# FORMATIVE RESEARCH SUMMARY

Saving lives of mothers and children through Community Birthing Centers


## ABSTRACT

Formative research to understand why women continue to deliver at home and delay care-seeking for obstetric emergencies, why stunting remains prevalent, and what are the needs of the three targeted health facilities in Ksii County, Kenya was conducted January 15 – 25, 2018. Group interviews with mother giving birth at home, mothers giving birth in health facilities, traditional birth assistants, community health workers, community health volunteers, and county and sub-county health officers and staff are synthesized and supplemented by key finding from a best-practice benchmarking interchange between the Ksii County Health Department project leadership and Lwala Community Alliance.

Overview

Curamericas Global Program Manager for Africa, Florence Amadi, MPH, orchestrated a two-week formative research agenda in Ksii County, Kenya between January 15 – 25, 2018. She was accompanied and assisted by Curamericas Global volunteer, Cynthia Redwine. The Kisii County Minister and Director of Health both reaffirmed their commitments of support in ensuring the success of this project, and desire for its eventual replication and expansion. The Chief Public Health Officer (CPHO), Melitus Kabar, generously lent his leadership, time, and expertise, ensuring the project team is adequately resourced, organized, and supported. In addition to attending various project functions throughout the Formative Research work cycle, Mr. Kabar was instrumental in hiring the project team, promoting the project, and negotiating the execution of the Memorandum of Understanding between Curamericas Global and the Kisii County Ministry of Health. Kisii County Ministry of Health Project Coordinator, Kevin Kayondo, and Anne __, Ksii County Ministry of Health Project Coordinator, proactively embraced their project leadership roles, co-facilitating presentations and interviews, and coordinating operations and logistics for the newly hired Field Officers.

Formative research to understand why women continue to deliver at home and delay care-seeking for obstetric emergencies, why stunting remains prevalent, and what are the needs of the three targeted health facilities in Ksii County, Kenya was conducted January 15 – 25, 2018. Group interviews syntheses are organized by: barriers to facility delivery, suggestions to increase facility delivery, care desired, traditional birth customs, and shared birth experiences. The series of group interviews were conducted with:

1) mother giving birth at home, mothers giving birth in health facilities, traditional birth assistants, community health workers, community health volunteers;

2) Kisii County Health Management Team (KISII CHMT): Chief Nurse, Nutritionist, Health Promotion Officer, Community Health Focal Person, County Rural Health Coordinator, and Chief Public Health Officer; and

3) Kitutu Chache South Sub-County Health Management Team (SCHMT), and Matongo Clinic Staff

Ms. Amadi and Mr. Kabar also forged a community partnership through Julius Mbeya, Managing Director of Lwala Community Alliance, a community of interdependent organizations operating a hospital and community health ecosystem empowering the community in Migori County. Summaries from the day-long interchange, which including presentations from each of the Lwala Programs, a tour of the hospital, and a community visit to observe a community health training and community health volunteer weekly review meeting are below. Misters Kabar and Mbeya committed to ongoing collaboration between the organizations to ensure best practices, common challenges, and potential synergies between the organizations are explored and shared.

# Group Interview Key Themes

## Barriers to Facility Delivery:

**Cost** was consistently indicated across groups, among participants, as a key barrier to facility delivery. In addition to the cost of the delivery itself, the cost of transportation is a critical barrier to mothers delivering in facilities. It was noted that mothers were motivated to seek maternal and child healthcare when clan elders communicated that the care would be free.

**Fear** was noted among the mothers as a reason they had chosen not to pursue facility delivery and noted by health professional and volunteers as a reason frequently cited by mothers that they might choose not to purpose facility delivery. This fear included the frequently cited fear of bodily harm ("being beaten" by the facility staff), generalized fear of examinations in facilities, as well as the fear of scolding or shaming by facilities staff and nurses of mothers who had not pursued prenatal care in the facilities prior to their delivery.

**Culture**: this multi-faceted barrier was comprised of the following themes

- **Gender Role**: Lack of support from husbands; while wives might initiate discussions, husbands are decision-makers with regard to locale for deliveries. Some wives also must consult with mothers-in-law
- **TBA-preference**: Familiarity, experience, and connection with Traditional Birth Attendants (TBAs, or Unama Salamas), as opposed to lack of family experience with facility delivery. They also appreciated the one-on-one attention of TBAs, compared to the short-staffed health facilities
- **"Just bear it:"** Belief that a woman who delivers at home is a "real woman," who can endure the pain and deliver without assistance
- **Child's Gender**: Some fear the "shame of delivering same sex children, especially female." Some mothers are left at facilities if they deliver a female baby and the husband wanted a male

**Access**: this common barrier theme included:

- **Planning**: Among both first-time and "experienced" mothers, there was a lack of knowledge or skill to effectively identify and estimate the progression of labor toward delivery
- **Travel time**: Given the amount of time it can take to travel to a facility (compounded by weather during rainy seasons, road conditions, and the time of day/night during which they have to travel), the mothers reported that they were unable to travel to the facilities before their water had broken and their babies were crowning
- **Transportation**: while mothers did not speak to the availability of transportation means, if they did not/could not effectively plan, the cost thereof might be greater in an urgent situation, and their options could be limited. Health workers did mention lack of ambulances multiple times. They also mentioned a poor road network, which made transportation a challenge.

- **Strikes**: industrial strikes were mentioned twice as a reason mothers might not deliver at a healthcare facility
- **Hours**: some facilities do not offer 24/7 services

## Suggestions to Increase Facility Deliveries

- **Health education** was the most frequently cited suggestion. While public health education is ongoing, many suggested that simple communication of the benefits of prenatal care, nutrition, facility delivery, and antenatal care by *trusted community health volunteers* CHVs (versus MOU staff) would increase the effectiveness of the trainings
    - **Barazas (Community Forums):** dialogue days," and barazas; public health education during recurring community events utilizing creative forms of communication (theatre, poems, songs, drama, etc. ) were suggested as effective means of community education
- **Care Groups**: community members are more likely to listen to clan elder or community leaders than health workers. Increased meetings, increased sharing of information, and increased co-celebration of successes were suggested to increase engagement
- **Increasing support and resources for CHWs and TBAs:** who in turn encourage mothers to deliver in health facilities, health education, data, etc. Increased communication and working together between clinics and CHWs
- **More staff at health facilities**: a common theme. It was also mentioned that they lacked morale or respect, so training/support to be more motivated and respectful
- **Open dialogue**: community-based public health conversations on an ongoing basis that actively seek to honor mothers' voices was suggested across groups as an opportunity to improve prenatal care and increase facility deliveries
- **Incentives:** basin, diapers, baby shawls, etc. were suggested to increase facility deliveries
- **Sensitization**: the second-most cited theme (also appearing many times in its "negative" form as a barrier), was the suggestion of increased training of healthcare workers and communities regarding respectful, culturally appropriate care to delivering women.
    - Supportive supervision including training of staff on best practices with regard to patient rights was suggested to supplement health workers' sensitization trainings
- **M&E**: monitoring, gathering, analyzing, and sharing quality data regularly was suggested

## Care desired

- **Respectful and culturally appropriate care** was cited many times by every group. This was loosely defined by the groups to include privacy, respect, dignity, being listened to, being responded to in a prompt and friendly manner, not being rushed, and being informed of estimated anticipated timings of deliveries

- KISII CHMT and KITUTU CHACHE SCHMT described recognizing and allowing mothers to have a say in delivery decisions (e.g, position), and using appropriate language among their definitions of respectful and culturally appropriate care

- **Safe care**: being free of the fear of beatings was also frequently cited
- **Professionalism**: handling of complications and emergencies: reduced maternal and infant mortalities, knowledge of warning signs of complication and skill to effectively manage, and following prescribed standards were all listed as desired professional care for facility deliveries
  - Effective cord clamping that does not result in infection was cited as a reason that some mothers had chosen a facility delivery over a TBA-assisted home birth
- **Cleanliness and hygiene** (of facilities and health workers) was mentioned, both with regard to expectations of facility deliveries, and as a reason that some mothers had chosen a facility delivery over a TBA-assisted home birth

## Traditional Childbirth Customs

- Amasangi: if children born in a family are dying, a child that is born is to be placed along a village path for passersby to wish the child well, and give leaves, incentives or money to the child to help ensure his or her survival
- Ebibiriri: when an “evil person” looks at a small child, it is believed that an inedible “staff” is thrown into the child’s stomach, leading to illness or death if not treated by a traditional herbalist
- Some tribes prefer to carry placentas home after birth for use in traditional customs/ceremonies

## Notes from Shared Childbirth Experiences

### At Home Births

- Failure to recognize or estimate the timing of the progression of labor was a common theme
- Deferring the decision whether to give birth in a facility or at home to a husband or mother in law was also a common theme
- Quick deliveries were a common theme
- Seeking facility-based antenatal/post-partum care after home-delivery was a common theme

### In Facility Births

- Indication of breach delivery was a surprisingly common theme
- Prenatal care indicating potentially high-risk pregnancies and/or deliveries was cited multiple times by mothers who chose to deliver in facilities
- All mothers interviewed ultimately had safe deliveries, although dissatisfaction was cited among some for issues including painful vaginal delivery (versus C-section), and postpartum cramping (purportedly from “improper uterus cleaning”)

## Nutrition

**Lack of knowledge and poverty** and the leading contributors to malnutrition in Ksii County. CHWs mentioned other challenges to addressing malnutrition, including parent behavior such as: alcoholism, separation of parents and laziness

- Nutrition education, EBF, kitchen gardening, proper handwashing, and growth monitoring are offered erratically. Successes: They have been able to reduce malnutrition, implement kitchen gardening, reach out to people through health education, and get people vaccinated. CHWs also described efforts to encourage mothers to give their kids a balanced diet and vaccinate them, give them malnutrition supplements. (unclear of how often/methods)
- CHEWs and CHWs provide health education, but they lack the support to do their work as indicated in the MOH community health strategy. They also refer malnutrition cases to health facility, discourage alcoholism, "utilize health resources available at community level"
- Level 1 services are not functional due to lack of resources, and lack community organizing and lack of empowerment
- Capacity building is crucial as lack of knowledge is leading problem in malnutrition in the county
    - While Kisii has an abundance of food due to the conducive weather and soil, mothers often sell produce, like eggs, and purchase children less nutritional options
    - Mothers lack knowledge of a balanced diet

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| | KISII CHMT | KISII KITUTU CACHE SCHMT AND MATONGO STAFF |
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| Successes | • Increased resources: nutritionists, paramedics, ambulatory care, labs MRI and CT, free maternity services<br>• Minimal stock outs due to quarterly protocols entailing requests for actual needs | • Improved County procurement supplementing national supply, including locally procured non-pharm commodities can be (e.g., gloves)<br>• Budget has gone down, and they enjoy some autonomy with budgeting and spending, and 100% of money collected on sub-county level comes back<br>• Staffing has increased to about 40% of recommended capacity (more health workers at facilities, although still insufficient)<br>• Training on Health Management Information System provided, although no tools<br>• New facilities – including surgical theatres (but no staff) |
| Overall Challenges | • Lack of awareness of plan<br>• Transition away from top-down management<br>• Lack of education regarding M&E indicators developed by county.<br>• Financing (given devolution), and need for political support (Hospital Leadership, County Leadership, Cabinet; plan to advocate via education).<br>• Lack of research or funding for research – with specific focus on semi-arid regions. | |

| | KISII CHMT | KISII KITUTU CACHE SCHMT AND MATONGO STAFF |
|---|---|---|
| Level 3-4 Maternal-Newborn and ER Obstetric Facilities Challenges | • Improving/updating staff's skills<br>• Too many registers<br>• Lack of equipment<br>• Dissemination of new protocols/policies and guidelines (e.g. Linda Mama program has expanded, offering free maternity care thru direct reimbursement to a health insurance plan administered by NHIF)<br>• Abortion is not a covered health service<br>• Lack of community involvement; not enough community units, not involved in identifying issues<br>• Influx of facilities being upgraded (level-wise) but standards are less and investments are often politically motivation.<br>• Poor referral system<br>• Focus on curative versus preventative health (e.g., vitamin A deficiency, and deworming, versus vector control)<br>• Still struggling with deworming, Vit A, and stunting due to MTCT. Pre-term and underweight infant deliveries mostly in teen pregnancies due to intrauterine stunting<br>• Loss of herd immunity | • Inadequate staffing<br>• Lack of equipment; - some facilities cannot even infuse blood but are called Level 4<br>• No ambulances<br>• Financing is erratic and inconsistent; lack of communication on what funds belong to which budget<br>• Hands-on training is challenging and most training is from County- versus national). This challenge is attributed to a leadership and governance shortfall |
| Role of CHVs in addressing maternal/neonatal care and child nutrition | • Identification, health education, and referrals, and follow up not done effectively due to lack of support e.g. stipends.<br>• Lack of training | • CHEWs and CHWs are supposed to be working with communities (Level 1) but cannot perform their duties because they are not adequately supported<br>• Help needed:<br>○ Involving the community<br>○ Supporting the CHWs and TBAs with stipends |

## Lwala Community Alliance

Lwala is a health-focused interdependent alliance of organizations that employs more than 180 staff from the Ksii and Migori region and follows a human-centered design and participatory approach to address health challenges, which are complicated by financial instability and educational barriers. Two supervisors, ,23 Community Health Workers, and 58 "Unama Salamas" (traditional birth attendants) visit 2,300 "priority" households with pregnant women, children between the ages of two to five, and those living with HIV/AIDS. The Lwala model includes clinical care, economic development, public health outreach, and education. Their health facility is an integrated part of the county's health system, delivering services and collecting data in partnership with local government. Economic programs are built off market-based models, and, after initial investment, are run independently. Education programs are delivered by 17 government-owned and -operated schools.

Lwala 2020 Strategy Goals include:

1) Deliver holistic program that create impactful change in people's lives
2) Measure definitive improvements in lives of beneficiaries to ensure quality and impact
3) Unify Kenyan and US efforts and mature leadership and governance capacity of the organization as a whole
4) Build a durable organization with diverse funding
5) Demonstrate that quality community development can be achieved in a rural setting and share practical insights for advancement of global development

Following an introduction by Director Mbeya, professional and informative presentations were made by leaders from the Sexual Reproductive Health (SRH), Community Education, Nutrition, and HIV+WASH programs, as well as their M&E manager. After a tour of the campus and hospital, the Kisii County and Curamericas Global team visited a community at which Lwala staff and volunteers conducted a health education program and monthly review session between the supervisor and CHWs. Highlights include:

- Director Mbeya cited collaboration between Lwala, other community organizations, and the County, bolstered by support from the Ministry catchment, as critical to the success of their model and programs
- Each CHW is responsible for delivering home-based care related to every program and responsible for ~50 households, each
  - Of the households of each CHW, ~0-4 include a pregnant woman at any given time
  - Each CHW is equipped with a tablet (see M&E below for details), malaria treatment, measuring tape, and scales

    - CHWs/Unama Salamas work independently, managing their priorities on a daily basis (balancing household and community activities alongside volunteer responsibilities) and seasonally (balancing planting and harvest priorities with volunteer responsibilities)
    - CHWs and Unama Salamas are experienced and trained to identify pregnancies in the first trimester, and seek for mothers to access four or more ANCs, facility deliveries, vaccinations for children through year 5, nutrition and kitchen-gardens, and family planning
        - Mothers who complete the target number of ANCS receive socks, a baby bonnet, a onesie, and a swaddle
        - Mothers who deliver in facilities receive a baby carrier
    - Unama Salamas are trained to do community education, and refer women to facilities for deliveries
        - Unama Salamas receive a small stipend of 3,000 – 7,000 KSh to compensate from the lost income they previously earned from at-home births
            - The stipend amount is determined by identified skill levels including health education, community organizing, communication, and data collection aptitude
            - To ameliorate potential dependence on the stipends, they are not paid – at random – one month out of each year
    - CHWs engage trusted female village elders and provide them with information to share in communities
    - CHWs meet with supervisors weekly to review data and work plans
- SRH focuses on family planning, provision of supplies and equipment, a youth-friendly clinic, and outreach events
- Community education is a prevention-focused community-needs centered initiative that sees a constantly increasing number of participants alongside decreases in inpatient care
- Nutrition, born as an outgrowth of the economic development program, seeks to reduce malnutrition in children less than five years of age and people living with HIV AIDS via education, malnutrition symptom identification, prioritized referrals to supplement home-health education, and “agro-nutrition” programs seeking to maximize nutritional value of available food
- HIV+WASH seeks to decrease stigma and regression of those living with HIV/AIDS while also promoting water sanitation and hygiene via CHW community education and support groups
- Data-driven M&E focuses on integration and transparency to ensure community ownership of information and progress
    - CHWs utilize Posh Mobile Andriod tablets to gather and track data including MOH-approved indicators, registrations of mothers and children, electronic medical records for those living with HIV/AIDS, and surveys for program evaluations and household data
        - It was noted that Posh Mobile does not have warranty facilities in Kenya
    - Data is managed via the open-source mobile data collection platform “Commcare”
    - Data is synced in person, and pushed to the Salesforce database (they call this Simba) for regular assessment by the M&E team