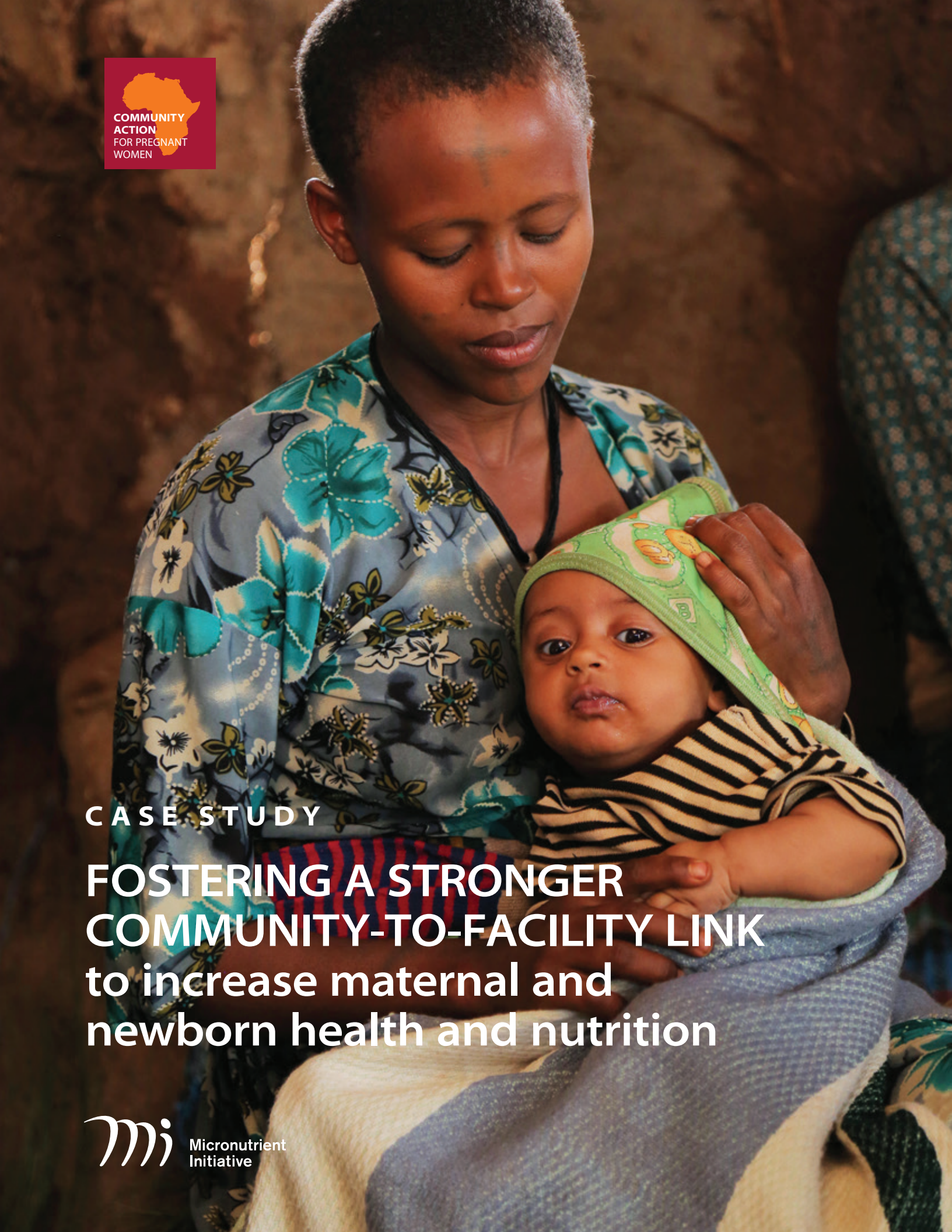

COMMUNITY ACTION FOR PREGNANT WOMEN

CASE STUDY

FOSTERING A STRONGER COMMUNITY-TO-FACILITY LINK to increase maternal and newborn health and nutrition

Micronutrient Initiative

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INTRODUCTION

Many women in Sub-Saharan Africa do not have the resources needed for a healthy pregnancy and birth experience. This is often due to inadequate access to vital health services, such as antenatal care, birth care, and postnatal care, and limited access to important information to boost their knowledge and understanding of maternal nutrition for optimal health and delivery. These gaps put them and their newborns at higher risk of illness and death.

In order to make a meaningful impact, it is vital to tailor a series of interventions to the exact needs and realities of each particular area. Furthermore, international development agencies, policy-makers, healthcare professionals and other stakeholders in the field need to be aware of the work other organizations and governments are doing in the same area. Ideally, the global community should work together on a cohesive plan around maternal and newborn health to mitigate mortality and improve access to health and nutrition services.

In 2011, the Micronutrient Initiative (MI)— in collaboration with national governments and partners — embarked upon a five-year project in unique areas of high-need populations in Africa to address this gap in knowledge and services, with two primary aims:

1. To improve the quality and uptake of antenatal care (ANC), birth care and post-natal care (PNC) in remote populations
2. To integrate essential nutrition interventions into maternal and newborn health programs that will support optimal nutritional status throughout pregnancy and beyond

In Kenya, Ethiopia, and Senegal, MI and partners — with the lead taken by each country's Ministry of Health — tested a variety of community-based models of service delivery for maternal and newborn health and nutrition through unique demonstration projects.

"Nothing could change me from conducting delivery at home because I was not only very famous, but also had a ward in my house and clients of all walks of life. I was even wanted by the police because of a maternal death but still continued. Only *Linda Afya ya mama na Mtoto* project convinced me when we were called to attend a dialogue meeting that changed my life! I no longer conduct home deliveries."

IO-Ekero
Birth Companion

In the regions targeted by this project, the link between community and health facilities was crucial. Health facilities offer life-saving interventions and emergency care but are often located far from the communities they serve. In some cases, the barriers to accessing health services throughout pregnancy, birth care and postnatal care include prevailing community practices that place a higher value on respected, but untrained, traditional birth attendants than on the formal healthcare system.

This project set out to demonstrate community and health facilities do not have to be mutually exclusive. In all three regions, it was clear the connection between communities and the health facilities that served them had to be strengthened; MI and partners hypothesized that by involving communities in the healthcare systems and processes, it was possible to pave the way for safer pregnancies and births.

THE STATE OF MATERNAL AND NEWBORN HEALTH IN THE SELECTED COUNTRIES

The project was carried out in hard-to-reach communities in Africa, each with unique challenges in maternal and newborn health, as follows:

KAKAMEGA, KENYA

Despite the growing awareness that skilled attendants at health facilities can manage complications during birth, in Kakamega County over half of all births take place outside of health facilities and without the support of a skilled attendant. Among pregnant women, only 20% receive antenatal care during the first trimester of pregnancy and only 7% of pregnant women consume over 90 tablets of iron-folic acid[1].

AFAR, ETHIOPIA

The pastoralist lifestyle of communities in the Afar region make it especially difficult for healthcare workers to reach pregnant women and newborns. No pregnant women receive over 90 tablets of iron-folic acid and only 23% receive any tablets[2]. Only 31% of pregnant woman receive even one antenatal care visit from a trained healthcare provider and just 10% give birth with a skilled attendant[3].

KOLDA, SENEGAL

The region's remote location makes it difficult for women to access quality healthcare. It is estimated that less than half of pregnant women have at least four antenatal check-ups that are recommended for a healthy pregnancy. During labour, just over 30% of mothers give birth with a skilled attendant present, far lower than the national average of 65%[4].

THE APPROACH

The project used a multi-country model and engaged local governments, global experts and international and national partners.

It focused on the crucial 10-month period between conception and the first month after birth. Each country project included a strong evaluation component and advocacy plan, which facilitated the documentation and dissemination of lessons learned; together, these resources can be used to inform program implementation nationally or in other regions with a similar context as the target areas.

One of the most exciting elements of this project was the modular design of the demonstration projects. Rather than applying one blanket approach to three distinct target areas, each intervention was specifically designed to meet the unique needs of the target area.

Moving forward, this strategy will provide a blueprint to scale up the initiative within Kenya, Ethiopia and Senegal. Furthermore, it will enable interested parties in other regions of Africa — and in other similar contexts or communities — to identify the intervention best suited for their own context and thus replicate the program to address relevant issues within their communities.

"I am at peace because I do not have to worry of a woman or baby dying during delivery period under my care. I can now sleep peacefully knowing that in hospital, both the mother and child are safe."

Agnes Makina
Birth Companion

PROJECT TARGETS

Reach 100,000 pregnant women and newborns through improved health services, including ANC, birth care and PNC

Train 2,000 community- and facility-based health personnel to provide improved coverage and quality of care through health services

PROJECT ACHIEVEMENTS

Reached nearly 200,000 pregnant women and newborns

Successfully trained more than 8,000 community- and facility-based personnel

1. Kenya Demographic Health Survey, 2014
2. Ethiopia Demographic Health Survey, 2011
3. Ethiopia Mini-Demographic Health Survey, 2014
4. Senegal Demographic Health Survey, 2010

KAKAMEGA, KENYA

The approach taken in Kenya was to build a community-based health model to increase the uptake of antenatal, birth and postnatal care services for pregnant women and improve the quality of care provided at the facility level. With a focus to strengthen the link between community and facility, the approach also aimed to improve the connection between Traditional Birth Attendants (TBAs) and the local health facilities, and thus support safe and healthy pregnancies to reduce maternal and newborn morbidity and mortality.

AFAR, ETHIOPIA

The approach taken in Ethiopia was to improve coverage and quality of care for women and newborns by focusing on training community-level providers, and ensuring participation by facility staff in monitoring and quality improvement. The approach also aimed to engage the community in creating innovative ideas and projects geared toward improving the health of mothers and infants, in order to further strengthen the link between the community and the facility.

KOLDA, SENEGAL

The approach taken in Senegal was to develop and demonstrate an integrated package of community-level interventions to increase uptake and improve the quality of maternal and newborn health services. Improving local health huts so they could serve as a gateway to access was another strategy to strengthen the link between the community and the facility; training healthcare providers in outreach activities, such as local health visits to the community, also supported this goal.

REGIONS

KENYA

ETHIOPIA

SENEGAL

KENYA

From Traditional Birth Attendant to Birth Companion

In Kenya, Traditional Birth Attendants (TBA) play an important role in the community, providing care and support for pregnant women. In 2014, 19% of all births in Kenya were assisted by TBAs; in Kakamega County, that number was close to double the national average, with 30.1% of all births taking place with a TBA by the mother's side[5].

While the role of TBAs is well-respected by pregnant women and their families, TBAs often lack formal training and are unprepared to handle complications and emergencies during childbirth; they learn skills passed down from older generations, as well as from on-the-job experience. There has long been a separation between TBAs and the formal health system.

In 2007, Kenya's Ministry of Health (MoH) introduced a policy that banned TBAs from performing deliveries and recommended they undergo training to become Birth Companions, although no clear guidance was provided on how this could be operationalized. This new role of the Birth Companion would build upon the trusted position of TBAs within the community and give them the knowledge and skills required to provide support the pregnant women in their communities; a significant move towards reducing maternal and newborn mortality.

The primary task of the Birth Companion is to accompany pregnant women to local health facilities to deliver their babies in a safe environment. They are also tasked with providing essential information on prenatal nutrition, support women and healthcare providers during labour, and promote — and support — early and exclusive breastfeeding. Ultimately, the conversion of TBAs to Birth Companions is meant to increase the percentage of births delivered in health facilities, rather than at home.

Recognizing that access to obstetric care from a trained health professional during birth is crucial for reducing maternal and neonatal mortality[6], the project partners wanted to find a way that TBAs could work with the local health teams to encourage healthy pregnancies and safe deliveries, while honouring the role of TBAs as trusted community resource.

"The community has accepted me as their own. If possible they come to the health post to deliver. If not, I go to their home and ensure that the baby is delivered in a clean environment and with the assistance of a skilled attendant."

Abeba Hagazi Abera
Nurse at the Lekura health post of Aura Woreda.

Over the course of the project, the MoH, in collaboration with MI and partners, supported the empowerment of TBAs to Birth Companions by:

- Conducting a needs assessment survey of the TBAs.
- Developing a training manual for Birth Companions.
- Implementing a training program.
- Overseeing the performance of the TBAs in their new roles.

The response was excellent. Since 2014, 90% of active TBAs have reported they were "very willing" to become skilled Birth Companions and 345 TBAs in the project site successfully transitioned into their new role.

Birth Companions now enjoy improved relationships with health facility staff as a result of orienting facility staff on the new responsibilities of Birth Companions. Facility staff have grown to respect the role of Birth Companions, seeing them as invaluable, and Birth Companions appreciate the knowledge and service provided by the facility staff.

Since the beginning of the project, this mutual respect between Birth Companions and facility staff has created a stronger link between the community and facility health centres.

To date, 11,427 women have gone to health centres accompanied by a skilled Birth Companion, which has led to an increase in healthy and safe deliveries in the area. Since 2014, many health centres saw a significant increase in deliveries. For example, before the start of the project, health facility staff at one health centre were only delivering 20 babies per month; by the end of the project, staff at that facility were delivering an average of 60 healthy and safe births every month.

Birth Companions are satisfied with their new roles for a variety of reasons, especially now that their work is recognized and valued by health professionals at health centres. Birth Companions appreciate the compensation they receive for the costs of helping women get to hospitals and health centres, as well as the continued respect their role earns them within the community.

5. Kenya Demographic and Health Survey, 2011
6. Kenya Demographic and Health Survey, 2011

ETHIOPIA

Collaborative Quality Improvement (CQI) Teams

In Afar, the project revolved around maternal and newborn health services in pastoralist communities, which are communities constantly on the move seeking out new grazing lands for their livestock. Without a permanent home base, pregnant women in this community are dramatically underserved by the healthcare system. Pregnant women of Afar rely on Traditional Birth Attendants (TBAs) in their communities for antenatal, birth and postnatal care. The trusted TBAs move with communities and are much closer to pregnant women than nurses in a health centre.

The project strategy involved engaging TBAs and community members in planning, implementing and monitoring maternal and newborn health and nutrition using the Collaborative Quality Improvement (CQI) model. The CQI model gave communities the tools needed to review local maternal and newborn needs, identify and prioritize challenges in delivering or receiving care, and develop new ideas — called "change ideas" — to improve the uptake and quality of antenatal, birth and postnatal care services.

Sixty-five communities, or *kebeles*, developed CQI teams, which included community leaders, elders and religious leaders, as well as representatives from the general community.

Facility staff conducted monthly coaching visits to support the implementation of the change ideas, and identify and assess best practices. This link between the community members and the facility staff strengthened communication and provided a platform to discuss other issues as well.

Every three months, a workshop and review was held at the district, or *woreda*, level where the CQI teams shared their lessons learned and participated in a facilitator-led review of coverage data, evaluation of change ideas and planning of activities. The workshops offered further training on quality improvement methodology and allowed participants to share the results and data from their work and learn how other *kebeles* approached their maternal and newborn health challenges.

EXAMPLES OF CHANGE IDEAS

One CQI team organized a feeding ceremony where they celebrated mothers putting the newborn to the breast within the first hour. This idea originated from a traditional blessing ceremony, which can take place up to several hours after birth, where a respected elder comes to bless the child and provide its "first food".

The CQI model included the creation of Guide Teams (GT), which consisted of two TBAs. The GTs held meetings to provide education on health and nutrition to pregnant women and their families.

To date, the CQI model has yielded significant results. More than 90% of all pregnancies were identified and referred to health facilities for antenatal care because of the involvement of the CQI teams and TBAs. Antenatal care visits are crucial because they provide key nutritional information, vaccinations as well as health monitoring required for a healthy pregnancy.

TBAs continued to play an important and respected role within their communities through the demonstration project. With their help, the number of deliveries by a trained attendant increased by 33% and the number of women who received postnatal care within 48 hours of giving birth doubled.

By integrating community involvement into the healthcare process, the project in Afar broke down barriers and built understanding between the community and health facilities. Women better trusted medical professionals and gained an understanding of the benefits of giving birth in a health centre. TBAs worked with healthcare providers to support pregnant women and ensure they got the care they needed to have a healthy pregnancy and birth experience.

Through the continued involvement of the federal and regional ministries of health, the project has already expanded into two new *woredas* and plans are underway to expand even further.

SENEGAL

Outreach visits from health centres to community health huts

In Senegal, the health system is made up of various levels of care facilities, from community health huts to regional health centres and hospitals.

The health huts in Kolda serve approximately 2,000 community members and are run by volunteers who provide some basic health services and refer patients to health centres and hospitals when needed. In rural Kolda, the nearest regional health centre can sometimes be up to 40 km away and, without access to transportation, pregnant women are less likely to go there for care. Thus, the services health huts provide to communities are essential to improving maternal and child health outcomes; they serve as a vital link between communities and facilities.

The project involved the development of a package of interventions geared toward mobilizing community health huts to provide the best care possible for women and children.

One of the components of the package was to strengthen the link between health huts and health centers to overcome the barriers of transportation and distance. Before that link could be strengthened, health huts needed to be functional. The project supported the renovation of 90 health huts, as well as the selection of community-based staff in order to meet the basic criteria for maternal and newborn health service delivery. Furthermore, the project saw 244 health huts equipped with modern equipment and adequate provisions of medical supplies to prevent stockouts.

Once the health huts were fully functioning, the Ministry of Health (MoH) reinforced a program of outreach visits, where nurses and midwives from health centres paid monthly visits to the health huts.

"The midwife used to only receive 3 to 5 clients each month who attended the recommended four antenatal care visits. Now, she receives around 12 clients each month who have been to all their antenatal care visits. The outreach activities are very well received by the population and help solve their problem of distance and money."

Midwife
Kolda region

During these visits, the nurses and midwives conducted antenatal and postnatal care for women and newborns who otherwise may not have been able to access these services. Community birth attendants, known as *matrones*, and other community actors would share dates of monthly visits via local organizations and home visits so that pregnant women and new mothers would know when to go to health huts. Once pregnant women were at the health hut for a check-up, *matrones* shared information and education on maternal and newborn health issues, such as nutrition, breastfeeding and newborn care.

As well as reaching pregnant women with educational messages during these outreach activities, often grandmothers, mothers-in-law and men participated in the sessions where antenatal care, the consumption of iron and folic acid supplements, birth assistance and postnatal care were promoted. Altogether, these regular visits resulted in a total of 39,424 antenatal visits and 12,431 postnatal visits.

The project strengthened the relationship between facility-based staff and community actors and brought quality care to women and newborns who otherwise may not have been able to access it.

Matrones played a key role as educators and community liaisons, supporting the efforts of nurses and midwives. The newly renovated health huts ensured a reliable base for nurses and midwives to provide the care pregnant women and newborns needed to survive and thrive.

"Thankfully, today in the health huts, we have medicine and community health workers and *matrones*. Even sometimes, we have the midwife come to the village to offer medication and services to the pregnant women that we follow."

Community support group member (CVAC)
Talto Diega

IMPLICATIONS FOR SUSTAINABILITY

The best practices from this project are intended to be adapted for use throughout Africa and in other countries with similar contexts. The project design offers innovative methods tailored to support pregnant women in hard-to-reach areas of the world.

Throughout this five-year project, there were a variety of successes and challenges. Below is a summary of implications to consider when implementing any of the interventions discussed in order to strengthen the link between the community and the facility:

ENGAGE EARLY AND OFTEN

The formation of a project management group, which included national and regional leadership in each country, facilitated political goodwill and management support. Regular meetings kept the project on track and provided opportunities for feedback and idea creation.

INVOLVE THE COMMUNITY

The involvement of the community to identify and create solutions to maternal and newborn health and nutrition issues was key to enhancing understanding and driving demand for health services. It is important to note that the health facilities must be in place to supply the demand before strengthening the link between the community and facilities.

EMPOWER LOCAL HEALTHCARE WORKERS

The training and supervision of community-based health personnel was essential to the project because it allowed them to take responsibility for the health of pregnant women and newborns in their communities. Local healthcare workers drive the link between the community and the facility; empowering them as the gatekeepers to their communities can lead to better communication and better overall healthcare system.

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