Overview of a Community Based Maternal and Newborn Health project and lessons learned in Kenya & Ethiopia

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Background

- Pregnant women and newborns are among the vulnerable populations in any community
- ~800 women die each day because of complications

The CBMNH-N projects aimed to demonstrate how to integrate nutrition into health programs at community level with proven interventions.
Rationale

✓ SDG focus on universal health coverage and nutrition integration

✓ Evidence that prioritizing health facility deliveries will reduce maternal mortality

✓ Human resource shortages at the health facility are common but there is potential to complement available health staff using community based personnel through task shifting

✓ Sufficient evidence available for community-based scale-up
✓ Barriers to safe maternal health care at individual, community and facility levels.

✓ Integrate nutrition into health programs at community level with proven interventions.

✓ Varied health system contexts - approach used in each country suitable to existing health system context

✓ We evaluated the impact of the CBMNH-N project on knowledge and practices related to maternal and neonatal care

Study Context: Multi country study
Systematic approach to ensure the project design responded to country, donor and global priorities

✓ Selected countries with varied contexts
  – Rural/remote communities (all countries)
  – Mobile populations (Ethiopia, Niger)
  – Functioning facilities but low demand (Kenya)
  – Multiple and sometimes conflicting NGO/government programs (Senegal, Ethiopia)

✓ Selected partner agencies to fill key gaps
  – Community engagement (MaNHEP/Amref)
  – Health system strengthening (PRONTO/MaNHEP/Amref/ChildFund)
  – Targeted implementation research (UCD)
  – Harmonized approaches (Ministries of Health with partners)
Systematic approach to ensure the project design responded to country, donor and global priorities

✓ **Approach contextualized to each country’s needs**
  – Iterative process of engagement with government and partners (Senegal and all)

✓ **Robust monitoring and evaluation systems**
  – External impact evaluation to inform scale-up (Ethiopia, Kenya, Senegal)
  – Improvements in key outcomes measuring:
    a) ANC, b) ENA (IFA, Breastfeeding, delayed cord clamping) c) delivery with skilled and trained birth attendants; d) PNC
  – Knowledge and practices (recipients and providers)
Overall Program Theory using CDC/WHO generic logic model

**Inputs**
- Policies, production, delivery, quality & behavior change communication

**Activities**
- Availability of policy documents that support interventions in the four countries
- Coverage of components of CBMNH-N interventions
- Providers' knowledge skill and commitment to maternal newborn health services improved
- Delivery of maternal and newborn health services with trained facility and community based personnel
- Quality and uptake of ANC; Essential nutrition actions (IFA, breastfeeding, delayed cord clamping); delivery and PNC

**Outputs**
- Access & Coverage
- Knowledge & Appropriate use
- Target population uses intervention appropriately
- Target population knows, demands, accepts & has ability to appropriately use the intervention

**Outcomes**
- Improved skills knowledge and commitment to Maternal and newborn health nutrition
- Improved Maternal Health and newborn nutrition service quality
- Decreased anemia prevalence in pregnant women
- Decreased Maternal and Neonatal mortality and morbidity
- Increased care and nutrition of pregnant women and newborns
- Other Maternal and Newborn health Interventions – Kangaroo Mother Care, Cord care etc

**Policies**
- Ethiopia – MNHN training guideline
- Senegal - MNHN strategy;

**Production & Supply**
- Training materials printed
- BCC material printed
- Procurement of essential commodities – IFA and MgSO4

**Delivery**
- Ethiopia - training of CHW, TBAs and HEW;
- Kenya - CHW training, TBA re-orientation as birth companions, Emergency obstetrics and newborn care and team work & simulation for the health workers;
- Niger – training of community health volunteers;
- Senegal - training of community actors - Bajenou gox, relais matrones and ASC;

**Quality**
- Monitoring and evaluations plans developed and implemented

**Behaviour Change Communication**
- BCC material developed and implemented
- Strategies used include: social mobilization, interpersonal communication, branding and use of promotional materials; dramas, scripts and skits.

**Impact on intake, status and function in target population**

**Effective Project Management & Monitoring and Evaluation**
Ethiopia
Context – Pastoralist community Afar
Maternal and Newborn Health in Ethiopia Partnership (MaNHEP)

✓ MaNHEP model was developed specifically for Ethiopia and had been successfully implemented in rural Amhara and Oromiya regions of Ethiopia

✓ The MaNHEP model integrates specific maternal and neonatal nutrition actions into their basic package of essential services using a three pronged intervention approach which includes:
  a) community- and facility-based maternal and newborn health training,
  b) continuous quality improvement,
  c) and BCC for demand creation.
Continuous Quality Improvement

Key activities
✓ Community QI training
✓ Community QI implementation - change ideas
✓ Facility QI training
✓ Facility QI implementation – change ideas
✓ Community Facility Collaborative rolled out
✓ Quarterly PHCU review
✓ Monthly Coaching – by field officer
✓ Quarterly Woreda/District mini-learning workshop
✓ Bi-annual Regional Learning workshop
Community engagement

Key activities
✓ community drama pieces were developed and produced
✓ live drama/video screened at community gatherings - quarterly
✓ Quarterly joint supervision - MNHN advisors, RHB
✓ Bi-annual Birth audit
✓ Bi-annual DQA
✓ CHIS/HMIS
Steps in scaling up

**Step 1**: Needs Analysis: To identify the most needy populations

**Step 2**: Strategic Analysis: To identify the optimal mix of intervention strategy Options

**Step 3**: barriers & gaps analysis: To prioritise key barriers limiting the effectiveness of the chosen strategies for delivering the intervention, and/or their sustainability.

**Step 4**: SWOT analysis of MI: To evaluate MI’s ability to address key barriers, and to define the scope offered by collaborating with others.
## Expansion plan

### Demonstration project
- **Geographic**: 6 woredas in Afar
- **women & Newborn in targeted**: 20,000
- **Project value**: ~ 6 million CA$

### Sub-national scale-up
- **Geographic**: 186 woredas in 6 regions
- **women & Newborn in targeted**: 1.6 million
- **Project value**: 5.2 million CA$ + asset 1 million CA$
Adaptation of the model – scaling up

- Scale-up plan maintains the 3 pronged approach to deliver the community based MNHN in areas similar to pilot sites
  - more responsibility is placed on PHCUs
  - technical and monitoring support from the pilot partners

The modifications made

- QI & MNHN coaching & monitoring - from monthly to quarterly
  - Annual reinforcement training
  - PHCUs – tasked – monitoring

- Dropped the community CQI - PHCU QI Team

- BCI- Community orientation meeting – annual

- MNHN care package –
  - misoprostol distribution dropped
  - DCC & CCC- 4% Chx gel - added

From 6 Woredas in a region to 16 woredas in 2 regions
Adaptation of the model - expansion regions

- in agrarian region - MNHN delivery – focus - facility-based approach
  - better off health system - capacity & function

- BCI strategy developed by adapting the CMNHN family meeting
  - dialogue facilitation manual & job aids adapted
  - Training of midwives & Nurses

- The National Health Care Quality Strategy
  - MI supports the MoH to implement the MNHN QI plan - prepare the MNHN QI kit for the PHCU - MNHN care standards, training manual, MNHN QI scorecard,

- Technical, financial and monitoring support will be provided but it is expected to be required for a shorter period of time.

170 woredas in 4 regions
PROJECT CORDINATION

National Steering Committee
• Composed of high level partner managers; MOH DFH and HMIS Unit heads-chaired by DMS
• Main role is translating evidence into policy

National Technical Advisory Committee
• National Technical Advisory Committee: Composed of representatives of partner organizations and of relevant MOH Units-Chaired by CHDU;
• Main role technical and implementation oversight

County Project Implementation Team
• Composed of Project team plus County and Sub-County MOH, RH Coordinators, Community Health focal persons and Nutrition Officers-chaired by CHD:
• Main role is synchronizing project & MOH work-plans, implementation of project activities
Simulation & Team Training (PRONTO)

177 Health workers trained
Health workers reported they are able to manage obstetric emergencies they used to refer beforehand.

Installation of instant heater at Police Line Dispensary—warm shower postpartum
RE-DEFINING ROLES OF TBAs

- **Identification of TBAs**
  - Provincial administration
  - Snowballing
  - Through CHWs

- **Formative assessment and development of manual**

- **KAPB survey of TBAs on MNHN for development of a Birth Companion manual**

- **Structured Dialogue with TBAs**
  Model based on cIMCI dialogue with the steps below: {starter; brainstorming on perceptions on issue; clarifying perceptions; current status; vision for the future; set objectives; consensus on actions; action plan}.

- **Training, Implementation & Recognition**

- **Re-orientation of TBAs using the birth companion manual; start implementing new roles; public recognition.**
PROJECT DOCUMENTS

All adopted by MOH as National Documents

Other products:
- Birth companion monitoring tool;
- Modified Near-miss tool;
- Tool for improving Quality of community dialogue
Task shifting for TBAs into birth companions

345 former TBAs changed roles to become birth companions. These redirected 11,427 of their clients to deliver in health facilities in a year.

County First Lady wearing project branded head scarf and lesso gives her acceptance speech as a maternal and child health Champion.

Birth Companions match with the county first lady in celebration during her inauguration as MCH champion.
Community Health workers

- CHEW trainings
- CHV trainings
- 65 CUs made fully functional
- 19,370 people reached through community dialogue meetings
- Individual and group incentives
- Community Dialogue meetings
Other Behaviour change interventions

- **Branding-(rock, wall)**

- **70** Mother to Mother support groups formed: shared knowledge and experiences in MNHN; encouraged adoption of best practices; reached out to other women with messages

- **23** F2F support groups formed. Increased knowledge and involvement; changed mindset; facilitates gender mainstreaming

- **1** mixed group for persons with disabilities formed comprising more than 50 members

- **20** CSOs oriented on MNHN messaging and used for health communication
Programmatic experiences & lessons learned

- Systematic process of scaling up allowed us to identify and incorporate the most critical project components to maximize impact while reducing the cost of initial implementation.

- Community sensitization and engagement of community leaders as part of stakeholder dialogue was critical for the implementation of cultural sensitive health and nutrition services.

- Stakeholders participation and agreement on common results framework helped to get the endorsement by partners and their effective translation into action at scale.

- Political and community leadership back–up has been critical for the implementation of the project approaches and required early dialogue and engagement.
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