Dissemination of the safe motherhood advocacy package in Tanzania

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Abstract

The White Ribbon Alliance Tanzania, which is a coalition of 102 organizations and 800 individuals interested in making childbirth safe, has advocated for the reduction of maternal and newborn mortality ratios (MMR/MNR) since its inception in 2004. In August 2007 the alliance conducted a baseline assessment followed by advocacy with district authorities and community mobilization for skilled health workers in Sumbawanga and Monduli Districts. A follow-up assessment was carried out six months after the advocacy activity. Advocacy and mobilization resulted in an increase of three skilled workers and a 50% increase in facility deliveries at 17 dispensaries in Sumbawanga. Seven dispensaries in Monduli had an increase of five skilled workers and 18 deliveries compared to 0 deliveries before the advocacy. This assessment concludes that advocacy contributed to changes in employment/deployment policy, and that community mobilization changed behavior, for example, the villagers opted to give birth at dispensaries, something they did not do before the mobilization.

White Ribbon Alliance for Safe Motherhood in Tanzania (WRATZ) is a coalition of NGOs, Professional Associations, Government Institutions, Religious Based Organizations, Community Organizations (102) and 800 individuals interested in making pregnancy and childbirth safe. In Tanzania, maternal and newborn mortality ratios (MMR and MNR) have been constantly high (MMR 578/100000 live births and NMR 32/1000 live births) for the past ten years (National Bureau of Statistics, 1996; Tanzania Reproductive and Child Health Survey, unpublished; National Bureau of Statistics, 2005).

Skilled birth attendance is the primary proven strategy to reduce maternal and newborn mortality ratios (Abour, 1998; Hogberg, 2004; Kurowski, 2003; MacDonald and Starrs, 2003; Joint Learning Initiative, 2004). It is presumed that, if 15% of all births that result in complications are effectively stabilized and referred by professional midwives to be attended by medical doctors, and if 85% of the normal births are attended by professional midwives, then maternal and newborn mortality ratios would be reduced (UNFPA, 2002).

Demographic health survey (National Bureau of Statistics, 2005) findings indicate that 94% of Tanzanian women receive antenatal care, but only 47% access the health facility for childbirth and of these only 46% access a skilled attendant (professional nurse/midwife or a medical doctor) during childbirth. It is known that the critical moment in which most women and newborns die is during labour, delivery and immediately postpartum (UNFPA, 2002), and is the time when skilled birth attendance and emergency obstetric and newborn care (EmONC) must be available in case of complications.

According to Chen (2005) Tanzania requires 35 000 skilled workers to fill the existing gap. This could be the reason skilled birth attendance in Tanzania is so low, but the other reason could be the women and families decided to give birth at home without realizing that fatal complications that require skilled health staff could arise. Such practices needed community mobilization for behaviour change.

A WRATZ survey (unpublished) that was conducted in 2005 indicated 21 dispensaries in Sumbawanga Rural, 1 in Geita and 7 in Monduli districts had no skilled personnel; rather, they had one medical attendant as the sole health care provider at all times. According to the Ministry of Health and Social Welfare (unpublished) Manning Level, which guided the survey, a dispensary should have two clinical officers, two nurse-midwives and one medical attendant. The one medical attendant found in the 21 dispensaries diagnoses, prescribes medications, runs maternal and child health clinics, counsels and tests for HIV, conducts deliveries, and conducts home visits/outreach for immunizations as well as fetching water and cleaning the dispensary. A medical attendant's job description is to do all the cleaning at health facilities. The chronic underinvestment in human resources (Joint Learning Initiative, 2004) led to the freezing of employment and recruitment in Tanzania since 1994. Based on findings from the survey and literature reviews, WRATZ launched an advocacy campaign on adequate numbers of skilled health workers throughout

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Figure 1. Advocacy visits. WRATZ team and a dispensary worker (medical attendant in a green blouse) coming from a traditional birth attendant's house

the country in 2006. The aim of the advocacy was to reinforce political will and commitment and technical knowledge of decision and policy makers toward investing in human resources to revive employment/deployment of skilled health workers, particularly at rural areas.

The activities of the campaign included a walking rally in March 2006 which was led by Hon. Ally Hassan Mwinyi, the Second Term President of the United Republic of Tanzania. Mr. Mwinyi launched the WRATZ Advocacy for Adequate Numbers of Qualified Health Staff and the White Ribbon Day on every 25 March to commemorate all women who have died due to pregnancy, labour and childbirth complications. The event was covered by all Tanzania Radio, Television and Newspapers. Additionally billboards with messages pointing to the importance of adequate numbers of qualified health workers as a strategy to reduce maternal and newborn deaths were put up in strategic places in Dar Es Salaam City for a period of six months. The outcome at national level was that the government gave the Ministry of Health and Social Welfare a permit to employ all graduates from health institutions with immediate effect. For example, the November 2006 permit instructed the Ministry of Health to employ more than 3 500 health professionals. Health colleges and schools doubled their intake and salaries improved for retention of the workers. However there are still problems retaining qualified workers at rural areas because of hardships. The advocacy work conducted by WRATZ significantly contributed to all of these improvements.

As a follow-up to the initial campaign, a WRATZ team visited Monduli and Sumbawanga Districts between 29 January to 19 February in 2007 to assess the outcome to date of the campaign at the district level and to disseminate the advocacy package on adequate numbers of qualified health workers to district leaders. The dissemination of the advocacy package targeting District Health Management Teams (DHMT) and village leaders was conducted. Seventeen dispensaries in Sumbawanga and seven in Monduli that were found to have one medical attendant as a sole health care provider during the WRATZ survey in 2005 were visited.

During the visits discussions took place with the dispensary worker(s) about the emphasis on facility deliveries rather than home deliveries. Villagers near the dispensaries participated in the dialog as it is crucial for women to make informed choices that are not necessarily depending on their male partners' decisions. Gender equity with a focus in empowering women to make personal decisions has helped in improving maternal health (UNFPA, 2005).

Feedback of the visits to dispensaries was provided to the district authorities. Thus two dissemination meetings took place with the leaders. One meeting took place on the WRATZ team's arrival and a second after visits to villages. The DHMT developed an action plan to address maternal, newborn and children's health aiming at achieving Millennium Development Goals (MDG) 4 and 5.

This report is an experience of the dissemination of the advocacy package and community mobilization at district level.

The approach

A tool based on indicators from the February 2007 district action plan, the situation at the dispensaries and community around these dispensaries guided the information gathered.

A visit with the regional commissioners and regional medical officers took place on arrival to Rukwa and Arusha Regions in August and September 2007 consecutively. This was followed by meeting with district executive directors and district medical officers in Sumbawanga and Monduli districts. An interview with the regional and a district leaders basing on the tool was conducted at this level.

The WRATZ Regional Contact persons and one District Health Management Team member from each of the two districts joined the team (core committee members) from Dar Es Salaam City to visit the 7 dispensaries in Monduli and 17 dispensaries in Sumbawanga Districts. Data was obtained by administering the questionnaires to the dispensary worker and from reading the records. Also stories were obtained by talking to villagers around the facilities.

Findings

It is realized that the policy and behaviour changes reported in this paper could also have been influenced by efforts other than WRATZ advocacy and mobilization toward improving maternal newborn and child health. That is why the report is from records exactly six months before and six months after the intervention to make sure these other factors were there before and after the mentioned periods.

Box 1. Qualifications of health care personnel

Clinical Officer (CO) (completed 'O" or 'A" levels) has completed a three-year medical assistant diploma course.
Maternal and Child Health Aide (MCHA) (completed grade 7) has completed a two-year course in maternal and child health care.
Medical Attendant has completed no midwifery, nursing or medical courses.

It was encouraging to learn that the districts had done several activities basing on their action plans, such as deploying skilled workers and equipping some dispensaries with delivery beds, sphygmomanometers, stethoscope/fetal scope and writing letters to the villages encouraging facility deliveries. However it was dismaying to learn that the Ministry of Health and Social Welfare had posted 23 qualified health workers to Sumbawanga Rural District but that only 3 reported. Of the three, two left within a short period, the reason being hardship coupled with low salary.

The district authorities in Sumbawanga district are currently updating Laela and Mtowisa health centers so they can handle basic emergency obstetric care; but specifically to conduct cesarean sections, which is above basic emergency obstetric care. To accomplish this the district sent two assistant medical officers (AMOs) to Sumbawanga Regional/ District Hospitals to learn how to conduct cesarean sections. They also reported discussing building maternity waiting homes.

Box 2. Magdalene's story

'I am 18 years old. My mum and daddy died when I was 5 years old. I lived with my aunt who was a teacher. Last year I completed standard seven and passed my exams to continue with secondary education at a government school. As a requirement for admission into the school I needed a physical examination. In this process I was found to be pregnant.

My aunt and I reported the matter to the village authority who advised us to report to the police. [In Tanzania it is a crime to make a school girl pregnant.] We went to the police. They wrote down the entire story how I got pregnant. They told us to go home. I just waited at home until one day I experienced severe pain.

My aunt and other relatives took me to our dispensary. The nurse [medical attendant] examined me and said I have to go to Sumbawanga Regional Hospital because she could not help me. The nurse called for transport. She and I jumped in the car ready to go. My aunt came quickly and took me off the car. We went home. The pain was very severe. I suffered. The following day my mother came with an old lady [TBA] who assisted me. I gave birth to a dead baby. I bled profusely. I fainted. I was told the old woman poured cold water on me and I came to my senses again. I was bleeding and bleeding. There was something like a piece of meat between my legs. It started to smell and something watery was flowing.

My aunt died two weeks after I gave birth. My cousin and other relatives took me to the dispensary. The "nurse" said I should go to Sumbawanga Hospital. My cousin took me to Sumbawanga, but they told us to go back home and wait for experts in November. So my cousin brought me here [another village] to live with my other aunt.'

Table 1. Changes before and after advocacy and community mobilization at Sumbawanga Rural District in 17 dispensaries within a period of 6 months

Serial no.	Variable	Before Feb–July 2006	After Feb–July 2007
1	No. of skilled attendants (c/o, nurse/midwife)	8	10
2	No. of MCH aides	5	6
3	No. of medical attendants	9	10
4	No. of women giving birth at dispensaries	227	497
5	No. of referrals from dispensary to higher level	3	11
6	No. of BP machines	13	14
7	No. of delivery beds	3	6

Table 2: Changes before and after advocacy and community mobilization at Monduli District in 7 dispensaries within a period of 6 months

Serial no.	Variable	Before Feb–July 2006	After Feb–July 2007
1	No. of skilled attendants (c/o, nurse/midwife)	2	7
2	No. of MCH aides	1	1
3	No. of medical attendants	4	4
4	No. of women giving birth at dispensaries	0	18
5	Dispensaries that remained shut down because of lack of health workers	4	2

In general the districts are working hard to achieve MDGs 4 and 5, although they think the basket funding (a collection of funds from many donors supporting the government's activities), which is their only source of funding, is not enough.

Most of the dispensaries had more than doubled the number of women delivering at the facilities. In the dispensaries that could not conduct deliveries the medical attendant mobilized his community so the women gave birth at a nearby dispensary. Monduli has done more in improving the skilled health care situation. The comparison of changes before and after advocacy and mobilization in a period of six months is in *Tables 1* and *2* and indicates how powerful advocacy and mobilization can be. There were not many changes in staffing levels in Sumbawanga compared to Monduli, but because they had people visiting and talking to them and a letter from their district authority, they could, in turn, bring changes within their communities.

In Sumbawanga Rural District, there was an increase of three skilled workers six months after advocacy and mobilization. There was a more than 50% increase in facility deliveries after the advocacy

In Monduli there was an increase of five skilled workers and facility deliveries increased from 0 to 18 six months after advocacy and mobilization.

Figure 2. Car stuck in the mud

The dispensaries in Monduli that remained shut down belonged to the Lutheran Church. Clients went to government facilities for services because of charges at the mission facility and therefore the district did not post their few staff there.

One dispensary in Sumbawanga had assisted many deliveries. However, the WRATZ team visited a traditional birth attendant (TBA) in the neighborhood who painfully told her story in the local vernacular. The translators (the dispensary medical attendant and the Maternal and Child Health District Coordinator who were part of the team) said the TBA was recalling a young woman whom she assisted to deliver at home. The 18-year-old woman delivered a dead fetus. What followed was an inverted uterus that did not return after several days:

'The thing protruding through her smelled terribly'.

The young woman was traced and Magdalene's story (names have been changed) can be read in *Box 2*.

The WRATZ contact person who was with the team is a surgeon with skills to repair obstetric fistulas. So Magdalene was assessed and given an appointment for repair of her vesico-vaginal Fistula (VVF) The young woman was successfully repaired and now she is ready to go to school.

Discussion

From the two tables we see in increase of eight (34%) skilled workers in the 24 dispensaries, which is actually not sufficient. Dispensaries are the health facilities that are in the rural areas where the majority of poor people reside. Thus, if MDGs 4 and 5 are to be achieved, the majority of Tanzanians who are poorer and live in the rural areas must access a health facility and skilled birth attendance.

Lessons learned from Sri Lanka and Malaysia in which there was a great fall in the numbers of maternal deaths (Pathmanathan et al, 2002) tell us that the two countries ensured that rural people accessed skilled care at the rural health facilities. For example, in Sri Lanka the rural roads were improved, maternity homes staffed with public health midwives and ambulance services were expanded to improve skilled birth attendance.

The experiences from Sumbawanga and Monduli show that the district is not yet near to filling the skilled health workers gap. However the communities were mobilized and changed their practices; instead of giving birth at home, they opted to go to the dispensary. Dispensaries were not equipped to handle emergency obstetric complications, but the workers could better access health centers through radio call, mobile phones than relatives at home.

Conclusion

Advocacy and mobilization are key to changes at policy and community levels. Advocacy messages pointing to the importance of women seeking for skilled birth attendance at rural settings has worked in developing countries such as Sri Lanka and Malaysia (Pathmanathan et al 2002). The story of Magdalene speaks for the women who have died needlessly or suffered serious morbidity due to complications such as obstructive labour/prolonged labour and many other avoidable complications that could only be attended and managed by skilled personnel.

Although health facilities lack skilled workers, it is better for women to give birth at facilities because the health workers, through constant supervision, know their limitations and therefore would refer on time and it is much easier for the facility worker to access transport. Some health centers have an ambulance or some kind of a vehicle and radio calls or mobile phones. If contacted by dispensary workers they will send transport and this would save lives.

Recommendations:

- Expand advocacy and community mobilization of safe motherhood to the entire country
- Use media campaigns
- Avoid mixed messages to the community, e.g. home births versus facility births. The message should be all women in Tanzania should give birth at health facilities
- Invest in skilled birth attendance to reach the Millennium Goals 4 and 5
- Inform women and their families on birth preparation; acting quickly and appropriately in case of obstetric emergency
- Men must become involved in the avoidance of unecessary maternal, newborn and child deaths
- Establish maternity homes staffed with nurses/midwives backed up with ambulances or other transportation
- Establish maternity waiting homes to address delays
- Research to assess the outcomes of advocacy and mobilization for maternal and newborn child health in the country.

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Key Points

- **Advocacy changed employment and deployment policies.**
- **Community Mobilization changed health seeking behaviour among families.**
- **Skilled birth attendance is a proven strategy in reducing maternal and newborn mortalities ratios.**
- **Community midwifery is needed in rural areas where the majority of people live and are poorer.**

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