



PREVENTING MALARIA IN PREGNANCY THROUGH FOCUSED ANTENATAL CARE: WORKING WITH FAITH-BASED ORGANIZATIONS IN UGANDA

Kasese District, Uganda

INTRODUCTION

In Uganda, 50% of maternal and child health services are provided through faith-based organizations (FBOs). The ACCESS Program, through IMA World Health (IMA) and JHPIEGO, collaborated on a pilot program in the Kasese District with three FBOs—the Uganda Protestant Medical Bureau, the Uganda Muslim Medical Bureau and the Uganda Catholic Medical Bureau—to increase uptake of intermittent preventive treatment (IPT) to prevent malaria in pregnancy (MIP), using the focused antenatal care (ANC) platform. This program was supported by U.S. Agency for International Development (USAID) East Africa, USAID Africa Bureau and the Malaria Action Coalition.

In 2003, before program implementation, the uptake of IPT 1 was at 35%, IPT 2 at 27% and the use of insecticide-treated bed nets (ITNs) was at 5%.¹ Following the World Health Organization's (WHO) three-pronged approach,² the pilot study's program objectives were to increase:

- Uptake of IPT
- Use of ITNs among pregnant women
- Capacity among providers to deliver focused ANC services
- The number of pregnant women coming early (first trimester) for ANC

IMPLEMENTATION OF FOCUSED ANTENATAL CARE IN KASESE DISTRICT

In collaboration with the Uganda Ministry of Health (MOH), through the Uganda Protestant Medical

Bureau, IMA led the management and coordination components of the nine-month pilot program, while JHPIEGO led the technical assistance component. These efforts were to augment the existing efforts under way in the public sector. Local FBOs worked in close collaboration with the public sector to ensure no missed opportunities to prevent and treat MIP. This comprehensive approach was designed to lead to improved maternal and newborn health outcomes related to the four objectives mentioned previously.

The pilot program was implemented in the Kasese District in the Western region of Uganda. The five facilities in the program were: Kagando Hospital, St. Paul Health Centre IV, Lwasande Health Centre IV, Kasese Muslim Health Centre III and Kasanga Health Centre II. The Kasese District was chosen on the basis of its high prevalence of malaria and low IPT uptake, as well as a need for services addressing focused ANC and MIP. There is also a strong FBO presence supporting this district. Selected communities served by the five facilities were targeted for the orientation and training of Community-Owned Resource Persons (CORPs) (community health workers), as well as for advocacy and mobilization of community and religious leaders in the communities.

PROGRAM ACTIVITIES

The following activities were conducted in the district:

- **Advocacy and planning.** Advocacy and planning meetings were held for stakeholders, including the MOH, Kasese District Health Team, community leaders, religious leaders and in-charges of

¹DHS 2003, Uganda Ministry of Health 2004.

²World Health Organization (WHO). 2004. *A Strategic Framework for Malaria Prevention and Control during Pregnancy in the African Region*. WHO Regional Office for Africa: Brazzaville. "IPT is part of the WHO-recommended three-pronged approach to malaria prevention and control during pregnancy. All pregnant women in areas of stable malaria transmission should receive at least two doses of IPT after quickening—IPT1 being the first dose and IPT2 the second dose. Doses should not be given more frequently than monthly."

health facilities involved in the program. These meetings helped promote ownership of the program and build community support for maternal and newborn health improvements, while strengthening the relationship between the facility and the CORPs regarding care and treatment of pregnant women and newborns.

- **Baseline survey.** A rapid assessment was conducted at all five target facilities and in the surrounding communities. The assessment found the use of ANC during the first trimester to be low. It also found that IPT uptake and community knowledge and attitudes to prevent MIP needed improvement, thus providing insight for training at both the clinical and community levels.
- **Development of focused ANC materials.** In collaboration with the MOH, all materials were developed based on Uganda's national standards and guidelines, the evidence-based JHPIEGO focused ANC/MIP training materials and the WHO's *Strategic Framework for Malaria Prevention and Control during Pregnancy in the African Region*.² Simple, user-friendly, evidence-based orientation packages and job aids were adapted and developed to support training for focused ANC and MIP at both the facility and community levels. The materials included:
 - Orientation package for service providers: Focused ANC, MIP and prevention of mother-to-child transmission of HIV (PMTCT)
 - Orientation package for CORPs: Focused ANC, MIP and PMTCT
- **ITN procurement.** Prior to program implementation, FBO facilities did not have ITNs. ACCESS supported the procurement and distribution of ITNs for the five selected facilities. ITNs are available in some facilities at subsidized costs.
- **Focused ANC training.** Service providers were oriented on the concepts of focused ANC, MIP and PMTCT. This orientation improved the service providers' knowledge and attitudes about delivery of focused ANC services.
- **Orientation of CORPs.** CORPs were empowered to take focused ANC, MIP and PMTCT messages to the community. Their roles and responsibilities were defined, and the importance of linkages to the health facilities emphasized. In addition, the orientation included specific interventions that

CORPs can implement to promote better services for pregnant women, both in the community and at the facility.

- **Supportive supervision.** During the supportive supervision visits, the program and MOH team offered reinforcement for the trained providers and assisted them in recognizing and correcting service delivery gaps. Focus group discussions were conducted for the CORPs who attended the training. CORPs immediately started using the knowledge they gained. One said:

“Some of the issues we discussed as CORPs were starting ANC early, use of ITNs, testing for HIV, savings as part of the birth plan, involving men during pregnancy.... I have noticed a great change in the preparation for delivery—gloves, emergency funds and other materials.... This program has given me knowledge that has assisted me to help my community. Can ACCESS train more of us?”
—CORP from Kasese.

KEY POINTS

This program was developed and implemented by building on existing structures and systems. Despite the short duration of the intervention, significant improvements were made. A few “key points” that contributed to the program's success include:

- **Focused ANC accepted.** It is not seen as a new approach that burdens the providers, but as one that improves services while also saving time.
- **Directly Observed Treatment (DOT) accepted for sulfadoxine-pyrimethamine (SP).** Providers started using the DOT method for administering SP and requested that management facilitate this method by providing cups, etc.
- **Partnerships built at the community level.** The active participation of the District Health Officer, bishop and other religious leaders, providers, CORPs and private midwives resulted in increased awareness and commitment to improve and scale up maternal and newborn services in the district.
- **Partnership with the MOH and FBOs strengthened.** The program team worked closely with the National Malaria Control Program, the Uganda MOH and the Reproductive Health Division of the MOH throughout implementation. Leadership from the MOH is essential even when working with the faith-based sector. During this

KEY PROGRAM INDICATOR	BASELINE	ENDLINE
Percentage of ANC clinic staff trained in MIP in the last six months (including IPT and counseling on ITNs for pregnant women)	2%	100%
Percentage of pregnant women who received ITNs or purchased ITNs during ANC	0%	27%
Number of community health workers trained in MIP	0	25%
Number of religious leaders sensitized for advocacy and support for pregnant women	0	10%
Number of days with SP stock-outs in the last month (in FBO facilities)	0	0
ANC attendance in first trimester	0	5%
Percentage of pregnant women who received first course of IPT under direct observation	43%	94%
Percentage of pregnant women who received second course of IPT under direct observation	63%	76%
Percentage of pregnant women who reported sleeping under an ITN the previous night at second ANC visit	37%	14%*

*This drop in ITN use most likely is due to the fact that the endline assessment was conducted during the hot season and the baseline during the winter months, when women are more inclined to sleep under a bed net.

program, key FBO leaders were champions for change in the Kasese community. This support made a difference not only in the implementation, but also in the outcomes with regard to changes in attitudes and practices.

- **Focused ANC materials for national use developed.** As mentioned previously, all materials were developed based on Uganda's national standards and guidelines, the evidence-based JHPIEGO focused ANC/MIP training materials and the WHO's *Strategic Framework for Malaria Prevention and Control during Pregnancy in the African Region*.² The materials developed were simple, user-friendly orientation packages designed for providers and community health workers.

RESULTS

This program was implemented over nine months in collaboration with the MOH and the faith-based sector. The gains achieved during this short period have laid a strong foundation for future efforts in

Uganda. The District Health Officer plans to replicate the model throughout the Kasese district, recognizing its effectiveness and results-oriented approach as illustrated by the improvements in key program indicators in the table above.

FINDINGS

At a stakeholders' meeting, results and lessons learned were shared and the following opportunities to scale up program activities were identified:

- The District Health Officer will use this program as a model for scale-up in both the private and public sectors. Because resource and time constraints make it impossible to train every provider in a country, a training approach that could lead to sustainable scale-up was used. It has been found that a cascade training approach (train providers who will then train other providers) to disseminate national guidelines is more effective in reaching more providers through echo-orientations.³

³ Stanback J et al. 2007. Improving adherence to family planning guidelines in Kenya: An experiment. *International Journal for Quality in Health Care* 19(2): 68–73.

- Pilot program facilities can be used as “mentors” to other facilities adapting this approach.
- The training approaches and materials are essential to ensuring a change in knowledge and attitudes among providers, clients, and community and religious leaders.
- Male involvement was discussed at great length and the specific ways that men can support their female partners should be identified.

CONCLUSION

Uganda is well positioned to scale up its health care programs to prevent and control MIP. The Kasese program showed that much can be gained in a short time. To replicate the Kasese successes, it will be important to ensure that the approaches used in this pilot program are supported throughout scale-up. Addressing skilled care and community awareness at the same time is very important and leads to informed demand for high-quality services. The MOH’s participation was a key component of the program’s success and provides a strong foundation for Uganda to implement and scale up future programs.