- for dissemination to all interested parties

Annex xii

# CONTROL OF STANDARDS IN PRIVATE MATERNITY PRACTICE

A PAPER PRESENTED AT THE SAFE MOTHERHOOD CONSULTATIVE WORKSHOP ON
28th – 29th SEPTEMBER, 1998

BY

R.C. MBVUNDULA (MISS) BSc. CERT ED. RNM
NURSES AND MIDWICVES COUNCIL

## NURSES AND MIDWIVES COUNCIL OF MALAWI

## CONTROL OF STANDARDS IN PRIVATE MATERNITY PRACTICE

### 1. INTRODUCTION

THE Nurses and Midwives Council is a regulatory body for nurse-midwives and nursing midwifery technicians in the country and is responsible for nursing and midwifery standards. In this paper I will highlight how Nurses and Midwives Council controls the standards of private maternity practice. However, before discussing this, the definition of standards and why midwives in private practice need standards will be explained.

### 2. DEFINITION OF STANDARDS

The word "Standard" in dictionaries has several meanings. One that concerns us in the use of standard is to mean.

Measure for quality or required degree of excellence.

ICN (1989) defines standards as "Desirable and achievable level of performance against which actual practice is compared".

ANA (1989) defined standards as "An agreed upon level of excellence or level established by authority, custom or general consent as a model or example".

### 3. WHY DO MIDWIVES IN PRIVATE PRACTICE NEED STANDARDS

Standards of midwifery practice are needed for several reasons:

3.1 They guide the midwives into purposeful, safe and effective midwifery care.

3.2 They serve as a basis for objectively evaluating staff performance and quality of midwifery care. (Quality Assurance Programs).

3.3 They serve as management tool to aid in planning of midwifery care and resource allocation e.g. equipment, supplies, staff required and procedures.

3.4 They enhance professional identity and communicate nature of midwifery practice to others (e.g. the public, other health professionals, policy makers etc)

3.5 They promote universal level of performance which enhance a broad and uniform development of midwifery and increases the mobility of midwives.

3.6 They describe incompetent practice less than the predetermined standards of practice.

3.7 They form a basis for legal sanctions in case of incompetent practice.

## 4. STANDARDS PUT IN PLACE FOR PRIVATE MATERNITY PRACTICE BY NURSES AND MIDWIVES COUNCIL

4.1 An application should be made to Nurses and Midwives Council by anyone wanting to set up the practice stating specifically what services they want to provide e.g. maternity services

- antenatal
- intra-natal and postnatal
- under-five
- family planning

4.2 Nurses and Midwives Council checks the eligibility in terms of

- qualifications e.g. registered/enrolled under the Nurses and Midwives Act

- suitable experience in midwifery – at least 2 years period.

- Registration status with the Council.

4.3 Advised to construct a building suitable for maternity practice to include the following:

- Antenatal ward
- Labour ward
- Postnatal or (combined with antenatal ward)
- Sluicing area
- Placenta pit
- Incinerator

No premises shall be used for the purpose of private maternity practice unless authorised by the Nurses and Midwives Council.

4.4 Requirements as per list provided to be purchased.

4.5 The Midwife or employee of the practice to undergo refresher course in the specified area to update in knowledge and skills.

4.6 To make arrangements for referral of patients e.g. transport or make arrangements with Doctor or Clinician to see the patients at the clinic.

4.7 To be supervised by District Nursing Officer in the district and be incorporated in workshops/seminars for update purposes.

4.8 Pay a prescribed fee for licence – initial fee is K5,500.00 and annual renewal fee of K2,000.00.

4.9 The Nurses and Midwives Council may for good cause, refuse to issue a licence or may withdraw or cancel such a licence issued to any person indefinitely or until such time as the condition if any imposed by Council have been fulfilled.

4.10 Any person who engages in private maternity practice without a licence authorizing her/him to do so in accordance with this Act or regulation made thereunder shall be guilty of an offence and liable of a fine of K2,000.00 or imprisonment for a year.

## 5. CONTINUOUS MONITORING FOR CONTROL PURPOSES

From time to time the Nurses and Midwives Council is mandated to enter these premises to conduct such monitoring functions to ensure that the midwifery standards are maintained.

During such visit the following are checked:

### 5.1 Oragnisational factors and physical environmental conditions

These include:
- general hygiene
- staffing patterns and their qualifications
- current registration status
- refresher course or any update
- review of equipment and facilities available
- transport arrangement/referral mechanisms
- policies available in relation to the practice

### 5.2 Outcome factors

- Number of deliveries conducted
- Type of deliveries e.g. twins etc
- Number of referrals
- Number of deaths – maternal/neonatal and reasons given
- Patients response to the care given

This course takes account the best use of available resources.

**References:**

American Nurse Association – Standards for Nursing Services, Kansas City 1989.

International Council of Nurses (ICN) Report on the Regulation of Nursing (based on a Project Report by Dr. Margretta Styles) ICN, Geneva 1989.

Nurses and Midwives Act 1995.

By R.C. Mbvundula (Miss)
**SENIOR NURSING OFFICER (INSP) NMCM**

ANNEX XIII

**ASSISTING DISTRICT HEALTH MANAGEMENT TEAM PROVIDE QUALITY BASIC OBSTETRIC CARE THROUGH C.E.S.T.A.S SAFE MOTHERHOOD PROJECT: BY. E. KARI – MIDWIFERY PROJECT CONSULTANT.**

One year ago a workshop was held in Lilongwe at DHO to identify problems at district level on Mother and Child Health for the CESTAS Safe Motherhood Project Implementation.

**Problem Identification**

From the problem identification exercise, the poor quality of mother and child health service in the district centers was agreed upon as a major problem requiring assistance from external funding.

The poor quality of health Service was attributed to low staff moral resulting from:

- Inadequate distribution of health personnel
- No inservice training and educational program
- No supportive supervision
- Low salaries and incentives

**Proposed Solution:**

- Frequent supportive supervisions
- Inservice training
- Provision of equipment and supplies
- Improving working conditions
- Improving salary/allowances

**Assisting HCs to provide quality maternal and neonatal care**

According to the findings and solutions put forward by the participants in the workshop mentioned above CESTA Safe Motherhood Project's team consisted at that time of four Malawian and one Italian Midwives started supervision at the HC's in Lilongwe District in the beginning of this year.

Only HC's with maternity ward was included in the supervision, but now HC's with ANC are included, 33 all together. Later this year even CHAM hospitals will be included in the project. Health centres who provide antenatal care are now included because if we want to take part in the battle in reduction of maternal and neonatal death then the care of women has to start during the pregnancy.

In June/July the project introduced the high risk pregnancy registered at the HC's. With the already heavy work load on the midwives, introduction of one more thing as the HRR met some resistance in the beginning. This was viewed by the project staff as a healthy attitude, as it provided opportunity for the midwives to voice out some of their concerns.

But now 23 HC out of 33 are using the High Risk Pregnancy Register. Women identified as HR from either previous obstetric history, medical history, family history or from the present pregnancy by examination will be registered and followed closely during pregnancy.

After three months the feedback from nurses/midwives are positive, they found it useful.

**Important:**

The mother is given time for the next visit, how frequent, depends on the problem identified.

**Community Involvement**

To increase communities awareness on risk factors during women's childbearing age, was mentioned as an important factor for solutions.

If she is not coming, what has happened?
The community health workers participation!
The TBAs participation
The co-operation with the trainers of TBAs and the TBAs is part of the project. We have till now only visited briefly the F.T. centre and supported two courses with TBA delivery kits.

TBAs on training will be informed what the STAR means:
HRP, Transfer to hospital. Are not supposed to be delivered by TBAs.
From the experience we have with the TBA training and practice, there is a need for the Safe Motherhood Program to critically look at the content of the TBA curricular and areas that need to be stressed during training.

**ANTENATAL CARE**

The card is a tool for the professional and caring midwife. It can not be emphasised enough on how important it is to take this card seriously. The way the card is used and analysed tells how caring and professional the midwife is.

It will still take time before this is really understood. Some midwives do not use the card appropriately.

It is understandable that Bp is not taken when there is no BP machine, but still there are centres that are not checking on BP with BP machine. THE ANC CARDS. Too often we see mothers at the HC coming with a piece of paper to

the ANC. How can we expect that all the above mentioned information can be written down on a tiny little piece of paper snatched out of a book. It is more time-consuming and easy for the midwife to look for information of the HR-pregnant woman without proper ANC cards.

CESTAS is now printing the ANC cards, but this is not a good solution in long term. The responsible authorities must see the importance. And we always have the needed amount of cards available. We can expect 50,000 pregnant women in Lilongwe district yearly.

Here I would like to put forward some observations of the midwives we have met at the HC. Apart from maybe being the most important professional staff to fight the high maternal morbidity and mortality, they are individuals with different education, social status, interest and background. This has to be taken into consideration when doing the supervision. That is one of the reasons that frequent visits are of importance.

**Frequent supportive supervision and inservice training was high upon the SOLUTIONS of the problem on LOW Staff Moral**

Communication between the staff members is a common problem at most of the centres. Our experience is that information/supervision given at a centre, meant to be shared with the staff not on duty that day, is not shared. We are very pleased to get some good ideas on what will be the most successful methodology for solving this problem.

**Inadequate Equipment:**

Another mentioned constraint for the staff and a reason for the low moral.

Provision of equipment and supplies has been delivered to 27 HC with labour ward.
Apart from the delivery kit from UNICEF for midwives we have some important tools to our assistance. When labour is established the labour graph is one of the tools.

We must not give up the supervision until all the midwives understand and I repeat understand the importance in the labour graph. |Care includes several factors. From the professional use of the labour graph to the intuitive and a nearly radarlike feeling, build on experience, knowledge and the importance of care for the mother and her baby.

It is proved that a woman who is taken care of during labour will always have far less complications. That is one of our goals. But the lack of staff is another sever constraint for the midwives. 13 HCs have only one midwife on duty 24 hours.

One midwife in a centre can during the day have a big number of ANC clients waiting to get the best quality of care. In the labour ward a prim gravida is

waiting to deliver. She is in labour and there is no transport. She is afraid and she is alone.

Assisting HCs to provide quality maternal care depends on making a long chain of responsible factors working. If one part is broken it will effect the quality of care and the responsible midwife will most probably feel deserted. And we can see, as mentioned before, the need for frequent supportive supervision and even we as midwives have to take care of each other.

**Care During Delivery**

Is there anything in the whole world as beautiful as a delivery when mother and baby are well? I am sure we all can agree on that. The care to be given to the mother and her baby now is so simple and so important. Keep the baby warm. Africa can be so cold.

Too many new born babies die just because they are not kept in the most natural way after birth, SKIN TO SKIN with the mother and started breastfed as soon as possible.

Our supervision will sometimes go against traditions and culture, and it has to be taken into consideration. Grand-ma can still hold the new born baby but may be after the breastfeeding has been established and when we know the baby is kept warm.

Most of the HC are without electricity, and are therefore dependent on either gas or paraffin. It must be quite difficult to give the care you want to and are expected to give when there is no paraffin on the lamp, and unfortunately most deliveries occurs when it is dark. Some of the midwives buy candles from their own money. The salary is a difficult to issue that "someone" soon has to look into.

Even in Malawi we see that the private sectors have better conditions to offer for the qualified nurse-midwives who can blame them to take this chance.

**Care for Complicated Pregnancies and Delivery**

Unfortunately not all pregnancies and deliveries are without complications. Identification of the HR mothers in time is one way of prevention. If we can transfer to the hospital for management accordingly, the need for expertise.

During deliveries at the HCs we still meet complications not identified and when having emergency cases for transferrals to find transport is a problem.

21 HCs, DHO, 2 ambulances and labour ward at Bottom Hospital (BH) have radio. When it is need for advise on management the nurse/midwife at the HC can get advice from the more experienced staff at BH. The radio has to be considered as an improvement. When calling for an ambulance and the ambulance is coming it is an improvement. The TOTAL CARE HAS IMPROVED, as long as everything is working.

Unfortunately we have seen some disadvantages in the introduction period of the radio. Before the radio was introduced at the HCs relatives tried to find transport for their patients. It is easy to think: The radio will now solve the problem the ambulance will come, but not always. We have introduced a register for callings for an ambulance. The reasons for not coming can be:

- No ambulance due to lack of fuel
- No ambulance available

From calling, and to an ambulance is coming to the centre it can TAKE MORE THAN 6 HOURS (it should take one).

When introducing a new kind of equipment it will take some time to know how to use and maintain it. Preferably the supervision on the use and maintenance is done by the technicians which is not the case in other projects. It has to be looked into.

## ANNEX XIV

# NATIONAL POLICIES ON SAFE MOTHERHOOD AND NATIONAL STATISTICS ON MATERNAL AND NEONATAL IN MALAWI

Paper Presented at the
SAFE MOTHERHOOD CONSULTATIVE WORKSHOP
KALIKUTI HOTEL – LILONGWE
28TH – 29TH SEPTEMBER, 1998

BY

Christon Moyo
Ministry of Health and Population
Lilongwe, Malawi

## 1. HEALTH POLICIES, STRATEGIES AND PLANS

Since independence in 1964, the Government of Malawi has implemented three health plans. The first Health Plan 1965-1969 was devoted primarily to curative services emphasizing the construction of health facilities and manpower development. As the 5 year plan was implemented it became clear that these endeavours could not alone achieve the desired impact on the health status.

The second Health Plan covered 15 years, 1973-1988 and had the following priority areas: the reorganization of the Ministry of Health, the development of basic health services, the control of communicable diseases and manpower development.

Soon after the approval of the 15 year plan, a "mini plan" was developed to strengthen maternal and child health services. The objectives of the mini plan were to

- provide family health and nutrition education to combat malnutrition among children, pregnant women and nursing mothers including reducing maternal morbidity and mortality among pregnant women and children, and
- increase immunization coverage of children under 5,

These objectives were to be achieved by improving the maternal and child health through the provision of adequate antenatal delivery and postnatal care to all pregnant women, and reducing mortality and morbidity among pregnant women and children.

The overall policy of the health sector as set out in the third National Health Plan for Malawi (1986-1995) is to raise the level of health of all Malawians by reducing the incidence of illness and occurrence of death in the population. This is to be achieved through the development of a health delivery system capable of:

- Promoting good health through the transfer of information and health behaviour and ensuring the community to act to improve their health.
- Preventing, reducing and curing disease by ensuring accessible and affordable basic treatment of ill health, providing the highest level of care within available resources
- Protecting life and fostering general well being through action to reduce health risk and by ensuring preventive services
- Increased productivity by ensuring rehabilitation of those affected by ill health allowing their return to productive lives.

Given the high childhood and maternal morbidity and mortality rates, particular attention was to be given to the provision of services for mothers and children. In this connection, the objectives of the plan were to, among others:

- expand the range and quality of services directed at maternal health and children between 0-4 years. This was sought through an extension of peripheral, particularly community based services and upgrading of the basic health facility network and

- improve the nutritional status of mothers and young children and coverage

- improve coverage through a network of available and acceptable facilities and services.

## 2. ACHIEVEMENTS OF THE NATIONAL HEALTH PLANS

The implementation of these strategies has produced some improvements:

- geographic accessibility has improved. Eighty percent of the population is estimated to be within 8km of a health facility
- increased awareness of health problems among the population. General awareness of HIV/AIDS and Family Planning is now near universal
- the basic government hospital network has been upgraded
- childhood immunization rate has increased to 82 percent from 30 percent in the early 1980's.

Despite the implementation of these strategies the demographic and health status of the people remains very poor.

Malawi's population grew from 4.4 million in 1966 to 7.9million in 1987. In 1997, the population was estimated to be about 11 million. The population growth rate is estimated at 3.2 per cent per annum.



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Fertility is very high in Malawi. The 1977 Census indicated a total fertility rate of 7.6 children per woman which declined to 7.4 by 1987. The 1992 Malawi Demographic and Health Survey showed a further decline in total fertility rate to 6.7.

Although mortality is exceptionally high it has been declining slowly since the 1960's. Trends on the survival of children indicate that infant mortality has been declining slowly from an estimated 200 per 1000 live births in the 1960s to about 190 per 1000 in the early 1970s. The trend also indicates that child mortality has declined from 150 per 1000 in mid 1960s to around 140/1000 in the early 1970s. Infant Mortality Rate is now estimated at 133 deaths for every 1000 live births and under five mortality is 211 per 1000. Under 5 mortality is mostly due to malnutrition, anaemia, pneumonia, diarrhoea and malaria. Malnutrition is endemic in Malawi as half the children under 5 are chronically malnourished.

Maternal mortality trends indicate a steady rise in maternal mortality rates. For instance, an MMR of 170 and 400-600 per 100,000 live births were reported for 1987 and 1991 respectively. According to the Demographic and Health Survey 1992 Malawi MMR is now estimated to be 620 deaths per 100,000 live births. The differences in the estimation may either mean poor documentation methods or ineffective maternal health care.

**Table 1: Trends in Mortality Rates in Malawi, 1960s-1990s**

| | Mid 1960s 1/ | Early 1970s 1/ | 1982-1985 1/ | 1987 2/ | 1991 3/ | 1992 4/ | 1995 5/ |
|---|---|---|---|---|---|---|---|
| IMR /1000 | 200 | 190 | 151 | - | 137 | 134 | 133 |
| CMR /1000 | 150 | 140 | - | - | - | 234 | 211 |
| MMR /100000 | - | - | - | 170 | 400-600 | 620 | 620 |

Sources:

1/ Ministry of Health, The National Health Plan of Malawi, 1986-1995

2/ The World Bank, 1989 Malawi: Country Economic Memorandum: Growth Through Poverty Reduction, Volume II, Technical Appendices

3/ Estimated from the 1987 Population and Housing Census, National Statistical Office

4/ Malawi Demographic and Health Survey, 1992

5/ Ministry of Economic Planning and Development, Poverty Monitoring Unit, Poverty Monitoring System News, Vol.1, No.1, October 1996, Table3, page 3

Life expectancy is low in Malawi. Overall, life expectancy at birth improved from 41-43 years in the 1970's to about 51.7 years currently. Life expectancy is estimated at 51 years for males and 52.4 years for females.

The adult literacy rate is low, at 42 per cent and only 32 per cent of women are literate.

## 3. THE FORTH NATIONAL HEALTH PLAN

The Health Policy Framework, a precursor to the forth Health Plan, identified Safe Motherhood Initiative as a priority health strategy for addressing the high maternal mortality rate. Consequently the forth National Health Plan which will become operational by the end of this year outlines strategies to be implemented within the framework of the National Safe Motherhood Programme whose goal is to reduce the high morbidity and mortality rates in Malawi by ensuring a safe pregnancy and child birth for all women of child bearing age. This will be achieved by:

- creating awareness at the community level on the risks of pregnancy and the need for utilisation of health services
- Strengthening risk identification skills of Traditional Birth Attendants (TBAs)
- Improving quality of maternal and natal care
- Improving communication and transport systems at community, health center and district levels for easy referral of patients
- Mobilizing community self help efforts for construction of maternity waiting homes
- Institutionalizing MVA in health facilities for the management of incomplete abortions
- Providing quality essential obstetric and neonatal care at health center and district hospital levels.

## 4. IMPLEMENTATION OF THE SMI PROGRAMME

District Health Management Teams are the implementing agencies of the National Safe Motherhood Programme. A Multi-sectoral approach is, however, recommended when planning district and national activities so that both underlying and immediate causes of maternal deaths are addressed concurrently.

# ANNEX XV

# POSTABORTION CARE (PAC) IN MALAWI: THE USE OF MANUAL VACUUM ASPIRATION (MVA) AND CONTRACEPTION

BY

V.M. LEMA, M.B;Ch. (Mak); M.Med.O.G. (Nbi)
Associate Professor and
Head of Department of Obstetricts and Gynaecology
College of Medicine, University of Malawi
Private Bag 360, Chichiri
Blantyre 3, Malawi

Presented at the

SAFE MOTHERHOOD
CONSULTATIVE WORKSHOP
KALIKUTI HOTEL - LILONGWE
28TH – 29TH SEPTEMBER, 1998

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V.M. LEMA, M.B;Ch.B. (Mak); M.Med.O.G. (Nbi)
Associate Professor and
Head Department of Obstetrics and Gynaecology
College of Medicine, University of Malawi
Private Bag 360, Chichiri
Blantyre 3, Malawi

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## INTRODUCTION

### (a) Definition:

Postabortion care (PAC) has traditionally been defined by its three elements, namely;

- Emergency treatment of incomplete abortion and potentially life-threatening complications.
- Postabortion family planning counselling and services.
- Links between postabortion emergency services and the reproductive health care system (Winkler et al 1995).

This has been broadened by Rogo and Lema (1998) to include,

- Prevention of the need for abortion services through effective information, education, communication (IEC) on reproductive health as well as the provision of appropriate services, such as contraception to individuals at greatest risk of unwanted pregnancy and/or induced abortion.
- Provision of safe abortion services, where legal.
- Psycho-social support to clients on short, medium and long-term basis.

These are fairly new concepts. In Malawi until recently, management of postabortion patients has only involved one of these elements, namely emergency treatment(Lema et al 1998).

### (b) Rationale for postabortion care (PAC)

. Abortion forms the commonest indications for acute gynaecological admissions in health facilities within Malawi. It constitutes up to about 60% in some facilities (Mtimavalye et al 1994, Lema et al 1994).

. A good proportion of these are unsafely induced (Lema et al 1998).

. About 30-50% of individuals with abortion report that the pregnancy was unwanted and/or unplanned, at least at the time of conception (Mtimavalye, 1994, Lema et al 1998).

- Abortion contributes to about 30% of maternal mortality, and by inference morbidity in Malawi. (Mtimavalye 1994). The maternal mortality ratio in Malawi stands at about 620/100,000 live births (MDHS 1992), which is unacceptably high. Those who die and or sustain serious morbidities are usually young women at the prime of their lives, and the most economically productive (Lema et al 1998).

- Repeat unwanted pregnancy and induced unsafe abortion are common sequelae.

- These are essentially due to lack of or poor utilisation of contraceptives (Lema et al 1994, 1998).

The need and role of postabortion care (PAC) has been expressed and high-lighted at many international fora and in several publications (IPPF, 1994; ICPD 1994; Lema et al 1998; Mati et al 1993; Rogo 1996; Wolf et al 1994; WHO 1995) The national Safe Motherhood Programme - Malawi has endorsed the concept as well as adopted it as one of its tasks.

## USE OF MANUAL VACUUM ASPIRATION (MVA) TECHNIQUE:

One of the major factors predisposing postabortion patients to serious morbidity, such as sepsis or haemorrhage, and mortality as a result thereof is delay in providing appropriate emergency treatment, i.e uterine evacuation (Mtimavalye 1994). In realisation of that the department of Obstetrics and Gynaecology, College of Medicine, University of Malawi, introduced the manual vacuum aspiration (MVA) at the Queen Elizabeth Central Hospital, in Blantyre, in December 1993 under the support of IPA's. MVA has been shown to be superior to sharp curettage in the treatment of incomplete abortion (Greenslade et al 1993) and the WHO (1995) has recommended it as the treatment of choice especially for developing countries with limited resources.

The manual vacuum aspiration technique has now been accepted as the standard treatment of incomplete abortion of gestational age or uterine size of $\leq$ 14 weeks, in our department (Lema et al 1997). It has been shown to:-

- Reduce the amount of bleeding

- Reduce delay in offering appropriate emergency treatment.

- Reduce the duration of hospitalisation.

- Reduce postabortion sepsis.

- Reduce the overall costs of managing postabortion patients. (Lema et al 1997).

As a result of that, the Government of Malawi through the Safe Motherhood Project has also endorsed the MVA as the standard treatment for postabortion patients within its health facilities.

Plans are underway to expand it to the other health institutions in Malawi.

## POSTABORTION CONTRACEPTIVE COUNSELLING SERVICES

The main underlying cause of unwanted pregnancy and induced unsafe abortion in Malawi as indeed other parts of the world is lack of, or poor utilisation of contraceptive services. It has been stated that induced abortion almost always indicates a desire on the part of the individual(s) concerned to avoid or postpone childbearing (Lema et al 1998). Studies have also indicated that majority of postabortion patients have not being using contraception. In three studies on postabortion patients in Blantyre Lema et al (1994; 1997; 1998) found that very few of them had ever/were using contraception before the index pregnancy.

The National CPR in Malawi is also very low. It is currently at 14.0% for modern contraceptive methods (NSO, 1996). Studies have also shown that repeated unwanted pregnancy and induced unsafe abortion are common sequelae of induced unsafe abortion. These tend to increase the risks of maternal morbidity and mortality.

In recognition of the foregoing, and in order to complement the gains achieved by introducing the MVA technique, the department decided to introduce postabortion contraceptive counselling and services in December 1995. The nurse incharge of MVA was trained on family planning counselling and service in mid-1995 and services started in December of the same year.

All postabortion patients receive IEC on reproductive health before, during and after emergency postabortion treatment. They are then asked if they would wish to receive further counselling on contraception. Those who do, are counselled and given all relevant information on all contraceptive available in Malawi. They are then asked if they wish to start using contraceptive thereafter that and what method. If they agree, they are given appropriate counselling on the method chosen.

If the method is felt to be suitable for her situation, it is either provided there then (i.e in the gynaecological ward) before discharge, or she is referred to her nearest FPC with a note.

The clients are subsequently told where they can go for follow up, check ups, and resupply. They are also given an option to come back to the same place if they wish, on any working day (Lema et al 1998).

Up to the end of July 1998 (Over a period of 31 months since its introduction) a total of 1800 postabortion have received postabortion contraceptive counselling and/or services. They form just about 30.0% of all patients with incomplete abortion seen and treated at the Queen Elizabeth Central Hospital, Blantyre.

Based on the results of a pilot study aimed at incoorporating PABFP counselling and service provision into postabortion care, in all health facilities where it is provided (Lema et al 1998). The SMP Malawi - has also endorsed the recommendation. Lema et al (1998) showed that $\geq$ 80.0 of the postabortion patients who received contraceptive counselling agreed to start using there and then. They remarked that with more organised and well conducted PABFP services more postabortion patients will accept contraception. This will increase the CPR thus reducing unwanted pregnancy and induced unsafe abortion.

## CONSTRAINTS

. Supply of MVA equipment - though these are cheap, they need replacement on a regular basis. Considering the financial situation nationally this may be a problem.

. Staff to be trained.
  - This may not be easy because of limited numbers, and that the ones available are overwhelmed by other clinical/administrative work.

. Sustainability of the services
  - These services require
    - appropriate equipment
    - appropriate supplies
    - appropriate sterilisation/infection prevention measures
    - appropriately trained staff.

  These may not always be available. Their lack or deficiencies may influence the quality of care of services offered to patients.

. Funding required for expansion
  - The government may not be able to do so fully. This means we will need donor support to at least start off.

## POSSIBILITY STRATEGIES/RECOMMENDATIONS

Cognisant of the foregoing, the following are probable strategies which may be used to implement appropriate PAC programme in Malawi.

- Proper planning before hand.
- Procurement of adequate supplies
- Funding mechanism to be clearly stipulated
- Training of Trainers - first
- Expand step-wisely - a certain number of facilities at a time.
- Have guidelines/protocols
- Regular monitoring, evaluations
- Wherever expanded to -> provide PAC as a total package
- Review of curricular - Nurses, CO, MA, MO to incorporate PAC.
- Update inservice courses
- Policy change/statement - need to be made.
- Expand to lowest possible level of health system in Malawi i.e. Health Centre.
- Consider - using private and NGO facilities as well so as to provide uniform health care services throughout the country.
- Donor support to be enlisted.

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## ANNEX XVI

## CONSULTATIVE WORKSHOP: 28TH TO 29TH SEPTEMBER, 1998.

## MALAW SAFE MOTHERHOOD INITIATIVE: SHARING EXPERIENCES ON INTERVENTIONS THAT CONTRIBUTE TO MATERNAL AND NEONATAL SURVIVAL

**DAY I** : Arrival of participants
: **Chairperson : Mr. C.M. Moyo**

08.00-08.30 : Registration

08.30-08.45 : Maternal and Neonatal Survival Pathway – ***by National Safe Motherhood Co-ordinator/Advisor***

08.45-09.15 : **ASSISTING COMMUNITIES TO RECOGNIZE PROBLEMS AND MAKE APPROPRIATE DECISIONS THROUGH:**

1. Community-Based SMI IEC – **Women for Women's Health Project – Lilongwe District**
2. Community-Based Maternal Death audit – **Monkeybay Safe Motherhood Project**

09.15-10.00 : Discussions

10.00-10.15 : Coffee Break

10.15-11.45 : **IMPROVING ACCESS TO MATERNAL NEONATAL CARE**

- Utilization of maternity waiting homes – **Ekwendeni**
- Utilization of bicycle ambulances – **Kasungu**
- Utilization of radio communication – **Mulanje/Thyolo**
- Utilization of TBAs – **World Vision**
- Ambulatory Post-Abortal Care – **Q.E.C.H.**
- Levels of Care and Interventions for Maternal and Neonatal Survival – **Dr. Ebanyati**

11.45-12.30 : Discussion

12.30-13.30 : Lunch Break

| | | |
|---|---|---|
| 13.30-15.15 | : | **MONITORING QUALITY OF CARE**<br>• Trends in Maternal Neonatal Health<br>• Assessing availability of resources for Quality Essential Obstetric Care **(Southern Region Safe motherhood**<br>• Assisting Health Centers to provide quality basic maternal care- **C.E.S.T.A.S. Safe Motherhood Project**<br>• Implementation of Quality Assurance Program in Malawi – **Medical Council and Ekwendeni**<br>• Maintenance of standards in Private Maternity Homes – **Nurses and Midwives Council of Malawi**<br>• Role of Life Saving Skills Training in maintaining Quality Care – **Mrs. Bokosi – Southern Region Safe Motherhood Project.** |
| 15.15-15.30 | : | Coffee Break |
| 15.30-16.45 | : | Discussions |
| **DAY II** | : | **Chairperson Dr. R. Mataya** |
| 08.30-10.30 of SMI | : | Group Work – Interventions for Accelerating Achievement goals |
| 10.30-12.00 | : | Plenary |
| 12.00-12.20 | : | Summary of recommendations |
| 12.20-12.30 | : | Closing Remarks : Chairperson SMI Task Force |
| 12.30 | : | Lunch and Home |
| 13.30 | : | SMI Task Force Meeting |

ANNEX XVII

LIST OF PARTICIPANTS

| | NAME | POSITION | DUTY STATION |
|---|---|---|---|
| 1. | M.A. Bokosi | SM Proj. Manager | RHO(S), Box 3, BT |
| 2. | L. Thole | DNO | Box 225, Rumphi |
| 3. | S.N. Bandazi | PNO | ZCH, Box 21, Zomba |
| 4. | N.C. Jere | Ag DNO | Box 131, Mzimba |
| 5. | N. Mkhupela | DNO | P/B 18, Zomba |
| 6. | H.L. Kabambe | Nursing Officer | Box 149, Lilongwe |
| 7. | E.S. Mbawa | DNO | P/B 66, Blantyre |
| 8. | H.R. Phalaza | DNO | Box 44, Liwonde |
| 9. | R.T. Kanyangalazi | SMI Co-ord. | P/B 5, Ntcheu |
| 10. | D.C. Khonje | Planning Officer | P/B 328, Lilongwe |
| 11. | T.G. Salamba (Mrs) | Acting D.D. | P/B 328, Lilongwe |
| 12. | Lucia Collen | Acting DNO | Dowa |
| 13. | E.R.S. Banda | CHN-FP Co-ord. | Dowa |
| 14. | Mrs. Hilda Khonje | Ag DNO | Chiradzulu |
| 15. | Mrs. Julian Kaipa | SRNM-SM Coord. | Chiradzulu |
| 16. | Mrs. R. Kazembe | SMI Trainer RN/M | DHO Blantyre |
| 17. | Mrs. V. Kusunzi | Sen. Nursing Sister | Mchinji |
| 18. | J.C. Mwakanandi | CHN rep.SM Coord | Ntchisi |
| 19. | M.A. Kasawala | Ag DNO | Ntchisi |
| 20. | Monica Chalulu | SRN/M SM Coord | Nsanje |
| 21. | M.N. Ntambo | Acting DNO | Nsanje |
| 22. | M.T. Eliya | Acting DNO | Mulanje |
| 23. | S.L. Chanachi | Ag DNO, SMI Trainer | Thyolo |
| 24. | D.T. Kachoka | SNRM-SMI Trainer | Thyolo |
| 25. | W.E. Limbe | PPHC Coordinator | MOHP |
| 26. | R.C. Mbvundula | SNO (Insp) | Lilongwe |
| 27. | E.G. Liabunya | Lecturer | K.C.N. |
| 28. | A. Kazembe | Lecturer | K.C.N. |
| 29. | D. Chikuse | Acting DNO | Nkhotakota |
| 30. | S. Kazanga | Sen Nursing Sister | Dedza |
| 31. | P. Ngoleka | SMI Coordinator | Box 42, Mangochi |
| 32. | M. Kamanga | Nursing Sister | Dedza District Hospital |
| 33. | Dr. G.T. Kalanda | DHO | P/Bag 18, Zomba |
| 34. | C.S. Zikuwo | SMI Trainer | Box 19, Kasungu |
| 35. | M.C. Chipeta | DNO | P/Bag 5, Ntcheu |
| 36. | Joyce Ng'oma | Community Nurse | Embangweni Hospital |
| 37. | Doreen Thundu | EN/M | Kabudula |
| 38. | Sharon Bisika | Sen. Nursing Sister | DHO Zomba |
| 39. | Mary Kuwenda | SM Trainer | Box 131, Mzimba |
| 40. | Beatrice Chisenga | Field Manager | SM Proj. Monkey-Bay |
| 41. | Cecil Kamanga | Statistician | CHSU, Lilongwe |
| 42. | Dennis Nkhoma | ClinicL Officer | Nkhata-Bay |
| 43. | David Siyamanda | SRN/M | Nkhotakota |
| 44. | Hilda Gausi | Acting DNO | Box 32, Chikwawa |
| 45. | Alice Konyani | SM Coordinator | Box 32, Chikwawa |
| 46. | Dorothy Kamanga | SMI Trainer | Box 53, Salima |
| 47. | Julia Hussein | Technical Adviser | SM Project, Blantyre |
| 48. | Hazel Simpson | Associate Prof. Off | SM Projcet, Blatyre |
| 49. | Tambudzai Rashidi | Reg. SMI Coordinator | Box 95, Lilongwe |
| 50. | Dr. H. Juma | DHO | Box 53, Salima |