IMPROVING CHILD HEALTH IN SWAZILAND

BASICS III

INTRODUCTION

From June 2005 to July 2007, USAID/BASICS was responsible for the implementation of a facility-based operational research project in Swaziland entitled *Repositioning Postnatal Care in a High HIV Environment*, in partnership with the Ministry of Health, the Population Council, and the Elizabeth Glaser Pediatric AIDS Foundation. The objectives of the study were to determine if the provision of timely and improved quality maternal and newborn health services in the much-neglected early postnatal period would result in increased utilization of postnatal services, and improve the care and follow-up of HIV-positive postpartum women and their infants.

The operational research project covered seven facilities in the country's most highly populated region, Manzini, where approximately 7,500 in-facility deliveries occur annually; as well as one facility in the region of Hhohho, where roughly 3,760 in-facility deliveries are registered each year.

An intervention of this type is tremendously important to Swaziland, home to one of the world's highest rates of HIV infection—according to the 2007 Swaziland DHS, an estimated 39% of pregnant women are HIV-positive, giving birth to 17,000 HIV-exposed infants each year. At the time of the intervention there were no other internationally funded child survival programs except for the EGPAF funded national PMTCT strategy.

ACTIVITIES AND RESULTS

Newborn Health and Pediatric HIV

USAID/BASICS provided technical assistance to the Ministry of Health and Social Welfare (MOHSW) to integrate selected aspects of basic care for mothers and babies with HIV/AIDS services, particularly PMTCT. Based on gaps identified in a baseline assessment and taking into account time and budget realities, the project specifically focused its package on preventive Essential Newborn Care (ENC) in the early postnatal period and selected elements of postnatal care for women. These comprised:

1. Immediate care at birth and within the first six hours after delivery
2. Assessment and examination at least once a day during a stay in the facility
3. Assessment, care, and counseling at discharge, including setting an appointment for the first early postnatal visit.

4. Quality postnatal visits, including conducting a first visit within one week as requested by the MOHSW (ideally within 3 days of birth) and a later visit at four to six weeks or at shorter intervals as required; ensuring the inclusion essential newborn care and selected aspects of maternal health and family planning; provision of counseling on key aspects of preventive care at home, identification of danger signs, and appropriate care-seeking for the mother and the baby; and a review of selected elements related to HIV and AIDS.

The implementation of the intervention package focused on three key strategies:

1. capacity building of trainers and supervisors and health providers;
2. activities to facilitate organizational changes; and
3. supportive supervision, and monitoring and evaluation.

Capacity building
In order to maintain continuity and quality, the approach used for capacity building was a modified cascade method. Selected members of the trainers-of-trainers group continued to be involved in the capacity building of health workers in subsequent workshops together with the USAID/BASICS trainers to avoid some of the usual challenges of the cascade system—a lack of continuity as the program continues to expand.

Finalized in March 2007, training was provided to 132 health supervisors/staff trainers (from the MOHSW and the three main nursing schools in the country), nurses, midwives, physicians, and trainers for the Swazi community health workers, the "rural health motivators." Desired completion of training had been November 2006, but the MOHSW postponed a number of sessions, mainly due to competing priorities. Moreover, while training of all relevant staff in the seven intervention sites had been desired, the MOH opted for a mix of staff from those sites and staff from other sites. Although about 50% of personnel from the interventions sites were trained, a significant amount of spontaneous exchange occurred with untrained staff, resulting in roughly 77% of staff understanding and performing the targeted behaviors.

Organizational changes
The organizational changes facilitated during the intervention were (a) assigning a room where the mother and the baby could be evaluated and cared for together including providing immunizations for babies and family planning for women; (b) facilitating the process of procurement of basic equipment and supplies needed for the postnatal services; (c) improving client flow by shortening waiting times by offering various services in one place through a single health worker who attends to both mother and baby at the same time; and (d) appropriately allocating and limiting rotation of the trained staff. Advocacy meetings with authorities from the MOHSW took place to request equipment and supplies, and to limit staff rotation, which happened frequently.

With USAID/BASICS' support and as a result of the project's advocacy, every intervention facility established a specific postnatal care area, allocated staff to provide post-natal services, and procured necessary equipment.

Supportive supervision, and monitoring and evaluation

Monitoring and evaluation consisted of two major processes. The first included a baseline and end-line evaluation carried out by the Population Council and noted under data collection; the second approach, facilitated by USAID/BASICS, was an ongoing monitoring of quality of care as a part of monthly supportive supervisory visits by national supervisors. The health providers were evaluated for their competence using pre-defined checklists of key tasks included in the evaluation, care, and counseling of the mother and the baby immediately after birth, at discharge, and at the postnatal consultations. Gaps identified were strengthened by appropriate on the job mentoring. Relevant data from the clinics and hospital registers were also collected. Inputs were given to add necessary information to the maternal and child health card and the registers which had incomplete data on postnatal care. However this could be done only to a limited extent because tools had a strong bias towards documenting care related to PMTCT.

Impact

An evaluation conducted by the Population Council after eight months of implementation showed significant improvements in client uptake and provider performance:

- A 20-fold increase was observed in the utilization of services within the first 3 days after birth (12-fold within the first week)
- Among providers, knowledge of newborn temperature maintenance at birth increased by 25% and of danger signs by 50%.
- Initiation of breastfeeding within the first hour after birth increased by 40%
- Use of infant cotrimoxazole prophylaxis increased by 24%
- Mixed feeding for HIV-exposed newborns decreased from 17% to 6% .

The study also showed that, at the postnatal visit, it is feasible for the mother and the newborn to be evaluated and cared for by the same provider at the same encounter within 72 hours, and once again at six weeks. It is possible that an even earlier first evaluation at two days and an additional visit at the end of the first week would be valuable.

The emphasis on careful evaluation of mothers and babies by a health provider before discharge presents an excellent opportunity to identify and address problems, counsel on essential care, and specifically provide the first follow-up appointment for the early visit. The first postnatal consultation also provides a valuable opportunity to assess and strengthen infant feeding, identify and address danger signs, and reassure and counsel the mother on essential preventive care for herself and the baby and promote appropriate care seeking for subsequent problems. As shown in the study, it also

presents an opportunity to promote family planning, and care and follow up for both HIV-positive and HIV-negative postpartum women and their infants in a high HIV prevalence environment.

One of the most challenging findings in this study was that postpartum women were not always able to recall the information given to them during the postnatal consultations.

Despite there being a significant increase in health provider counseling on key messages related to essential care and danger signs in the postnatal period, there were many instances in which women could not repeat the information provided at the consultations. For example, only about 15 percent of mothers were able to cite two newborn danger signs, suggesting inadequate or inappropriate counseling. This finding has not been uncommon in other programs. Findings from USAID/BASICS' earlier work in Senegal showed that mothers' recall could be improved by mobilizing additional less skilled personnel, such as *matrones* and other community health workers, to reinforce messages, using visual aids (e.g., counseling cards) and other tools. It is also possible that mothers may relate more readily to less skilled workers and community health agents, with whom they may feel more comfortable to ask questions and discuss some of their concerns. Also in Senegal, additional support to interpersonal communications through mass media was also found to be beneficial. It is also important to improve the counseling skills of all categories of health workers as merely providing information to mothers and families may not be enough. Rather, time needs to be spent on negotiating the desired healthy behaviors at the facility and community levels.

Click here to download the Population Council's final report: *Repositioning Postnatal Care in a High HIV Environment*.

TRANSITION

After preliminary results of the final evaluation were presented at a stakeholders' meeting in July 2007 in Swaziland, the MOHSW expressed its interest in rolling out the intervention nationwide (4 regions). This would involve the training of 600 nurse midwives and nurses, roughly 2000 rural health motivators, and 70 trainers/supervisors, including teachers from academic institutions, regional supervisors, and senior physicians, and central MOH staff. An expansion of the program is being currently supported by EGPAF and UNICEF. Sustainability is apparent as the processes and materials that USAID/BASICS developed and adapted for this initiative were integrated into a generic tool kit covering all aspects of newborn health.

Click on the titles below to access reports and other materials developed during USAID/BASICS' Swaziland country program.

Title	Type	Description	Technical Focus Area(s)
Repositioning Postnatal Care in a High HIV Environment	Final Report	Final report, published by the Population Council, of the operational research project, *Repositioning Postnatal Care in a High HIV Environment*.	▪ Newborn Health ▪ Maternal Health ▪ PMTCT
Integrating Quality Postnatal Care into PMTCT in Swaziland	Journal Article	Article published in Global Public Health Journal of the Mailman School of Public Health detailing the impact of USAID/BASICS' inputs in the area of basic care for mothers and babies as part of *Repositioning Postnatal Care in a High HIV Environment*.	▪ Newborn Health ▪ Maternal Health ▪ PMTCT

Note

This report will be updated with the yet-unpublished USAID/BASICS Newborn Health Toolkit, many of whose generic tools were initially developed for the project's Swaziland program. These comprise:

1. Reference Manual for Training
2. Guide for Trainers
3. Guide for Participants
4. Booklet of Technical Presentations
5. Checklists for Learning and Supervision
6. Guide for Trainers of CHWs (with counseling cards)
7. Job Aids for Facility Workers in NBH
8. Counseling Cards for CHWs
9. Monitoring and Evaluation Tools