

maternal survival:

Improving Access to Skilled Care

A BEHAVIOR CHANGE APPROACH

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This summary is based on the CHANGE Maternal Survival Toolkit. The Toolkit is available online at: www.changeproject.org and on the cd-rom included with this summary.

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Acknowledgements

Many individuals contributed to the design, implementation and adaptation of the Maternal Survival Toolkit: Mona Moore, Senior Maternal Health Advisor, CHANGE/The Manoff Group, led all phases of the toolkit development; other key collaborators were Deborah Armbruster, Michael Favin, Judith Graeff, Marcia Griffiths, Mary Manandhar, Cindy Rider, Anton Schneider, Lisa Sherburne and Susan Zimicki. A number of organizations were key partners: Family Care International (Kenya and New York); Save the Children (Guinea and Connecticut); the Safe Motherhood Demonstration Program, Ministry of Health, Kenya; and the Population Council (Kenya and New York).

Special thanks to Mary Ellen Stanton, Elizabeth Fox and Holly Fluty-Dempsey, USAID.

A complete list of individuals and organizations who helped with the development of the Maternal Survival Toolkit is included on the website (www.changeproject.org) and on the cd-rom.

The CHANGE project is a cooperative agreement (HRN-A-00-98-00044-00) between the Academy for Educational Development (AED); its subcontractor the Manoff Group and the US Agency for International Development. The opinions expressed herein are those of the authors and do not necessarily reflect those of USAID.

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Photos courtesy of Photoshare: *Page 3: (l-r) CCP, Edson Whitney/CCP, CCP; Page 4: Edson Whitney/CCP; Page 8: Asem Ansari/ICDDRDB; Page 10: Harvey Nelson; Page 15: Melissa May Page 20: Answell Chipukuma/CCP*

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More than 515,000 women die each year from complications related to pregnancy or childbirth, nearly all of them in the developing world. More than 75 percent of these deaths occur during or immediately after delivery. For every woman who dies, 30 to 50 more women suffer childbirth-related injury, infection or disease. Research shows that beyond the emotional loss caused by mothers' deaths, the health of the surviving children is put in jeopardy and that both families and communities suffer significant economic and social costs. According to the Safe Motherhood Initiative, most of these serious problems could be prevented if women had access to appropriate health care—a health worker with midwifery skills and equipment—during pregnancy, childbirth and immediately afterward in the early postpartum period.

According to the World Health Organization (WHO), the cost of providing basic maternal and newborn health services in developing countries averages about US\$3 per person. An adequate number of trained health workers, especially in rural areas; sufficient equipment and supplies; and reliable transportation to a hospital or other health facility in the event of an emergency are all important to ensure women's access to skilled care.

Equally important is a woman's use of skilled care including behaviors by the woman and other household members, by community members and by traditional birth attendants and skilled providers in the health sector. In other words, not only is the supply of reliable, technically competent and accessible maternal care necessary, but the demand by women and

the community for these services also must be in place.

The CHANGE Project, funded by the US Agency for International Development, developed a framework and tools to identify behaviors related to women's use of skilled care and to develop programs to increase this use during delivery and the postpartum period. Research in Kenya, Guinea and Bangladesh to test and adapt tools found that women, families, communities and providers are willing to try new practices and change behaviors that result in increased use of skilled care. However, for them to do so, maternal survival programs must work with them to tailor activities to local contexts and use an integrated approach that promotes a change in behavior at the household, community and health facility.

The Role of Behavior Change

If people know that skilled care during pregnancy and childbirth increases the chances of a mother's survival, why don't more women seek this care before, during and after childbirth? Skilled providers assist in just over half (53 percent) of the births in Asia and about 42 percent of those in Africa. Clearly, the availability and cost of care play a crucial role particularly in poor or rural areas. But even with these factors in place and knowing that skilled care can help, many women continue to give birth at home with the assistance of a traditional birth attendant (TBA) or family member.

Making the leap from knowledge to practice is complex. As the CHANGE Project has learned in its work with maternal survival and in other health areas, many contextual factors including the behaviors of other family members, the community and health providers influence individual behavior. Behavior change involves consultations with these different groups to negotiate behaviors that achieve a desired goal (in this case, use of skilled care) and address barriers to these improved behaviors while respecting local realities.

To understand the reasons why women seek or do not seek skilled care and to suggest strategies to increase use of skilled care, the CHANGE Framework for Improving Maternal Survival aims to improve behaviors related to:

Seeking skilled care

WITHIN HOUSEHOLDS: The mother and others in her household choose to use the services of a health worker skilled in midwifery, in a timely manner, for delivery and during the early postpartum period.

The TBA's role is expanded and repositioned so she can serve as a link to skilled care if complications endanger the mother or infant, during delivery and the critical two weeks after birth.

Preparing for birth

WITHIN HOUSEHOLDS AND COMMUNITIES: The woman and her family have anticipated and made decisions about an upcoming birth, particularly should complications set in and the community supports these decisions.

Promoting more "caring" behavior

BY SKILLED CARE PROVIDERS: Skilled care providers provide more caring services valued by patients thus encouraging women to seek their services.

The work that CHANGE did to understand and develop programs focusing on the determinants of use of skilled care is discussed in this summary. It should be emphasized, however, how interrelated the behaviors are. For example, if a woman makes the considerable effort to travel to a health facility and has a bad experience, the likelihood diminishes that she, or other women in her community, will use these services again. Similarly, a woman's plans to prepare for birth and possible complications can contribute to increased maternal survival but she must be supported by her family and community to act on the decisions she has made. The CHANGE Project's approach and tools stress locally appropriate, behavior-based interventions that integrate what is happening in homes, communities and health facilities.

Seeking Skilled Care For Childbirth

Learning from Women

Maternal health experts identify increasing women’s use of skilled care during and after childbirth as a critical strategy to reduce maternal deaths. A skilled provider with equipment can recognize childbirth-related complications and either treat them or refer the mother to a hospital or other higher-level care facility.

For many women, using skilled care means a change in practice from delivering a baby at home with the assistance of a TBA or family member to delivering a baby in a health facility under the care of a midwife, doctor or other skilled provider. For numerous reasons, many women do not seek skilled care even when they understand the safety reasons to do so.

For example, a survey in Kenya found that nearly 70 percent of the women surveyed delivered at home with a TBA, relative or alone. Despite knowledge of the risk, fewer than 30 percent of the women delivered at a health facility. In partnership with Family Care International’s Skilled Care Initiative, the CHANGE Project focused on understanding why more women do not seek skilled care and what interventions might increase timely careseeking.

Findings on Seeking Skilled Care For Childbirth

Through community-based qualitative research in Kenya, CHANGE found:

- Women and men were aware of the danger signs that should signal the need to seek skilled care. Lack of knowledge is not the primary impediment to seeking skilled care.
- When a complication signaled the need for skilled care, women sought care from many different sources which often cost them precious time. Cultural “mismatches” between local understanding of causes and solutions and Western medicine were often responsible. For example, some people believed that a childbirth complication could only be treated by prayer groups.
- One of the most common reasons that women said they did not seek skilled care was they did not have a reliable due date.

Many stated that a reliable due date would help them prepare for the use of skilled care.

- Women and their families said that skilled providers' behavior influences their decision to rely on TBAs: they find TBAs are more comforting and supportive. Even skilled providers acknowledged that their behavior toward clients is a significant barrier to the use of their services.
- If TBAs are recognized and remunerated, they are willing to serve as a link to skilled care when complications arise. Women have confidence in them playing this role.
- When they did go to a skilled care facility, women often faced long delays in receiving care, even in emergency situations.

The research project used community-based interviewers to conduct focus group discussions and in-depth interviews and to gather complication narratives that documented what happened in the cases of obstetric emergencies. These narratives proved to be the most efficient method to gather information to design evidence-based, locally appropriate behavior change interventions. They involved talking with all the people who had participated in making decisions for a woman who had experienced life-threatening obstetric complications within the past six months, including the women themselves, other family members, community and religious leaders, TBAs and skilled providers. In many emergency cases, the narratives revealed



that women spent a considerable amount of time going to traditional healers and following other cultural and religious practices before seeking medical treatment.

Program Implications

These research findings confirm that increased knowledge and awareness by women and their families will not necessarily lead to use of services. However, the research helped the CHANGE project to develop promising practices and activities that can help overcome the specific local barriers to skilled care particularly related to birth preparedness. These activities include:

- Using complication narratives to understand current practices, especially detours and delays that women take on their way to skilled care and to learn specific barriers to address.
- Applying behavior-based, community-centered formative research to explore

A New Role for TBAs: “Linkworkers” to Skilled Care



Women seek the assistance of traditional birth attendants (TBAs) for a variety of reasons, including geographic proximity, local custom and the perception that TBAs provide more personal care than health facilities. However, global evidence shows that TBAs should not be solely responsible for attending deliveries or checking women in the early postpartum period. Even with training, they do not have the necessary skills or equipment to deal with the approximately 15 percent of cases in which a life-threatening complication occurs.

Instead, TBAs should be re-positioned to link women to skilled care at critical times. As respected and trusted members of communities, TBAs have the unique ability to encourage and support women and families to use skilled care.

Before birth and at childbirth, this means explaining the need for skilled care and accompanying women to skilled care for childbirth or for an emergency at a home delivery.

In the early postpartum period, programs need to create locally appropriate postpartum care options, which may include TBAs or other community members as a link to skilled care. These options include an early postpartum visitor who makes three visits to the mother and newborn in the first week after birth, when the vast majority of emergencies occur. This option is particularly relevant in cultures that sequester mothers and newborns after birth. Another option could be

early postpartum care stations in communities staffed by TBAs or others who could recognize danger signs and organize referrals to facilities. A third option could be facility-based care that checks new mothers as well as newborns during the first week after birth.

The CHANGE Project explored women's, families', TBAs', skilled providers' and community leaders' willingness to re-position TBAs to serve as links to skilled care for delivery, rather than as primary care providers. The concept was generally well received. In Kenya, redefinition of the role of TBAs to serve as links to skilled care providers during childbirth was acceptable under certain conditions. For example, one condition identified by respondents in Homa Bay was ensuring that the TBAs are compensated for this new role. In Guinea, where the mother and newborn typically remain at home after childbirth, the CHANGE Project learned that communities, skilled providers and community and village leaders accepted the concept of an early postpartum visitor and that TBAs were thought of as appropriate to provide this service and serve as a link to skilled care where needed.

Behavior-based research or consultations with women, families, communities and providers can identify people's perceptions of different types of care and motivations to use TBAs as linkworkers. Negotiations with each type of participant will help to define the conditions that would make this new role acceptable to all.

“When they did go to a skilled care facility, women often faced long delays in receiving care, even in emergency situations.”

people’s perceptions, beliefs, current practices and willingness to try new practices. Negotiation, in which program planners learn from the targeted group what would make new practices acceptable to them, can be included in this research.

- Identifying key pieces of information such as due date that are needed for appropriate careseeking.
- Recognizing that certain people in each community are key in setting norms and spreading information. Working with these people, who might be religious leaders, women’s group members or others, can provide a focus for community behavior change interventions and spread ideas quickly.
- Assisting health providers to make their services more suitable for women.



(The section on Birth Preparedness discusses the applications of these findings).

In addition to seeking skilled care during childbirth, maternal health experts stress the need for women’s access to skilled care during the early postpartum period. This was the subject of CHANGE research in Guinea.

Seeking Skilled Care During the Early Postpartum Period

Extended Roles for TBAs and the Community

Skilled care for mothers is critical in the days after they give birth. Up to 45 percent of all maternal deaths occur within one day of delivery, 65 percent within the first week and 80 percent within the first two weeks after birth. This period is also critical to newborn survival—50 to 70 percent of life-threatening newborn illnesses occur within the first week of life.

Because of this, WHO recommends four visits with new mothers during the early postpartum period: at 1, 3, 7 and 14 days after giving birth. The main objective of these visits is early detection of complications and prompt referral if needed. These visits could take place in the home, at community-based care stations or in health facilities.

Awareness is low about this critical period and the need to seek early postpartum care during it. Moreover, in some areas, cultural traditions shield the woman and her new child within their home and can complicate their traveling to a health facility or receiving visits from “outsiders.”

The CHANGE Project:

- identified the factors that contribute to patterns of early postpartum care-seeking behavior;

- tested the acceptability among families, community members, and skilled providers of introducing TBAs and other trained home visitors as “linkworkers” to skilled early postpartum care; and
- actively involved community members in designing a locally appropriate early postpartum care intervention.

Findings on Seeking Skilled Care During the Early Postpartum Period

In partnership with Save the Children/Guinea’s Community Health Initiative and Guinea’s Ministry of Health, CHANGE found:

- Although many respondents knew basic obstetric danger signs, awareness of the specific risks to mothers and newborns during the early postpartum period were not well understood.
- Most women expressed a willingness to learn more about early postpartum care and

suggested ways that this learning could conveniently take place.

- Few women sought skilled care during the early postpartum period although they expressed a high degree of willingness to do so.
- Increased communication between husband and wife related to birth preparedness.
- Communities, skilled providers and community and village leaders accepted the concept of new mothers receiving a home visit during the early postpartum period. Through negotiation, they helped define the qualifications of the home visitor and how to implement this concept.
- A strong cultural tradition determines what is done during the postpartum period. For example, in one part of Guinea, during the first week of the infant's life, the mother and child are protected within the home. However, incorporating an early postpartum visit with culturally sanctioned isolation of the mother and newborn during the first week of life is possible when defined as a way to protect them.
- Although many of the findings were similar in urban and rural locations, there were also differences that would have to be incorporated into any program activity. For example, urban women often talk to friends and TBAs about their pregnancies, while rural women rarely do.

Program Implications

People's willingness to learn more about the needs of the mother and child during the early postpartum period could support increased use of skilled care during this critical time. Programs can consider the following:

- Training TBAs to provide routine care and recognize and know what to do when they see danger signs can be an acceptable way to provide early postpartum care. In this way, the TBA serves as a link between the mother and skilled provider extending her usual "delivery only" role.
- Promoting in-home visits by the TBA or community woman as harmonious with existing tradition if local customs prevent outsiders from visiting the home during this time. Training family members to recognize the danger signs or facilitating a visit by the mother to a community-based station are also options.
- Encouraging communication between husbands and wives during pregnancy, particularly related to preparing for child-birth and the use of early postpartum care.

Preparing for birth through the use of birth preparedness cards can reinforce the need for skilled care at delivery and also for early postpartum care for infants and mothers. The CHANGE Project looked at how to make birth preparedness more effective through research in western Kenya.

Preparing for Birth

Improving the Birth Preparedness Card

Activities to improve birth preparedness and complication readiness at the household and community levels are a standard component of maternal survival programs. One aspect of these programs is a birth preparedness card which provides childbirth-related information and helps women make careseeking and other decisions before they go into labor.

These cards usually include information on danger signs of obstetric complications and emergencies and a list of needed supplies. They also list decisions that should be made before birth, such as choosing a preferred birth location and provider, making advance arrangements for transportation to a health facility and, in the case of an emergency, identifying who would accompany the mother to the facility.

Research in the Homa Bay area of Kenya showed that women and families prepare for the arrival of a new baby by setting aside some money but many do little else to prepare for the upcoming birth. CHANGE advisors recommended a more comprehensive birth preparedness plan that includes HIV testing and postpartum care. The expanded birth preparedness card was the subject of related CHANGE research that took place in Kenya's Western Province.

The CHANGE Project partnered with the Safe Motherhood Demonstration Project of Kenya's Ministry of Health, The Population Council and the United Kingdom's Department for International Development to develop a Birth Preparedness Plus package. The project adapted and tested a birth preparedness card designed to increase interaction among households, communities and skilled providers.

Additional information includes recognizing newborn danger signs; choosing a source of routine and skilled early postpartum care for both mother and newborn and making these arrangements in advance; encouraging HIV testing for the woman and her partner as early as possible in the pregnancy; and arranging for medical and social support if the HIV test is positive.

One model birth preparedness card (see figure 1) was formatted into three sections: for the women and their families, for women’s or other community groups and for health workers. The card could be introduced to community groups with the idea that these groups could use them as entry points with families to discuss local birth preparedness resources, social support and families’ plans. The groups could also use the cards during periodic visits to health facilities to report upcoming births and potential obstetric problems. Thus, the cards could strengthen links between households, communities and health facilities.

Findings on Birth Preparedness

Through a baseline survey, focus groups and a pilot intervention to test the new cards, CHANGE found:

- The cards were well received. The district health team and community group members suggested ways to adapt the cards for their use. For example, in the section of the card about advance planning for transport in obstetric emergencies, an entry to “identify and contact nearest neighbor with a cellular telephone” was added.

<p>PREGNANT WOMEN & THEIR FAMILIES SHOULD PREPARE BEFORE THE BIRTH</p> <p>DISCUSS THE BIRTH AND DECIDE ON THE FOLLOWING:</p> <p>I WANT TO DELIVER AT: _____</p> <p>I WANT TO BE DELIVERED BY: _____</p> <p>I WANT A CHECK-UP ONE WEEK AFTER BIRTH BY: _____</p> <p>SAVINGS FOR BIRTH COSTS</p> <p>COST OF DELIVERY: _____</p> <p>COST OF TRANSPORT: _____</p> <p>ITEMS FOR BIRTH</p> <table border="0"> <tr> <td>FACILITY BIRTH:</td> <td>HOME BIRTH:</td> </tr> <tr> <td><input type="checkbox"/> COTTON WOOL</td> <td><input type="checkbox"/> CLEAN RAZOR BLADE</td> </tr> <tr> <td><input type="checkbox"/> GLOVES</td> <td><input type="checkbox"/> PLASTIC SHEET</td> </tr> <tr> <td></td> <td><input type="checkbox"/> CLEAN CORD TIE</td> </tr> <tr> <td></td> <td><input type="checkbox"/> COTTON WOOL</td> </tr> </table> <p>MEANS OF TRANSPORT: _____</p> <p>THE PERSON WHO WILL ESCORT ME TO SKILLED CARE IS: _____</p> <p>FOR AN EMERGENCY DURING CHILDBIRTH, I WILL GO TO: _____</p> <p>NEAREST EMERGENCY CONTACTS: _____</p> <p>COMPATIBLE BLOOD DONORS WHO WILL HELP IF NEEDED: _____</p>	FACILITY BIRTH:	HOME BIRTH:	<input type="checkbox"/> COTTON WOOL	<input type="checkbox"/> CLEAN RAZOR BLADE	<input type="checkbox"/> GLOVES	<input type="checkbox"/> PLASTIC SHEET		<input type="checkbox"/> CLEAN CORD TIE		<input type="checkbox"/> COTTON WOOL	<p>BIRTH PREPAREDNESS RECORDKEEPING FORM FOR COMMUNITY/ WOMEN'S GROUP MEMBERS</p> <p style="text-align: right;">EDD: _____</p> <p>NAME OF WOMAN WHO RECEIVED BP CARD: _____</p> <p>ADDRESS/ LOCATION: _____</p> <p>NAME OF WOMEN'S GROUP MEMBER/ COMMUNITY CONTACT: _____</p> <p>ADDRESS/ LOCATION: _____</p> <p>VISIT DURING PREGNANCY</p> <p>DATE CARD DISTRIBUTED: _____</p> <p>HOW/ WHERE CARD DISTRIBUTED: _____</p> <p>BASIC INFORMATION ON CARD COMPLETE? _____</p> <p>WOMAN COUNSELED & TESTED FOR HIV? _____</p> <p>PARTNER COUNSELED & TESTED FOR HIV? _____</p> <p>DISCUSSED BIRTH PREPAREDNESS? _____</p> <p>DISCUSSED DANGER SIGNS? _____</p> <p>PLANNED BIRTH ATTENDANT: _____</p> <p>PLANNED BIRTH LOCATION: _____</p> <p>WOMAN & FAMILY KNOW WHAT TO DO IN CASE OF EMERGENCY? _____</p> <p>PLANNED ONE WEEK POST-PARTUM CHECKUP? _____</p> <p>WHO? _____</p> <p>WOMAN/ FAMILY NEED SUPPORT FOR BIRTH? (YES/ NO) _____</p> <p>IF YES, WHAT TYPE OF SUPPORT? _____</p> <p>HOW WILL FAMILY GET SUPPORT REQUIRED? _____</p> <p style="text-align: right;">(PTO)</p>	<p>BIRTH PREPAREDNESS RECORDKEEPING FORM FOR HEALTH WORKERS/ FACILITY</p> <p style="text-align: right;">EDD: _____</p> <p>NAME OF WOMAN WHO RECEIVED BP CARD: _____</p> <p>ADDRESS/ LOCATION: _____</p> <p>NAME OF WOMEN'S GROUP MEMBER/ COMMUNITY CONTACT: _____</p> <p>ADDRESS/ LOCATION: _____</p> <p>VISIT DURING PREGNANCY</p> <p>DATE CARD DISTRIBUTED: _____</p> <p>HOW/ WHERE CARD DISTRIBUTED: _____</p> <p>BASIC INFORMATION ON CARD COMPLETE? _____</p> <p>WOMAN COUNSELED & TESTED FOR HIV? _____</p> <p>PARTNER COUNSELED & TESTED FOR HIV? _____</p> <p>DISCUSSED BIRTH PREPAREDNESS? _____</p> <p>DISCUSSED DANGER SIGNS? _____</p> <p>PLANNED BIRTH ATTENDANT: _____</p> <p>PLANNED BIRTH LOCATION: _____</p> <p>WOMAN & FAMILY KNOW WHAT TO DO IN CASE OF EMERGENCY? _____</p> <p>PLANNED ONE WEEK POST-PARTUM CHECKUP? _____</p> <p>WHO? _____</p> <p>WOMAN/ FAMILY NEED SUPPORT FOR BIRTH? (YES/ NO) _____</p> <p>IF YES, WHAT TYPE OF SUPPORT? _____</p> <p>HOW WILL FAMILY GET SUPPORT REQUIRED? _____</p> <p style="text-align: right;">(PTO)</p>
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	<input type="checkbox"/> CLEAN CORD TIE											
	<input type="checkbox"/> COTTON WOOL											

Figure 1: Birth Preparedness Card



“Anchoring birth preparedness cards with community groups enables these groups to serve as a link between families, communities and skilled providers.”

- In an initial evaluation, birth preparedness cards appeared to stimulate demand for facility-based care. According to the evaluation, facility-based deliveries significantly increased in areas where the birth preparedness cards were distributed.
- In Kenya, one of the most common reasons cited that women did not seek skilled care in time was because they did not have a reliable due date. Many women stated that a reliable estimated date would help them prepare for seeking skilled care. Simple pregnancy calculators (*see figure 2*) were welcomed.

Program Implications

Developing a locally tailored birth preparedness card can be a useful tool to introduce the broader need of preparing for birth, keeping the following in mind:

- Birth preparedness cards are useful tools to help women, families and communities prepare for use of skilled care. Cards should include early postpartum care needs and

HIV/AIDS issues where appropriate.

- Community-initiated local adaptations can improve the utility of birth preparedness cards.
- Anchoring birth preparedness cards with community groups enables these groups to serve as a link between families, communities and skilled providers.
- Birth preparedness cards can be used with other tools, such as a simple pregnancy calculator and record-keeping forms, to improve planning and anticipate complications where needed and help women anticipate the need for skilled care.

An important aspect of birth preparedness is the emphasis on seeking skilled care during and after childbirth. Encouraged to seek this care, women must be reasonably assured that when they reach a health facility, they will receive quality and supporting care. A focus on the behaviors of skilled providers is the final piece of the CHANGE Project’s Maternal Survival Framework.

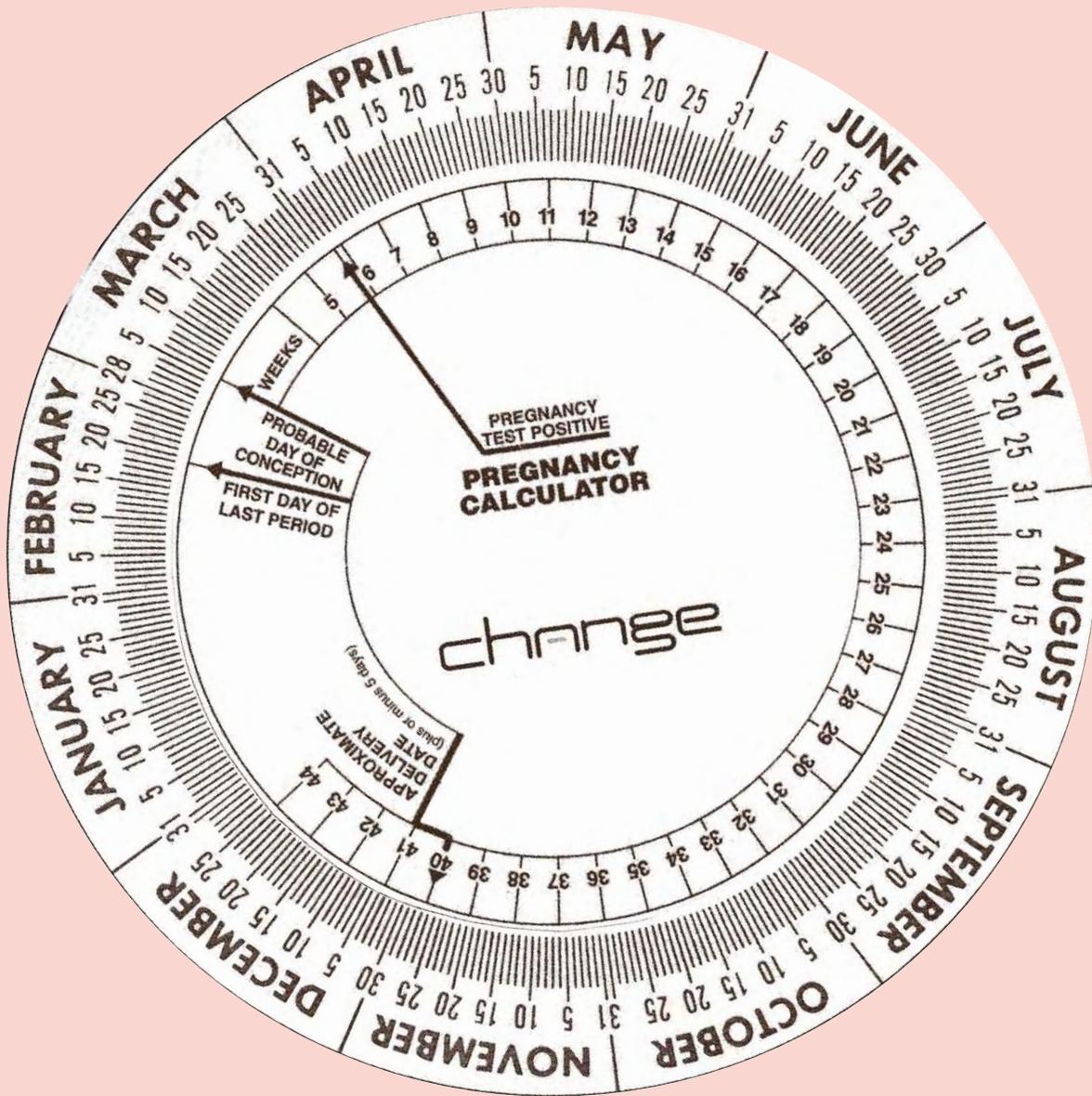


Figure 2: Simple Pregnancy Calculator

Providing Skilled Care

Improving Caring Behaviors of Health Workers

Health workers' behavior toward their clients plays a role in many women's use of skilled care. The perception that these providers are uncaring or abusive often has a greater influence on the use of skilled care than more widely recognized factors such as access or cost. In the Homa Bay area of Kenya, for example, women compared the kindness of TBAs with the less nurturing behaviors of skilled providers, even though they recognized the technical competence of the latter group. In the baseline survey conducted in Kenya's Western Province, 65 percent of the respondents expressed dissatisfaction with delivery in a health facility because of the providers' attitudes toward them. Women who did go to a health facility faced long waits even in emergency situations. Almost two-thirds noted that their greatest dissatisfaction with their care related to poor attitudes by the service providers.

Staff attrition and absenteeism, equipment shortages and high patient-to-provider ratios all contribute to highly stressful situations for many health workers. These situations can certainly create or exacerbate behaviors that patients perceive as negative. Helping health workers to be more "caring" in their behaviors toward their clients is one way to make skilled care more appealing to mothers without adding to the providers' already heavy workloads.

In consultation with technical experts, social scientists and maternal care providers, CHANGE

developed a list of 97 "caring" behaviors organized into these categories:

1. attend to physical needs
2. be accessible to clients
3. attend to emotional needs
4. respect human dignity/rights
5. inform/explain/instruct
6. involve family
7. incorporate cultural context

For example, a specific behavior under "be accessible to clients" is to "come quickly when patient calls"; under "incorporate cultural

“Almost universally, providers and planners recognized the caring behaviors as essential, but often overlooked”

context,” a specific behavior is to ask the patient and her family about any religious preference requirements during childbirth. The health worker can use the list as a self-assessment tool and managers or others can use it as an observation tool.

The tools were adapted and field-tested in urban and rural health facilities in Kenya and Bangladesh in partnership with Family Care International’s Skilled Care Initiative and the American College of Nurse Midwives, to help providers identify and improve their “caring” behaviors during labor and delivery. Strengthening positive behaviors and minimizing negative ones requires helping health personnel explore the factors that contribute to such behaviors and develop individual coping strategies.

Findings on Skilled Providers’ Behaviors

CHANGE focused on how providers responded to the identified behaviors, as well as how the findings could be used to improve provider behavior:

- Almost universally, providers and planners recognized the caring behaviors as essential, but often overlooked.



- Caring behaviors related to emotional care were more frequently observed than those related to cultural and family inclusion. The latter are essential elements of patient-perceived quality of care whose absence may contribute to women not using skilled providers more frequently.
- There was some difference between Kenya and Bangladesh as to which caring behaviors were more frequently performed: observing and talking to patients was the most common caring behavior in Kenya, while touching and demonstrating caring were more common in Bangladesh.
- Advising patients on their breathing and positions of comfort was the second most common behavior in both countries, as well as the one rated the easiest and most important to perform by nurse-midwives in both countries.



- Lists of caring behaviors were welcomed as aids to integrate caring into training programs.
- After local adaptation, the assessment tool was seen as a simple, user-friendly way to document provider caring behaviors through observation.
- The tools helped to document the level of caring behaviors being practiced; elicit provider insights on caring, including barriers and supports to caring; document clients' point of view; and develop evidence-based plans to improve providers' caring behaviors.

Program Implications

The information gathered from discussions and the provider-client behavior assessment tools can be used to:

- Determine the amount and quality of caring behaviors that are part of current maternal

- providers' practice during labor and delivery.
- Elicit provider perceptions of the content and quality of their caring behaviors and interaction with patients and families during labor and delivery.
- Involve midwives and other skilled providers in discussing and selecting which behaviors are most important, which are easiest and most difficult to perform, and which they can incorporate into their routine maternity care provision.

At national or district hospitals or health centers, the assessment can be used by:

- Program planners to design strategies and interventions on a larger scale to improve the behaviors of maternity care providers during labor and delivery.
- Midwifery educators as practical behavioral guidelines in pre-service training.



- Training coordinators as a part of ongoing in-service education.
- Supervisors of labor and delivery units to help assess the content and quality of their staff's behaviors on the job.
- Managers to demonstrate improvements in client/provider interaction.

Toward Improved Maternal Survival

Technical expertise and health care facilities that are equipped to provide services are clearly important to improving maternal survival and decreasing the number of unnecessary maternal deaths that occur every year as is ensuring that women have access to affordable services. However, another essential piece of the puzzle is understanding why women do and do

not choose to seek skilled care and the role that their families, communities and the health sector play in these decisions. Interventions based on this information have a better chance of achieving results.

The behavior change approach is a new way of addressing a long-recognized problem. The CHANGE Project found that women, families and communities are willing to try new practices, even in an area of life as sensitive as pregnancy and childbirth and the early postpartum period. The key is making global recommendations acceptable and feasible in local communities. Through consultation and negotiation with families, households and health providers, this can be done.

ABOUT THE CHANGE PROJECT

The CHANGE Project (1998-2005) provided leadership for behavior change innovation, tools and strategies. CHANGE focused on helping health and nutrition programs develop and apply practical solutions to behavior change problems.

www.changeproject.org

ABOUT AED

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ABOUT THE MANOFF GROUP

The Manoff Group provides technical assistance in Behavior-Centered ProgrammingSM and communications for health, nutrition, population and environmental health. For more than 35 years, the Manoff Group has worked in countries around the world with governments and private sector groups to design, manage, implement and evaluate programs that facilitate peoples' practice of health promoting behaviors that result in improved health outcomes.

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