

Linking Community with Primary Health Care through Peer Support in Swaziland

Mats Malqvist*

International Maternal and Child Health, Department of Women's and Children's Health, Uppsala University, Sweden

*Corresponding author: Mats Malqvist, Associate Professor, Uppsala University, Department of Women's and Children's Health, Akademisk sjukhuset, Uppsala, 75185, Sweden, Tel: +26876718152; E-mail: mats.malqvist@kbh.uu.se

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The challenge

Health care delivery in the continuum of mother and childcare is faced with multiple barriers in low- and middle-income countries and the “inverse care law”, which stipulates that the ones in greatest need are the ones least likely to receive adequate care [1], is painfully present. Swaziland is a small country with huge health problems. The country is displaying the world's highest HIV prevalence, with 26% of the total population and up to 50% of pregnant women being HIV positive [2]. Furthermore, Swaziland is among the bottom five countries when it comes to improvement in child mortality, with an under-5 mortality rate of 70/1000 live births [3]. Inequities in society are huge, despite being a middle-income country in terms of GDP, more than 60% of the population lives on less than 1.25 USD a day [4].

Major obstacles to the provision and improvement of maternal and child health in Swaziland are cultural factors and patriarchal gender norms. Limited autonomy of women caused by cultural, economic and administrative structures generate poor conditions for women and children to promote and maintain good health [5]. Polygamous relationships, high unemployment rates with subsequent poverty and malfunctioning governance aggravates the risks for ill health and stands in the way of health promotion and delivery. Hence, there is a need for approaches that could impact on a range of barriers related to societal and cultural norms.

Peer support through community-based Mentor Mothers

In settings where health systems are failing to deliver care and where cultural and structural constraints are abundant, like in Swaziland, peer support models have been suggested as a possible method for increasing access to the health care system and improving adherence to medical treatment [6]. Peer support serves as a method to advocate for women's and children's rights, empowering its clients to make, and carry through, informed decisions about their own health and life situation.

Since 2012 an outreach project for improved maternal and child health has been running in Matsapha, a semi-urban area outside Swaziland's largest city. The project, called Siphilile, builds on a peer support model developed in Cape Town, South Africa, by an organization called Philani. The primary goal of the Philani model is to improve maternal and child health and survival. The model deploys “Mentor Mothers” in the community and has been shown to improve overall health of its beneficiaries [7]. In practical terms, this includes; the identification of malnourished children through home-based growth monitoring, screening for tuberculosis (TB), encouragement of antenatal clinic attendance and HIV testing, nutritional and dietary counselling, encouragement of breastfeeding, training in sanitation, screening of maternal depression, assistance in gaining access to social assistance and referral to health facilities when necessary.

In October 2014, Currently 32 Mentor Mothers are working for Siphilile in Matsapha, covering a population of about 30 000. The core of this community-based Mentor Mother model is training and supervision. Applicants should be women who have managed to raise children despite harsh conditions and who are role models in their community. The positive deviant model is a theoretical foundation of the Mentor Mother model [8]. The mothers do not have to have any previous health education, but are required to have completed at least twelve years of schooling. Before being officially accepted as Mentor Mothers they undergo a one-month in-house training with strictly defined knowledge and skills assessments. Once a Mentor Mother is accepted, she is under continuous supervision by field coordinators and a standardized reporting system ensures intervention quality.

Broken social relations, unemployment and poverty characterize the population of Matsapha. Of the enrolled clients more than 10% are teenage mothers and a vulnerable life situation with multiple partners and economic dependence is commonplace. Siphilile does not provide HIV testing, but more than 35% of the mothers have disclosed a positive HIV status to the Mentor Mothers (Table 1). Stigma of an HIV positive status is still present and a culture of silence is prevailing in the Swazi context [5].

Enrolled women (n=1032)	n	%
Still pregnant	217/1032	21.0
Pregnant HIV positive	73/217	33.6
Pregnant on anti-retroviral therapy (Option B+)	89/217	41.0
Pregnant women not attending antenatal care	12/217	5.5
Pregnant teenagers	27/217	12.4

Delivered	817/1032	79.2
Teenage mothers	71/817	8.7
Low birth weight babies	41/817	5.0
HIV positive mothers	308/817	37.7
Infants older than 6 weeks to HIV+ mothers	280/308	90.9
Infants PCR tested at 6 weeks of age	278/280	99.3
HIV positive infants (PCR positive)	4/308	1.3
Enrolled children (n=173)		
Severely underweight for age	19/173	11.0
Low birth weight	37/173	21.4
HIV+ mothers	76/173	43.9
HIV+ children	10/173	5.8

Table 1: Clients enrolled in the Siphilile Mentor Mother program in October 2014 (n=1205)

Linking community with primary health care

The Mentor Mothers act as a link between the community and the primary health care through their presence and connection to the local context. Compared to Rural Health Motivators (RHMs), as the usual community health workers are called in Swaziland, the Mentor Mothers have a smaller area of responsibility, are more focused toward a specific patient group, mothers and children, and have a higher level of supervision, training and demand for accountability. This facilitates the possibility of a greater impact on health outcomes and assists the primary health care as its advocates in the community. In Matsapha, the Mentor Mothers collaborate with a local clinic run by Doctors without borders (MSF), which is the main primary health care provider. The collaboration works two ways; the Mentor Mothers can refer their clients to the clinic, and the clinic can utilize the Mentor Mothers in defaulter tracing, given their knowledge about the community and its inhabitants.

In settings like Swaziland, where resources for primary health care are limited and where prevention is key in order to reduce the further spread of HIV and TB there is a need to find new innovative ways to promote good health. To overcome the problems of inconsistent antiretroviral treatment and defaulting TB treatment there is a need for a community link [6]. To be able to follow up on patients outside the clinic might not be feasible for already overloaded clinic staff, but through task-shifting to Mentor Mothers this link can be sustained. The peer support model developed by Philani in Cape Town, now

successfully replicated in a different setting is suggested to be a viable intervention strategy to bridge the gap between community and the health care providers and expand services where governance and resources are poor.

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