Babies and Mothers Alive (BAMA) – Healthcare Innovations in Uganda

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November 3rd, 2022

Introduction

The Babies and Mothers Alive (BAMA) program grew out of a partnership between two physicians and their collaboration with government and health providers in the Rakai and Kyotera districts of Uganda. Maternal and infant mortality in the region was high, and resources in the health system were strained; there was little prospect of large new investments. Given these constraints, health authorities in these districts tended to see high maternal and infant mortality rates as inevitable. Yet the BAMA team believed better outcomes were possible for mothers and their babies. Based on years of relationship building and service, BAMA was able to establish a partnership with the government to surmount this challenge together.

About this Brief: This case brief is part of a series exploring practical lessons from ongoing innovations for early childhood development, made possible by the support of Grand Challenges Canada (funded by the Government of Canada), Porticus, and the Saving Brains Partnership.

The BAMA collaboration is a vivid example of how thousands of lives can be saved by building trustful long-lasting relationships and using innovative service models to harness the energies and capacities of people working in community health systems. The program is still evolving as it scales up, but the story to date offers lessons on the challenges innovators face, and the creative strategies they can use, to partner with governments to benefit mothers, children and families at scale. These challenges, in turn, are central for many programs working in low-resource settings to promote maternal and child health and wellbeing in a sustainable, system-wide way.

Daniel Murokora – a Ugandan obstetrician-gynecologist and former President of the Association of Obstetricians and Gynecologists of Uganda – and Marc Sklar – an American obstetrician-gynecologist working in global women's health – began working together in the early 2000s. Starting with cervical cancer screening, they embarked on a variety of projects to improve the sexual and reproductive health and living conditions of girls and women in Rakai and Kyotera.



BAMA's dedicated Mama and Papa Ambassadors assist pregnant women in rural areas to develop birth preparedness plans, stressing the importance of delivering at a health facility under the care of a skilled birth attendant. Photo credit: Jon Wallen.

After working hand in hand with local communities for more than a decade, in 2015 Murokora and Sklar built on the trustful relationships they had established and formed a larger partnership with the district health systems to directly tackle challenges of maternal and child survival and health. Through this partnership, the BAMA Program has trained and

empowered more than 450 government health workers in infant and maternal care. Under their distinctive service model:

- a core of "Mentor Midwives" is the center of a training cascade and an upgraded approach to supporting birth; while
- a larger cadre of "Mama and Papa Ambassadors,"[1] community health workers in the government system, work at the village level to increase utilization of maternal and newborn health services and, in turn, organize peer support groups for adolescent mothers.

This case brief presents the story of the BAMA Foundation[2] with a particular focus on the way the BAMA team effectively partnered with the local government health system to improve vital services for mothers and babies. Evaluation evidence suggests that this work has saved the lives of thousands of babies and mothers in the Rakai and Kyotera districts. For instance, in the last six years, the percentage of women dying at BAMA-partnering facilities due to serious obstetric complications has dropped by over 70%.[3] More than 1,500 newborns have been admitted to the program NICUs, of whom 92% were discharged alive.[4] Based on lessons learned from the program's implementation, the BAMA team plans to build on this success by extending and deepening its work in the two founding districts and scaling the model to neighboring districts and across Uganda.

Developing the Babies and Mothers Alive Program

Background and Approach

Daniel Murokora and Marc Sklar started their joint work in Rakai district as co-investigators on cervical cancer screening. From 2003 to 2015, they worked to improve the infrastructure and sanitation standards of nine rural schools and led an after-school program on sexual and reproductive health serving approximately 5,000 students. In 2015, recognizing the broader need to improve maternal and child health, and knowing that the most vulnerable people were often outside the education system, Murokora and Sklar decided to develop a more ambitious program. The program **they designed, called Babies and Mothers Alive**, had the following goals:

- Increase the demand for and utilization of institutional maternal, reproductive, newborn and early childhood health services.
- Ensure high-quality obstetric and newborn care, friendly to mothers and babies.
- Address critical needs in adolescent sexual and reproductive health.
- Increase access to cervical cancer screening and early treatment, and expand access to vaccination against human papillomavirus for out-of-school girls.

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[1] See the accompanying photograph. All photographs and captions were provided by the BAMA team.
[2] Formerly known as "Brick by Brick Uganda." This brief will consistently use "BAMA Foundation."
[3] BAMA (2022). *Building Healthy Communities*. p. 3. Retrieved from: https://7c0ecb75-bfb7-47e4-964f-2798093f233b.usrfiles.com/ugd/7c0ecb_3fef41ee7dd84b5a9ab3f1fea6bb7cf6.pdf
[4] Ibid.

- Improve district and facility-based health data systems.

Three types of delays (the "Three Delays Model" [5]) were causing much of the preventable maternal and newborn morbidity and mortality in the district: (1) "delay in deciding to seek care on the part of the individual, the family, or both"; (2) "delay in reaching an adequate health care facility"; and (3) "delay in receiving quality care at the facility."[6] BAMA's approach to overcoming these three delays, and to more comprehensively addressing the underlying health needs of mothers and their babies, was based, from the beginning, on working with and capacitating people in the existing healthcare system.

The BAMA model called for a cascade approach to training. The BAMA Program would select a group of leading and committed midwives and train them in maternal and infant care. With the tools provided by the BAMA Program, these lead health workers – called Mentor Midwives – would tutor a bigger group of midwives working in the Health Centers and District Hospitals, preventing emergencies and complications in childbirth that would require obstetric services. The Mentor Midwives would be selected according to their performance in the healthcare facilities. They would be the highest performers of their cohort of paid government healthcare workers, contributing with "knowledge and experience to their expanded duties."[7]



BAMA mentor midwife Olivious Tumusiime provides antenatal care to an adolescent mother in the Rakai District. Photo credit: Cynthia Rukundo.

To bring this concept to life, the team needed (a) international funding to support their training and capacity-building work and (b) full agreement with the Rakai and Kyotera district governments and health systems for joint implementation.

Early Funding Efforts

In 2015, Brick by Brick Partners, a U.S. 501(c)(3) organization that was the largest and most consistent supporter of the team's work, switched gears in its fundraising efforts from the school program to the new BAMA Program. They provided the BAMA Program with around US $350,000 per year of unrestricted funding and were also key to expanding the program's base of sustaining donors. Also in 2015, with a commitment of US $1.25 million over five years from the US-based Puffin Foundation, the BAMA team

[5] Collins, V. (2018). The Three Delays Revisited: Barriers to maternal and Infant Health. *Washington University Open Scholarship*, Volume 13, 213, p. 5: https://openscholarship.wustl.edu/cgi/viewcontent.cgi?article=1212&context=wuurd_vol13

[6] Thaddeus, S., & Maine, D. (1994). Too far to walk: maternal mortality in context. *Social Science & Medicine*, 38(8), p. 1092. Quoted in Collins, V. (2018), op. cit., p. 15.

[7] Materials provided by GCC and BAMA.

performed an extensive baseline survey in all government healthcare facilities providing maternal and newborn care. They used the survey results to engage the Rakai District – later joined by the Kyotera District when the districts split into two – and formed a partnership with the district health system. This partnership would then result in the official launch of the BAMA Program one year later.

Partnering with the District Health Systems

With funding in hand, the biggest challenge the BAMA team faced was sensitizing the government authorities and developing a shared understanding of the value and feasibility of taking concrete steps to improve maternal and newborn health. Initially, health officials viewed postpartum complications and infant and maternal mortality as inevitable consequences of the limited levels of available resources. Partnerships between NGOs and the local health system in Rakai and Kyotera were mostly centered on HIV prevention and care. It was therefore crucial that the Rakai and Kyotera district governments not only viewed infant and maternal mortality as an important problem, but also that they saw that improvement was possible: The district healthcare departments could play a crucial role in saving lives, through a joint effort with the BAMA team to improve access to and utilization of quality care in the government-run health facilities.

Convincing district officials that this was possible, and engaging them to build a joint effort, depended on the trusting relationships the BAMA team had already built with the districts, based on their long history of engagement. As noted above, the team had been present in the districts for over 12 years working on primary education and reproductive and sexual health. During this period, the BAMA team built a track record of successful engagement and developed personal relationships that, by 2015, had become deeply rooted. This enabled them to work effectively, with strong mutual communication, on the more complex task of implementing the BAMA Program with the district governments.

"There is a level of accountability that is built on close relationships and it is not present in the parachuting model. You do not want to disappoint someone who you actually know, who you might see at church or you might run into in the market. It is really at that granular level, I believe, that the trust is built."

– Marc Sklar

Additionally, the BAMA proposal to the district governments was based on strong data that quantified key problems they had to address and enabled the governments and the BAMA team to align their objectives.

Before the BAMA team gathered patient level data on infant and maternal morbidity mortality rates, this information was collected only during the Uganda Demographic and Health Surveys (UDHS). The data available at the start of BAMA was from the UDHS of 2011 and it was not specific to health facilities where BAMA works, so decision-making could not be based on current information.

Working with the 2015 baseline survey results, the BAMA team was able to show the local governments a pathway that they could follow together, by building a partnership, to support maternal and infant

health locally and at the same time advance the Ministry of Health's national goals.[8] From the government's perspective, it was important that the new model would not require large amounts of additional government spending. The program met this criterion because the BAMA model was based on building the capacity of people already working for the government to provide healthcare services. BAMA's annual expenditure is between US $350,000 – $400,000 per year, around 10% of the health expenditure in the region.

"You have staff, some of them are very senior, passionate, and some of them are already champions in the area of maternal health, so we would like just to provide them with skills so that we have a local solution for the local problems."

– Daniel Murokora

Implementing BAMA and Related Initiatives

In 2016, with seed capital from the Puffin Foundation and Brick by Brick Partners, the team in Uganda expanded from eight to 36 staff members and officially launched the BAMA Program. From 2016 to 2021, BAMA "reduced institutional maternal and perinatal mortality by 72% and 44% respectively, increasing demand and utilization of government-funded health services."[9] These results reflect the successful implementation of the original BAMA model along with related programs, such as the "Mama Ambassador Program" (described below).

Putting in Place the BAMA Model

To begin, the Foundation staff trained the first group of 30 government-employed, but newly designated "Mentor Midwives" in obstetric and newborn care. These Mentor Midwives then trained and supervised on a regular basis a bigger group of about 300 practicing midwives in the Rakai and Kyotera districts. In addition, the Foundation established three Neonatal Intensive Care Units and worked with the District Health Systems on improving relevant healthcare management practices and systems, while fostering a mother- and baby-friendly environment. They worked together to build capacity to assure the quality of care, in part by increasing the capacity of health managers to collect and analyze data for action.

The program's structure was based on existing human resources: All the health staff trained were already working with the government. This approach provided a sustainable upgrade to the system without requiring large new monetary investments.

[8] See, for example, the Ministry of Health of Uganda's 2013 Reproductive Maternal, Newborn and Child Health Sharpened Plan: https://www.healthynewbornnetwork.org/hnn-content/uploads/RMNCH_UG_APR_Nov2013.pdf
[9] Materials provided by BAMA.

The Mama Ambassador Program

In 2016, the team identified the need to complement the BAMA model with a new program focused on adolescent mothers. These mothers had the highest infant and maternal mortality rates; because of stigma, they were relatively unlikely to access the antenatal, maternal, and newborn care services that were the core of the BAMA Program.



The Mama Ambassador Program supports 1,000 adolescent mothers and babies with monthly parenting groups and regular developmental assessments, ensuring healthy babies. Photo credit: Cynthia Rukundo.

At that time:

- "[O]ne in four adolescent women between 15 and 19 years old in Uganda were already mothers or were pregnant with their first child."[10]
- "Stillbirths and child deaths are 50% more likely for babies born to mothers younger than 20 than for those aged 20-29 years."[11]
- "Despite the high rate of adolescent pregnancy [and pregnancy complications], the Ugandan Ministry of Health recorded that only 5% of public facilities in the country had youth-friendly maternal, sexual and reproductive health services."[12]

Additionally, "pregnant adolescents are often stigmatized, disowned by their families, [and] more likely to leave school."[13] A study in Wakiso district in Central Uganda found that "adolescent mothers were more likely to have dropped out of school due to pregnancy …. less likely to earn a salary …. and more likely to attend antenatal care visits less than four times [the minimum standard] compared to adult mothers."[14] Moreover, adolescent mothers often face challenging circumstances caring for their newborns,

[10] Materials provided by BAMA.
[11] Ministry of Health, Uganda (2016). Investment Case for Reproductive, Maternal, Newborn, Child and Adolescent Health Sharpened Plan for Uganda. p. 11. Retrieved from: https://www.globalfinancingfacility.org/sites/gff_new/files/documents/Uganda-Investment-Case.pdf
[12] Materials provided by BAMA.
[13] Ibid.
[14] Atuyambe, L., Mirembe, F., Tumwesigye, N. M., Annika, J., Kirumira, E. K., & Faxelid, E. (2008). Adolescent and adult first time mothers' health seeking practices during pregnancy and early motherhood in Wakiso district, central Uganda. *Reproductive health*, *5*, 13. Retrieved from: https://doi.org/10.1186/1742-4755-5-13

contributing to the increased risk of poor health and developmental outcomes for newborns and children.[15]

Therefore, in 2017, with a CAD $250,000 proof of concept grant from Grand Challenges Canada's Saving Brains program, the BAMA team launched the Mama Ambassador Program (MAP). The MAP works with adolescent mothers from 12 to 19 years old from seven months gestation through their children's second year of life. The aim is to empower the mothers through peer support groups – creating a sense of community and cohesion – and to stimulate their infants' brain development.

In 2016, the BAMA team also received a US Government PEPFAR grant of US $330,000 over three years for the DREAM Innovation Challenge to support the "My Pads" Program. These funds were used to provide sexual and reproductive health education through peer-support groups, and for the construction of gender-sensitive changing rooms and rainwater harvesting systems in 16 government-funded secondary schools.

The program trained 150 community health workers already working in the government health system, and already supported by Mentor Midwives, to become Mama and Papa Ambassadors. The Ambassadors were selected based on "their reputation in the community, proximity to the hospital, and knowledge and understanding of RMNCH [Reproductive, Maternal, Newborn, and Child Health] issues." [16] The Ambassadors are experts on women's health and rights and support adolescent mothers in accessing quality care at BAMA-partnering facilities by "developing birth preparedness and complication readiness plans"[17], providing information on sexual and reproductive health, and facilitating the MAP peer support parenting groups. The Mama and Papa Ambassadors "are well respected role models and champions of RMNCH care in their communities, and have helped to steadily increase the demand for, and utilization of facility based RMNCH services within the government system."[18]

Specifically, the MAP includes three components:

- "Caregiver capacity building: monthly childcare sessions focus on promoting developmentally appropriate communication, play, nutrition, hygiene, child health, growth, development, and improving the relationship between the mother and the infant.
- Improvement of maternal mental well-being: peer support sessions focus on the physical, emotional and developmental health of adolescent mothers, including a focus on the mother's relationship with herself, her child, the child's father, and extended family.
- Support system sessions: extended family members are invited to participate in activities to learn how to support the adolescent mother during pregnancy and after birth, including how to

[15] Materials provided by BAMA.
[16] Ibid.
[17] Ibid.
[18] Ibid.

facilitate maternal well-being, nurture a supportive environment, and protect infant development."[19]

With Mama and Papa Ambassadors as leaders and facilitators, the team created peer-support groups for over 400 adolescent mothers and babies and conducted a prospective cohort study from September 2018 to September 2020 that demonstrated significant improvement in early childhood development and maternal mental health. The MAP leverages the BAMA initiative by better enabling adolescent mothers to take advantage of the services that BAMA provides and by assuring ongoing support in the early childhood years.

Monitoring and Evaluation

Also supported by the Grand Challenges Canada's grant, in 2018, the BAMA team began a significant investment to create robust monitoring and evaluation (M&E) systems and an integrated data warehouse with the aim of strengthening the MAP and BAMA Program. These M&E systems allow the BAMA team and the district health services to continuously track program results and analyze how the program could be adapted in the best way possible. For instance, the team used infant and maternal mortality rates per healthcare facility, as well as obstetric and newborn complication rates, to focus their efforts on regions where improvement was most needed. In 2019, based on M&E tracking data, the team realized they needed to add menstrual health and prevention of sexually transmitted diseases as an explicit part of the MAP model. Insights from tracking data also led to the addition of adolescent-friendly family planning services. The M&E program also included a prospective cohort study to evaluate MAP, with encouraging results presented in the impact section of this brief.

Partnering with Government, Communities and Health Providers Around Shared Goals

Recruiting health workers to take on new, voluntary responsibilities – such as the Midwife Mentor and Ambassador roles – is inherently challenging, since these workers generally already have high workloads. The challenge is especially acute for programs – again like BAMA and MAP – which cannot provide new financial incentives for workers. Nevertheless, the team overcame these challenges and successfully energized workers, in part by assuring they benefited from empowerment and recognition.

For instance, the BAMA and MAP programs explicitly selected a core of high-potential healthcare workers (midwives and community health workers), recognized them with distinctive, visible titles (Mentor Midwives and Mama and Papa Ambassadors) and supported them through a series of training programs that gave them tools to have a higher impact on their community. The Foundation also gave awards and other non-material incentives to government staff working on its projects, included them on social media, and invited them to international online events – such as webinars hosted by the Saving Brains program – so that their voices could be widely heard.

[19] Materials provided by GCC and BAMA.

Relationships with health workers were also embedded in a series of constructive dialogues that the MAP and the BAMA Programs have held, since program inception, with the local community, health workers and local authorities, with the aim of engaging all parts of the system towards a common goal. These include regular coordination meetings at the community level with community healthcare workers and sessions with the district governments and the facilities' staff to engage them in the design and evolution of the BAMA Program. The meetings have also served as a forum for empowering the staff to own and improve their data collection systems, so they could receive timely feedback and use it to improve their services. This has helped the district governments and the facilities staff to take ownership of the MAP and BAMA Programs and take action based on the idea that they could significantly benefit the lives of mothers and babies in their community. The BAMA Program has made significant progress in the integration of its data system innovations into the government's Health Management Information System - for instance, by incorporating BAMA's Maternal Newborn Obstetric and Neonatal Complication Survey (MNOCS).



Robina Nalubega, an adolescent mother, demonstrating to other mothers how to prepare affordable healthy complementary foods for toddlers in their homes. Photo credit: Cynthia Rukundo.

"If you do not engage the local leadership, the local experts, you will be successful when you are there, but nothing will remain as soon as you are gone."

– Daniel Murokora

Extending and Scaling Up the Program: Work to Date

In 2020, the Foundation received a US $1.09 million USAID Partnership Plus Grant for 27 months to scale MAP over two years for 1,000 adolescent mothers and babies. At the same time, MAP has evolved to more fully address male engagement and sexual and gender-based violence prevention.

During the monthly sessions of the MAP with the young mothers, the Mama and Papa Ambassadors noticed that some of the women in the program presented physical evidence of domestic violence, a problem that was aggravated by the confinement and economic stress caused by the Covid-19 pandemic. In 2020, approximately 20% of the women in the program presented physical evidence of domestic violence; some families saw gender violence as a valid way of "correcting" mothers or a "signal of affection" related to jealousy. This sexual and gender-based violence was also affecting the development of the babies in the program since it could make parents less able to provide responsive care, and violence could also expose children to toxic stress.

Therefore, as part of the third component of the MAP – the support system sessions – the BAMA team started to work with extended families and fathers in a sensitization program against sexual and gender-based violence (SGBV), highlighting that violence is always damaging and never acceptable. MAP also connected young mothers to other resources available for women victims of SGBV. The surveys performed as part of the M&E system showed a decrease in emotional and physical abuse rates, with the portion of women in the MAP reporting SGBV (during the preceding three months) falling from 38.8% to 5.82%.

Currently, "the MAP and BAMA Programs are designed to work together to address both the demand and the supply side of the challenge of transforming outcomes for adolescent mothers and their children."[21] Together, these programs respond directly to the three types of delays causing much of the preventable maternal and newborn mortality in the region: With the MAP's peer-support groups, the BAMA Foundation addresses the delay in deciding to seek care. The BAMA Program approach to supporting birth reduces the delay in reaching an adequate health care facility and the delay in receiving quality care.

The BAMA Program's dependence on its own staff is transitioning, as its model is deeply integrated with the healthcare system to a point where it is difficult to establish where the BAMA Program ends and the health system begins:

- The BAMA team has trained 45 government-employed Mentor

In 2019, the BAMA team received a € 350,000 three-year grant to launch the Mama Rescue project. This grant was matched with the equivalent of € 180,000 from Brick by Brick Partners (a US 501(c)(3) organization that supports BAMA Foundation). The project links women in labour to motorcycle taxis through a mobile phone app and provides emergency transport for mothers who need to be referred from healthcare centers to hospitals in rural areas. From the program's start to October 2022:

- 20,956 women in labour were transported from home to health centers.
- 2,251 women with complications were transported for emergency referrals from health centers to hospitals reducing referral time from 3 1/2 hours at baseline to 35 minutes.
- The facility delivery rate increased from 79.7% to 94%, surpassing the goal of 90% by project end.
- Antenatal Care (ANC) 4 attendance has increased by 54% thanks to the program's Material Requirements Planning incentivizing attendance (women receive their transport voucher at the 4th ANC visit).

In 2020, the BAMA team also received a US $50,000 grant from the Islamic Development Bank to screen 10,000 women for cervical cancer and vaccinate 1,400 out-of-school adolescent girls against the human papillomavirus (HPV):

- "As of the end of 2021, we [BAMA] have screened 15,603 women, surpassing the target of 10,000 reproductive age women in Rakai and Kyotera Districts.
  Through our mother-daughter campaign model, we have also provided HPV vaccine to 8,342 out-of-school adolescent girls, five times our target of 1,650."[20]

[20] BAMA (2022). *Building Healthy Communities*. p. 2. Retrieved from: https://7c0ecb75-bfb7-47e4-964f-2798093f233b.usrfiles.com/ugd/7c0ecb_3fef41ee7dd84b5a9ab3f1fea6bb7cf6.pdf
[21] Materials provided by GCC and BAMA.

Midwives and 248 community health workers in government services to be Mama and Papa Ambassadors.

- "Initially, working in 24 Health Center IIIs and District Hospitals, we [BAMA Foundation] now partner with 67 facilities, including 19 private not-for-profits, outside of the Ugandan Government sector."[22]

The Impact of the BAMA and MAP Programs

Over the last 20 years of work, the BAMA team has built a trusting partnership with the local government and the Ministry of Health allowing it to reach sustainable, efficient and tangible results in maternal and infant wellbeing. The results of the MAP and BAMA Programs show that effective mobilization of the local resources along with small investments in human capital can have a significant impact on people's lives. Examples of results reported by the BAMA Foundation include:

- As part of providing high-risk newborn care, the BAMA Foundation established three Neonatal Intensive Care Units. "1,512 newborns were admitted to the NICUs, of whom 92% (1,391 infants) were discharged alive."[23]
- From 2016 to 2021, perinatal mortality dropped 44.6%.[24]
- "In 2016, 19 women died in government supported health centers and hospitals as a result of complications of pregnancy and labor. In 2020 this number was reduced to 6. The Institutional Maternal Mortality Ratio went from 220 per 100,000 live births to just 62, a 72% decrease....
- Institutional deliveries have increased steadily since 2015, … with the met need for obstetric services rising from 53.3% to [73.2% by the end of 2021]."[25]
- Finally, there was a "28% reduction in 'fresh stillborns,' those babies who likely died in the late antepartum or intrapartum (during labor) periods" [26] from 2019 to 2021.

Regarding MAP in particular, the team conducted a prospective cohort study to assess effects on child development and maternal wellbeing. Comparisons of child outcomes in 2018 and 2020 using the Ages and Stages Questionnaire (ASQ-3) demonstrated statistically significant benefits (compared to a control group) for babies between 2 and 12 months across five domains of child development: gross motor development, fine motor development, language development, cognitive development and social development.[27]

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[22] BAMA (2022). *Building Healthy Communities*. p. 3. Retrieved from: https://7c0ecb75-bfb7-47e4-964f-2798093f233b.usrfiles.com/ugd/7c0ecb_3fef41ee7dd84b5a9ab3f1fea6bb7cf6.pdf
[23] Ibid.
[24] Ibid.
[25] Ibid. Bracketed figures represent updated information provided by BAMA Foundation.
[26] Ibid.
[27] Materials provided by GCC and BAMA.

Results for maternal wellbeing included:

- "Using the Self Reporting Questionnaire and Multidimensional Scale of Perceived Sense of Social Support…: [The] mean scores for adolescent mothers who received monthly psychosocial support were above 5 compared to the counter parts whose mean scores was 2.8.
- Mental health: Improved from 54% to 94% in the intervention and dropped from 69% to 52% in the control group….
- Some mothers went back to school, improved interpersonal skills such as communication, [and] increased uptake of FP [family planning] (2.3 times more likely) in the intervention vs control." [28]



BAMA Foundation's Mama Ambassador Program creates safe spaces for young mothers and other people we interact with to feel comfortable saying, "I am not okay." Photo credit: Jon Wallen.

"To date, 1,470 mothers and babies have participated in this program [MAP], with 1,037 currently enrolled, representing approximately one third of adolescent mothers in Rakai and Kyotera districts. 90 Peer Support Parenting Groups have been established across 11 health centers and hospitals focusing on maternal and child wellbeing."[29]

In 2021, the BAMA Foundation won an award from John Snow, Inc. (JSI) [30] for the prevention of violence against babies.

Looking Ahead: Sustainable Scaling

BAMA Foundation's ultimate goal is to integrate the BAMA model into the district and national health system across Uganda. This is a major task, and the team recognizes that although the main work of the program is carried out by the local health system, the Foundation's own role will need to continue for a substantial period. In this context, a scaling challenge for the program is that the model depends on high-quality, trusting relationships with district health systems; yet, as BAMA's history itself shows, these can take years to build and require substantial ongoing dialogue to maintain. The team recognized it could not expect to do this on its own across the entire country. To overcome these challenges, the BAMA team has developed a three-tier scaling strategy that envisions: (1) local expansion; and (2) national NGO

[28] Materials provided by GCC and BAMA.
[29] Materials provided by BAMA.
[30] For information on JSI, see: https://www.jsi.com/location/uganda/

partnerships; both supporting (3) local and national integration with the health system. BAMA articulates this strategy as follows:

I. Expand the BAMA Program to our Neighboring Districts in the Masaka Region

Our initial goal (3-years) is to expand to the two adjoining districts of Masaka and Kulungu, followed by scaling to the entire Masaka Region of nine districts serving a total of 2,218,286 people. Directly overseeing this expanded BAMA Program implementation will allow us to adapt our model to support sustainable integration of our core interventions into the existing government health system, our ultimate goal.

II. Identify Potential NGO Partners in Uganda Working in Maternal, Reproductive, Newborn and Early Childhood Health and Development

Babies and Mothers Alive has a long history of high impact partnerships with national and international NGOs who are aligned with our mission. The establishment of a network of RMNCAH NGOs will support the dissemination our BAMA's core innovations, and extend and expand the reach of our program. We have begun by partnering with the Adara Group, an Australian foundation working in Central Uganda. Their work focuses on improving newborn care. We envision a learning exchange where both organizations, and the populations they serve, will benefit, Adara, through the adaptation of our program innovations in maternal and reproductive health, and BAMA, through improved newborn and early childhood health outcomes. Through such partnerships, and the establishment of an RMNCAH [Reproductive, Maternal, Newborn, Child and Adolescent Health] Stakeholder network, we will support NGO-government collaboration, promoting BAMA integration into the government health system.

III. Integrate BAMA into the District and National Health System in Building the BAMA Program

In full partnership with district government and the Ministry of Health, we participate in multiple fora at the national level overseeing maternal, newborn, reproductive, and adolescent health. Our senior staff are respected thought leaders. We will work to leverage our success to date, encouraging the adoption of key components of our program model. For example, we have already seen our Maternal and Newborn Obstetrics Complication Survey (MNOCS) integrated into the government health data system. Our Mentor Midwife and Mama Ambassador models are key to our work improving the quality of care in maternal, reproductive, and newborn health and can easily be adapted for integration into the Ugandan health system.[31]

[31] Materials provided by BAMA, italics added.

In 2022, the BAMA Foundation received a grant from Grand Challenges Canada to support its transition to scale. In September, the Foundation received a commitment from USAID to more than match the Grand Challenges Grant over a two-year period.

Lessons

When the BAMA Program started, the health system in the Rakai and Kyotera Districts faced tight resource constraints, and high infant and mortality rates were seen as inevitable. However, the BAMA Foundation demonstrated that by building alliances with the local authorities and working hand-in-hand with the community through an innovative, participatory service delivery model, it was possible to energize the existing resources to achieve significant changes even in vulnerable settings. BAMA is in the middle of its journey, but the story so far already offers lessons on partnering with existing service providers to achieve major change in low-resource settings.

In the first place, the story illustrates the value of taking time to build truly trusting and meaningful relationships with the local authorities and the communities. The team spent years working with local service providers on small-scale projects, and this work built the trust needed to propose a major joint initiative and effectively overturn the idea that change was not possible.

"It is really built on this long-term approach that the districts [authorities] can relax and realize, 'Oh! These people are here with us, in the trenches, for a long time. They are not going anywhere.' So, they can see that they do not have to feel threatened when they are confronted because we are working on this together."

– Marc Sklar

Second, the model was based on understanding the local system and building on its strengths. BAMA empowers local service providers and families through strategies like training cascades and peer support groups. This enabled the community in effect to better serve itself, supported by a shared, data-rich approach to monitoring and evaluation. To help motivate community members to take on new roles even without additional financial incentives, the team engaged them through empowerment and public recognition, including assuring their voices were heard. Thus, the BAMA story not only demonstrates that drawing on and energizing local people can help achieve core program goals like improved infant survival; it also shows that empowerment around shared commitment to those goals is an effective way to tap local energy.

The BAMA team reflected that creating a high-impact intervention is never straightforward. They realized that any important change, any proposal to do things differently, could face initial resistance. Their long-standing local relationships, where people realized that the goals of the organization and the community are aligned, put them in a good position to overcome such resistance.

In this context, the story of the BAMA Foundation invites us to see challenges as opportunities and to combat the often-debilitating assumption that significant investments are required to make an impact.

The limited economic resources available to BAMA and the local health system – what could be seen as the effort's biggest challenge – ended up being its greatest strength. The BAMA Foundation could not implement the whole program by itself, but it started a collaborative partnership with local service providers that has continued to expand year after year, with sustainable new capacity in the districts. Those providers are at the heart of BAMA's success.

"If you ask them who are they, they would say: 'Yes, I am a BAMA Mentor Midwife,' or, 'I am a Mama – or Papa – Ambassador.' They know that even if things are not perfect, there is a group of people called BAMA that appreciate them and that keeps telling them that what they do is important."

– Marc Sklar

The work of the Saving Brains Learning Platform Team to engage with this innovation and prepare this profile was made possible by the support of Grand Challenges Canada (funded by the Government of Canada), Porticus, and the Saving Brains Partnership.

For more information about **Saving Brains** and **Grand Challenges Canada**, please visit: www.grandchallenges.ca

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We extend a thank you to the **BAMA Foundation** for their work and for sharing their story with us.

For more information about the **BAMA Foundation**, please visit their website: https://babiesandmothersalive.org/