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A women's livelihood group seeks shade beneath acacia trees during a donkey cart handover ceremony in Balamabala. ESD provided the carts as part of its strategy to improve community linkages to health facilities.

The Extending Service Delivery (ESD) Project, funded by USAID's Bureau for Global Health, is designed to address an unmet need for family planning (FP) and to increase the use of reproductive health and family planning (RH/FP) services at the community level, especially among underserved populations, to improve health and socioeconomic development. To accomplish its mission, ESD has strengthened global learning and application of best practices; increased access to community-level RH/FP services; and improved capacity for supporting and sustaining RH/FP services. ESD has worked closely with USAID missions to devise tailored strategies that meet the RH/FP service delivery needs of specific countries. A five-year Leader with Associate Cooperative Agreement, ESD is managed by Pathfinder International in partnership with IntraHealth International, Management Sciences for Health, and Meridian Group International, Inc. Additional technical assistance is provided by Adventist Development and Relief Agency International, the Georgetown University Institute for Reproductive Health, and Save the Children.

Care for the Mother (*Daryelka Hoyada*): A Community-Based Model to Increase Use of Family Planning/RH/HIV Services in North Eastern Kenya

This paper describes how the Extending Service Delivery Project worked with women's livelihood groups, influential community members, and health providers in the North Eastern Province of Kenya. Begun in early 2009, the activity aimed to educate women on safe motherhood practices, strengthen the skills of health providers, and improve linkages between communities and local health facilities.

BACKGROUND

Spanning the length of the Somali and Ethiopian border, the North Eastern Province (NEP) of Kenya is home to 2.3 million people, more than half of whom are semi-nomadic pastoralists. It is an extremely isolated and culturally conservative Muslim region where only an estimated 42 percent of the population has access to health care services. The 2008-9 Kenya Demographic and Health Survey (DHS) revealed an urgent need for targeted health interventions in several health categories.

The average age of first marriage and first birth in NEP is low at 18 and 19 years old, respectively. A woman in this area has an average of six children over her lifetime, whereas the national average is between four and five children. Both maternal and infant mortalities remain high by Kenyan standards. Meanwhile, child spacing knowledge and family planning acceptance is extremely limited, with less than four percent of married women ages 15-49 using a modern contraceptive method, compared to 45 percent nationally. While the presence of HIV in NEP is low at one percent, it is rising. The increasing prevalence of tuberculosis in the region and its association with HIV, have also become a grow-

NEP: HEALTH INDICATORS¹

MATERNAL MORTALITY—	1,000/1,000,000
INFANT MORTALITY—	57/1,000
UNDER-FIVE MORTALITY—	80/1,000
CONTRACEPTIVE USE—	4%
FERTILITY RATE—	6 BIRTHS/WOMAN
DELIVERY AT HEALTH FACILITY—	17%

ing concern. Other health related challenges include minimal child spacing, weak linkages between communities and health facilities, home deliveries with unskilled assistance, and scant knowledge of key health issues. Long considered one of the most impoverished regions in Kenya, NEP has recently faced additional difficult circumstances related to recurrent drought, which exacerbates the existing issues of low literacy, high fertility rates, and poor access to health services.

SETTING THE STAGE

In 2006, USAID Kenya issued an Associate Award

¹ Kenya Demographic Health Survey, 2008-9.

² *Ibid.*

³ *Ibid.*

to the Extending Service Delivery (ESD) project to implement the AIDS, Population and Health Integrated Assistance (APHIA) II Project in NEP. This project was designed to address HIV/AIDS, malaria, tuberculosis, family planning, and maternal and child health (MCH); the overall objective was to promote healthier behaviors and increase adoption of high-quality HIV/AIDS and family planning/MCH services.

Starting in 2009, ESD and APHIA II collaborated on an intervention model to strengthen safe motherhood and reproductive health. The model was created specifically for a low-literacy, resource-poor context, recognizing the need to strengthen linkages between health providers (who are often inexperienced with the local language and customs) and the traditional communities they serve. ESD designed the model using community-based women's groups as advocates for a healthy pregnancy and safe delivery, as well as facility-based child spacing, maternal, neonatal, child health (MNCH), and HIV/AIDS services. This approach – called Care for the Mother – educates and empowers women who are members of existing livelihood groups on the importance of using available health services and the benefits of antenatal care, facility-based delivery, postpartum care, healthy timing and spacing of pregnancy (HTSP), and prevention of mother-to-child transmission (PMTCT) of HIV/AIDS. The women are encouraged to diffuse these ideas and values throughout their existing networks of family and friends and especially to refer pregnant women for services at the facility. To improve the likelihood of success and sustainable change, the model also orients and builds bridges with male stakeholders and religious leaders in the area. The ultimate goal of this activity is to increase uptake of safe motherhood services in the target communities, strengthen the skills of health providers, and improve FP/MCH outcomes, simultaneously strengthening HIV services.

In March 2009, APHIA II NEP conducted a rapid assessment in two agro-pastoral locations of Garissa District and identified four women's livelihood groups as platforms for the Care for the Mother activity, two in Balambala and two in Sankuri. Established between 1985-2000 with assistance from the Women Enterprise Fund, each livelihood group has existing by-laws, goals and objectives, elected administrators, an operational bank account, and recognition by the Kenyan government as a legal community-based association. Each

group is comprised of 20-30 women of reproductive age and meets monthly to discuss business and HIV/AIDS issues. APHIA II NEP selected these four groups since they had strong networks in the community, an existing infrastructure to organize health education sessions, and geographical proximity to Garissa for programmatic support, monitoring, and evaluation purposes.

A Knowledge, Attitudes and Practice (KAP) survey was conducted together with focus group discussions in July 2009 to collect baseline data on safe motherhood, child spacing, family planning, and HIV/AIDS information in the targeted communities. The assessment yielded the following findings:

- 58 percent of respondents said the ideal age of first pregnancy was 17 years old or younger.
- Women had an average of seven pregnancies, but reported they would eventually like 9-10 children.
- While 80 percent of the women favored child spacing, 21 percent thought women should wait one year between pregnancies and 22 percent thought they should wait six months. About half thought a couple should wait two plus years between pregnancies. Most women in focus group discussions had little understanding of the benefits of child spacing.
- There was evidence that men and women in both communities generally supported child spacing for health reasons (i.e., the health of the mother and baby). However, spacing was not the choice of the mother alone. Men and religious leaders exercise a great deal of authority over all matters – including reproductive health – and expect to be consulted and have influence over any final decisions.
- Uptake of contraceptive methods was very low and attitudes toward contraception other than exclusive breastfeeding remained negative.
- Knowledge of HIV transmission modes was limited and discrimination toward those in the community infected with HIV/AIDS was high.
- Women had some knowledge of family planning methods: 75 percent of the women interviewed knew about injectables and 50 percent knew about the pill. Over 40 percent of women ages 25-26 had used family planning in the past, and 25 percent

were currently using it (a large shift from the 2003 DHS data).

- Transportation to the nearest health facilities remained a significant challenge, especially for women in labor.

These findings revealed both opportunities and challenges for Care for the Mother. ESD and APHIA II staff used these data to design an integrated information package to educate the mothers' groups on healthy pregnancy, safe delivery, antenatal care, postpartum care, HTSP, and PMTCT. Implementation of Care for the Mother activities began in early 2010.

STRATEGY

Care for the Mother employed a three-prong strategy to reach community women:

- Training health facility-based providers (at least two from the two facilities in Balambala and Sankuri), who would educate the women's groups about key health topics during monthly meetings to ensure healthy pregnancy and safe delivery.
- Encouraging the livelihood group members to become 'change agents' by sharing their newly acquired health information with their families (daughters, sisters, co-wives, husbands) and their neighbors, while also referring pregnant women to facility-based health services for skilled delivery, antenatal care, and child spacing/family planning.
- Addressing the emergency transportation of women who need delivery services, have postpartum problems, or require assistance traveling to the health facility.

KEY ACTIVITIES

Care for the Mother employed several concurrent activities to deliver MNCH and family planning information and services to the target areas:

- *Obtaining the support of key religious leaders, civic leaders, and husbands via orientation meetings for the promotion of safe motherhood, healthy pregnancy, and HTSP:* Given the cultural role these groups play in the community, their support was critical. Religious leaders ensured the health of women by convincing husbands to encourage the use of health facilities



Donkey cart ambulances were provided by ESD and built to the women's specifications by local craftsmen.

Care for the Mothers' Referral Form

Name of WG:.....

ANC		<input type="checkbox"/>
PMTCT		<input type="checkbox"/>
HTSP		<input type="checkbox"/>
Safe delivery		<input type="checkbox"/>
PNC		<input type="checkbox"/>
Immunization		<input type="checkbox"/>
Others (specify)		<input type="checkbox"/>

(Tick in the appropriate box)

Referred By.....Date.....

This simple education tool allows health providers to convey information on FP, ANC, PMTCT, HTSP, and safe delivery to non-readers.

and to space their future pregnancies; their backing established a credible foundation for these changes.

- *Providing on-the-job training, continuing medical education, and support to the health facility providers:* APHIA II NEP staff were responsible for providing supportive supervision on clinical, communication, and counseling skills. They also assisted the health facility staff in integrating this new information into existing health services and community education activities.
- *Developing a simple education tool with integrated information on antenatal care, safe delivery, family planning, HTSP, postpartum care, and prevention of PMTCT:* Originally developed in English, APHIA II staff adapted this tool for use by the health provider, who understood English, but primarily spoke Kiswahili. The health provider was then paired with a local community member who knew both Kiswahili and Somali, and who then translated the “messages” into Somali when communicating with the women’s groups during their monthly meetings.
- *Educating livelihood groups:* The facility-based health providers led monthly meetings for mothers’ groups to educate women on topics included in the education tool.
- *Procuring emergency transportation for pregnant women and postpartum mothers with health problems:* ESD provided a donkey cart to each of the four livelihood groups to act as emergency ambulances to help women cross the hot, arid terrain; the women provided specifications for their carts and their own donkeys. When not transporting mothers to health facilities, the livelihood groups could use the carts to transport goods to the market for income generating purposes.

RESULTS

Results from baseline (n=106; 81 women and 25 men) and endline (n=112; 80 women and 32 men) survey comparisons clearly show the uptake of several new healthy behaviors, increased knowledge, and positive

Balambala and Sankuri health facility service statistics, 2010-2011⁴:

Type of service	Apr-Jun 2010	Jul-Sep 2010	Oct-Dec 2010	Jan-Mar 2011
1st antenatal care visit	83	108	99	111
All antenatal care visits	230	262	241	251
PMTCT (HIV counseling & testing in MCH services)	87	105	97	109
Deliveries	45	41	30	53
Referrals from mothers' groups	38	86	107	200
Use of donkey cart to transport pregnant woman to facility	NA	NA	8	16

attitude changes stemming from the project activities. Facility statistics over twelve months show modest gains, which APHIA II will continue to monitor going forward.

Referrals from the livelihood groups in particular increased rapidly each quarter, suggesting that the women's networks had a positive effect. APHIA II delivered the donkey cart ambulances late in 2010, and the livelihood groups used them eight times within months of their introduction.

Baseline and endline surveys indicate that the number of women delivering at health facilities more than doubled in the project areas, rising from 14 percent of deliveries to 31 percent. Combined with a drop in home deliveries and local dispensary deliveries, these results reveal the two communities' increasing acceptance of health facility delivery with skilled attendants.

The surveys also revealed strong gains in family planning knowledge. Women demonstrated rising awareness of the standards days method (65 percent increase) and injectables (25 percent increase) as family planning methods. During the project timeframe, the number of women currently using a family planning/child spacing method climbed from 18 to 24 percent.

Shifts in knowledge and attitudes were not limited to women. As the graph below shows, men in Balambala and Sankuri were increasingly open to discussing child spacing with their families and supporting longer birth intervals. At endline, three-quarters of the men surveyed stated they would permit their wives to deliver at a health facility.

Figure 1. Referrals from livelihood groups to health clinics

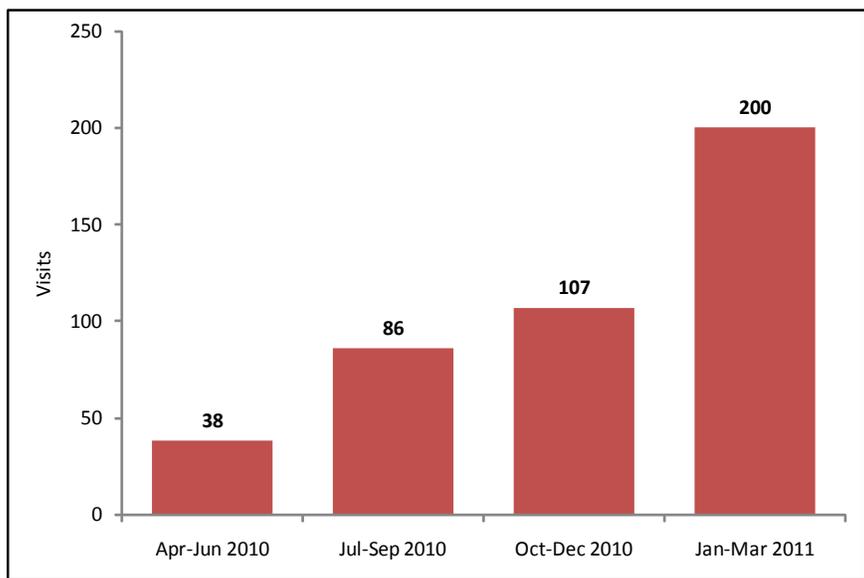
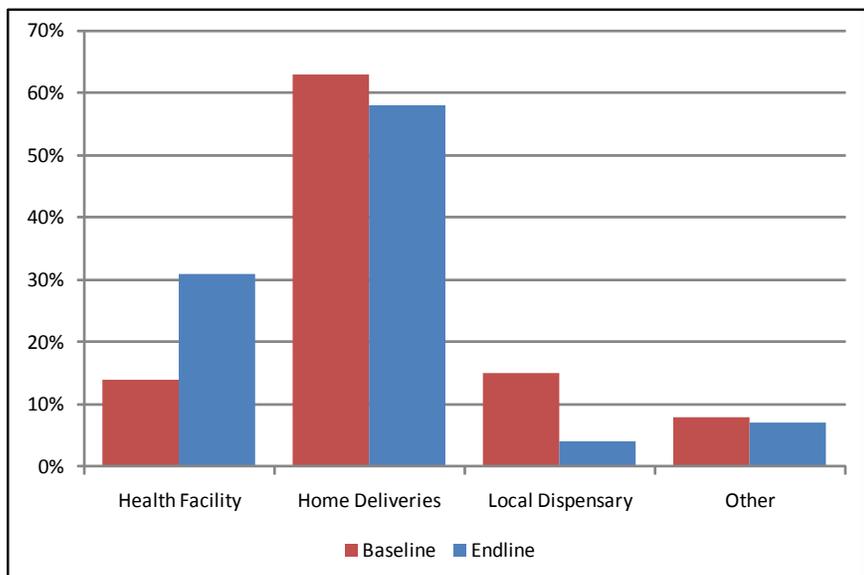


Figure 2. Deliveries at health facilities compared to other locations.



⁴ From Quarterly Reports submitted by APHIA II NEP and APHIA Plus NAL

Figure 3. Family planning knowledge gain among community members.

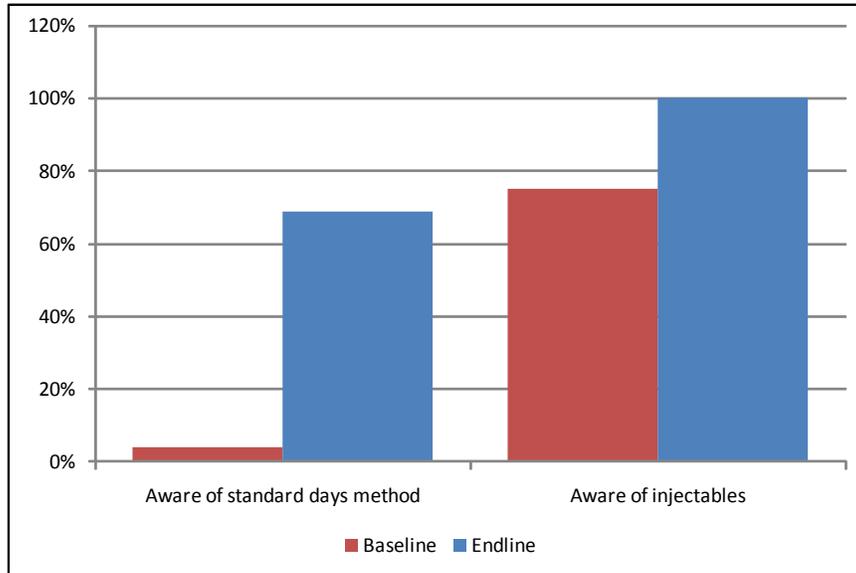
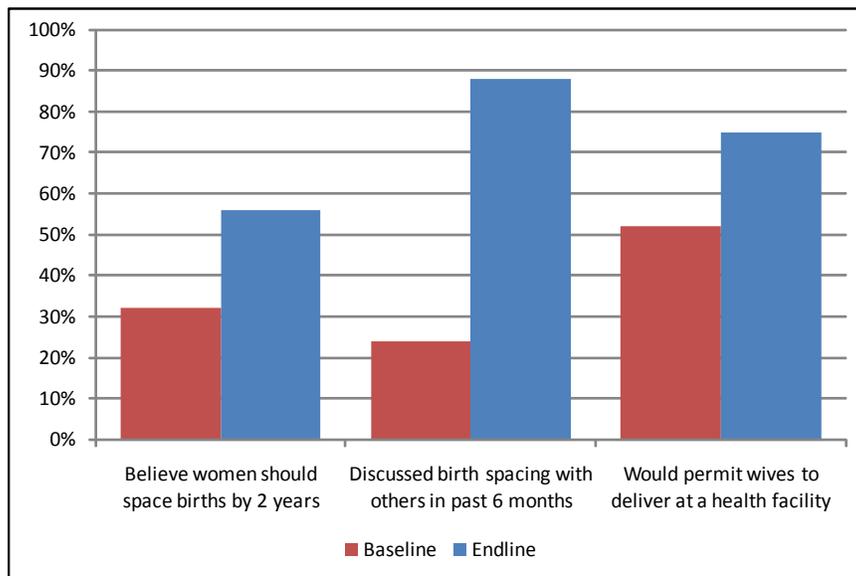


Figure 4. Male attitudes on birth spacing and facility delivery.



CHALLENGES & LESSONS LEARNED

Language and literacy issues presented a major hurdle for the Care for the Mother activity; since women's group members are mostly non-readers, communicating new ideas on family planning and health services proved challenging. The education tool developed for this purpose helped the health facility staff educate the mothers' group members since it was easily understandable to both the providers and non-readers on topics of antenatal care, safe delivery, postpartum care, HTSP, and PMTCT; the objective was to connect the community to a package of integrated services provided at a single point of service delivery.

Gaps in staffing of the health facilities proved problematic, especially early in the project timeline, as skilled health staff at the clinics were too few in number to provide services and collaborate with the women's livelihood groups. Staffing issues remain one of the chronic challenges facing NEP in general.

The availability of continuous onsite technical support was also a challenge. Because the APHIA II NEP Project was wide-ranging in both its geographic scope and technical mandate, it was difficult to provide constant program supervision, particularly during the crucial early months. If the activity were to scale up, a project coordinator with appropriate management and local socio-cultural experiences could strengthen the program's impact by working early and consistently with the women's groups and local health providers to ensure that the activity's foundation, systems, and processes are in place. This would also help establish a dependable flow and continuity of monthly meetings for the mothers' groups at the health facility to reinforce the knowledge transfer.

Additional challenges were often beyond the program's control. For example, severe and chronic droughts plagued (and continue to plague) the project area and led to cancelled meetings; in one instance, the area chief called upon the entire village to participate in the construction of a canal to divert water from a stream that had changed direction during the dry season. Such circumstances need to be factored into the overall process where possible.



ESD staff provides the official documentation for the handover of the donkey cart ambulance to leaders of the livelihood groups. The women brought their own donkeys to make the carts immediately functional.

NEXT STEPS

The Care for the Mother model has demonstrated strong potential for both sustainability and growth. The ongoing implementation of the activity in Garissa will continue under the guidance of the local women's groups with support from health facility staff and the new USAID-funded APHIA Plus Northern Arid Lands (NAL) expansion project. The NAL project, which has significantly expanded geographical coverage in Kenya, has already adapted this model for use in its intervention areas where appropriate, based on early results from Sankuri and Balambala. Care for the Mother can also serve as a model for other countries that face similar health challenges in conservative, pastoral populations.



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