MOBILIZING THE COMMUNITY TO PRIORITIZE NUTRITION INTERVENTIONS

CASE STUDY

COMMUNITY ACTION FOR PREGNANT WOMEN
"Before it was only the Community Health Workers and the Traditional Birth Attendants who spoke about health. Now you have the whole community talking about it, thanks to the work of the CVAC groups!"

Mr. Sadio
Community Health Worker, Wilingara district

INTRODUCTION
Maternal nutrition has a ripple effect that expands far beyond the individual health of a mother and her child. Healthy mothers raise healthy children, who contribute to the next generation of active and vibrant communities.

In Sub-Saharan Africa, many women lack the resources needed for healthy pregnancy, birth and postnatal care. With limited information and education on maternal and newborn nutrition, as well as a lack of access to health services like antenatal care, birth care and postnatal care, these women and their newborns are at a higher risk of illness and death.

There is no single solution that addresses maternal and newborn morbidity and mortality. Each community context has its own needs and challenges. For meaningful and lasting change to occur, a series of interventions must be tailored for each community.

It is important that international development agencies, policy-makers, healthcare professionals and other stakeholders are all aware of the work being done by others in the field. Ideally, the global community should work together on a unified plan to address maternal and newborn health in order to increase access to health services and reduce mortality.

In 2011, the Micronutrient Initiative (MI) — in close collaboration with national governments and partners — launched a five-year project targeting underserved populations in three African countries to address the gap in maternal health and nutrition knowledge and services. The project had two primary aims:

1. To integrate essential nutrition interventions into maternal and newborn health programs that will support optimal nutritional status throughout pregnancy and beyond.

2. To improve the quality and uptake of antenatal care, birth care and postnatal care in hard-to-reach populations.

The project focused on testing community-based models of service delivery for maternal and newborn health and nutrition in hard-to-reach communities in Kenya, Ethiopia and Senegal, with each country’s Ministry of Health taking the lead. The community-based models were tested through unique demonstration projects run by local partners.

In the regions selected, it was critical to mobilize the communities to effectively promote maternal and newborn nutrition in order to improve the health — and save the lives — of mothers and their newborns. Community and peer support groups were established and included expectant mothers and fathers, Traditional Birth Attendants (TBAs) and midwives, as well as other community leaders. Thanks to the leadership of community health volunteers, the peer support groups were able to mobilize the community to prioritize nutrition interventions that have long-lasting positive outcomes on the health of newborns. This was accomplished by raising awareness and sharing the extensive nutritional benefits of iron-folic acid supplementation during pregnancy; optimal cord clamping; and timely initiation of breastfeeding. The peer support groups also provided the opportunity for community members to ask questions, discuss the challenges they were facing, and to learn from one another.

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.

KAKAMEGA, KENYA

Most pregnant women have at least one antenatal care (ANC) visit, but only half have the recommended four visits that ensure adequate monitoring and identification of warning signs during pregnancy. ANC visits are also the main method for delivering iron-folic acid supplements. The World Health Organization recommends daily iron-folic acid supplementation throughout pregnancy; yet in Kakamega, only 59% of women consume any iron-folic acid supplements and a mere 7% take the supplements for more than 90 days.

AFAR, ETHIOPIA

Ethiopia has one of the highest rates of maternal mortality in the world, with 6.7% deaths per 100,000 live births. The neonatal mortality rate is also high, with a rate of 37 deaths per 1,000 live births. The pastoralist lifestyle in the Afar region makes it even harder for healthcare workers to reach pregnant women and newborns. Only 31% of pregnant women receive even one antenatal care visit from a trained healthcare provider, 10% give birth with a skilled attendant, and only 8% have a postnatal check-up within 48 hours of delivery.

KOLDA, SENEGAL

The region’s dispersed population makes it difficult for women to access quality healthcare, especially when the nearest health center can be up to 40 km away. It is estimated that only half of pregnant women have the minimum four antenatal check-ups recommended for a healthy pregnancy. After delivery, it is estimated that just 34% of women in the Kolda region receive postnatal care.
THE APPROACH
MI engaged local governments, global experts, as well as international and national partners to contribute to the project. Using a multi-country project model that focused on the crucial 10-month period between conception and the first month after birth, demonstration projects were developed, implemented and evaluated. Every demonstration project was tailored to address the specific needs of each of the participating communities.

The innovative modular project design and the lessons learned provide a blueprint for scaling up the initiative within Kenya, Ethiopia and Senegal. Furthermore, it can be adapted to similar contexts in the world to reach the most vulnerable people with an essential and integrated package of health and nutrition services.

KAKAMEGA, KENYA
In Kakamega County, the main approach in mobilizing the community was to involve fathers in the pregnancy, birth and postpartum periods and to educate them on the importance of nutrition during pregnancy, as well as early and exclusive breastfeeding of newborn children.

AFAR, ETHIOPIA
In Afar, the main approach in empowering and mobilizing the community was to provide nutrition counseling, educate pregnant women through an innovative family meeting model about the importance of facility health services, and the use of iron-folic acid supplementation.

KOLDA, SENEGAL
In Kolda, the main approach involved engaging the entire community in supporting pregnant women by creating five different types of support groups. These support groups included a community watch group conceived by the Ministry of Health that provided accurate information and dispelled common myths around maternal and child health.

“... My husband is in the father-to-father group and from what he has learnt about good nutrition in pregnancy and after delivery, my milk flow to my baby has been good since I eat well and he is there to support me when I need him.”

Peris Tatiro
Mother-to-mother support group member, Kakamega, Kenya

PROJECT TARGETS
Reach 100,000 pregnant women and newborns through improved health services, including antenatal care, birth care and postnatal care
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

REGIONS
KENYA
ETHIOPIA
SENEGAL

1. Demographic Health Survey Kenya, 2014
2. Demographic Health Survey Ethiopia, 2011
3. Mini-Demographic Health Survey Ethiopia, 2014
4. Demographic Health Survey Senegal, 2010
Empowering fathers to play an active role in maternal, newborn and child health

For decades, the importance of male involvement has been emphasized in various maternal, newborn and child health projects and programs. As fathers, spouses, brothers, healthcare workers, religious leaders and community members, men are able to influence their own health, the health of their families and the health of mothers and children all around them. Men are often the primary decision-makers, so they play an important role in integrating nutrition into maternal and child care in the communities.

In Kakamega County, pregnancy and childbirth are generally considered a woman’s affair. Expectant fathers often have little knowledge and involvement in maternal and child health issues. Due to the lack of reliable and accurate information, myths and misconceptions prevail that may be detrimental to the health and well-being of pregnant women.

For the same reason, men are not familiar with the benefits of antenatal check-ups, what to expect during childbirth, or specific ways they can support their spouses from pregnancy through to the postpartum period.

While support groups and peer education are not new initiatives, targeting men was a new challenge. At first, there were challenges in establishing the targeted 20 father-to-father groups, which were to be made up of spouses of pregnant and lactating women. Slowly, thanks to the combined efforts of the community leaders and community health workers breaking down the barriers and stereotypes of male involvement in maternal and newborn health, men became more interested in learning about maternal and child health issues. In the end, the project exceeded the target, with the creation of 23 successful father-to-father support groups.

The father-to-father groups included education on maternal, newborn and child health and nutrition, such as the importance of good nutrition during pregnancy. Through the meetings, they learned their spouses need physical and emotional support while pregnant — even with housework. The groups taught the value of early and exclusive breastfeeding and how to care for infants.

Within their communities, the groups served as advocates, boosting male involvement in maternal and newborn health issues. While the men hesitated to join the peer groups at first, by the end of the project many had become proud champions for maternal and child nutrition and health.

Focus group discussions revealed the father-to-father groups facilitated a change in the men’s attitude towards pregnant women by increasing knowledge in maternal and newborn health issues. Interviews with pregnant women suggested their partners became more involved in supporting them in household chores and accompanying them to antenatal clinic sessions.

Since the formation of the father-to-father groups, women reported fewer family disputes and a greater sense of love and togetherness within families. The knowledge that fathers gained through this project helped empower them to be more available to support their families and play a greater role in the health and nutrition of their spouses and other women, newborns and children.

Since I joined the father-to-father support group, my life has changed. When I joined the group, I was taught my wife should have good nutrition, have the support of her husband even in house work. I, as a father, should let my wife rest more after birth by offering to babysit the newborn. This will help reduce the stress associated with childbirth. It has also taught me that my baby should be breastfed for six months without giving him any other food. I was also taught that I can also bathe our baby when my wife is resting; it is not the responsibility of only my wife.”

Kalisto O. Otuko
father-to-father support group member, Kakamega, Kenya
**Ethiopia**

**Community-led family meetings boost maternal and child nutrition practices**

The poor nutritional status of women and children in Ethiopia has been a serious challenge for many years and improving overall nutritional status of women is crucial for maternal and child health.

In the Afar region, 34.8% of women of reproductive age had some form of anaemia and only 23% of women took any iron-folic acid tablets during their last pregnancy.

While 59.6% of women in Afar breastfed within the first hour of birth, this fell short of the Ethiopian Ministry of Health target of 92% of babies begin put to the breast within one hour of birth.

Community members, such as Traditional Birth Attendants (TBAs), are regarded as key decision-makers in the care of women from pregnancy to postpartum, as well as for any issues that have to do with the nutrition and feeding practices of mothers and their babies.

In collaboration with a local partner, Maternal and Newborn Health in Ethiopia Partnership (MaNHEP), family meetings were introduced as a community approach to provide education on health and nutrition to pregnant women and their families.

TBAs and other respected leaders were selected by the community to lead the family meetings as members of a Guide Team. Once nominated, members of the Guide Teams received training in maternal and child health and nutrition and learned how to organize and conduct family meetings. The Guide Teams were trained to identify pregnant women and reach out to these women to offer nutrition counseling and advocate for health services with a skilled attendant, including antenatal care, birth care, and postnatal care.

The family meeting series consisted of four sessions designed to promote good health, nutrition practices, preventative measures and emergency protocol. The meetings were conducted every two to four weeks in the community, and were led by two Guide Team members. The meetings engaged pregnant women, their spouses and their mothers or mothers-in-law, as well as other community members. Due to the low literacy rate in the region, the family meetings included pictorial health and nutrition messages as well as story-telling, which is consistent with the traditional information exchange practices in Afar.

The family meeting approach involves pregnant women, their families, caregivers and communities in ways that respect and build upon local knowledge and skills. By empowering the communities with accurate and practical information, the project laid the groundwork for sustainable development that will continue to provide benefits for years to come. This model received strong government interest and input and has had the collateral benefit of facilitating collaboration efforts between healthcare workers and the community.

Hawa Ali
Traditional Birth Attendant, Afar Ethiopia

“I give them a pictorial booklet that illustrates various stories on proper care. I narrate stories, especially about characters named Hasna and Medina. I share their life story quoting the book how the former died as a result of ignorance and the latter managed to survive through health facilities. These characters have quickly become a household name! Gradually, they come to realize how important maternal and newborn health and nutrition is and support the idea. I’m happy because people welcome me and others like me when we tour through our kebele.”

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Hawa Ali
Traditional Birth Attendant, Afar Ethiopia
In Senegal, there is a tradition where the older women in the community — called Bajenu Gox — help younger women with healthcare. In Kolda, the Bajenu Gox have the respect of their community and provide support to women throughout their pregnancies.

After a pilot study conducted in 2012, the Ministry of Health (MoH), along with other local partners, decided to build upon the strong tradition of the Bajenu Gox and their powerful community bonds, and create community support groups designed to decrease the amount of home births in Kolda. The initiative was a success. As the number of home deliveries decreased, the MoH and MI realized this strategy could be developed further to include community member discussions on methods of promoting antenatal care, good maternal nutrition, safe delivery in a healthcare facility, and postnatal care.

In this project, five different types of support groups were created: pregnant women groups, future father groups, grandmother groups, women financial care groups, and community watch and alert groups or Comités de Veille et d’Alerte Communautaire (CV AC).

The CV AC groups were composed of the Bajenu Gox, traditional birth attendants, traditional healers, and other respected women in the community. A considerable amount of coordination took place to establish the CVAC groups, including the involvement and approval from community decision-makers, such as village chiefs and religious leaders. After obtaining the necessary approvals, community gatherings were organized to explain the CVAC strategy and for community members to nominate potential CVAC group members.

The CVAC groups were successfully able to engage the community, identify and support pregnant women, promote childbirth in health facilities rather than at home, and encourage the use of postnatal services available from trained healthcare providers.

In addition, a key component of the CVAC groups was to create an accurate and up-to-date record of pregnancies, births, maternal mortality and breastfeeding by new mothers, which were practical resources for modifying healthcare services and informing future directions for the program.

Overall, the success of the CVAC groups impressed the MoH to the extent that it agreed to continue and scale-up this model.

In addition to the CVAC groups, the other peer support groups in the project model provided essential training on proper antenatal nutrition and care. The other support groups also underscored the importance of giving birth in a healthcare facility and explained the process and benefits of early and exclusive breastfeeding.

By involving the entire community, the CVACs and peer support groups disseminated accurate information, dispelled myths about maternal and child health and nutrition, and ensured everybody in the community received the same messages. The groups also encouraged an open discussion of pregnancy, including the problems and concerns that they were experiencing.

Altogether, 468 CVAC groups were formed and remain active today. Overall, the CVAC groups performed over 21,000 outreach activities including home visits, educational sessions, dramatic presentations and support group meetings. These activities reached more than 62,000 community members, of which, 78% were women.

Through the education and support provided by the CVAC groups, communities were able to integrate healthcare into their values, traditions and cultures for the benefit of good maternal and child health. Moving forward, the women and children living within the mobilized and highly-engaged communities of Kolda will continue to benefit from consistent and valuable support, which ultimately contributes to the overall health of the region.

“When you have the CVAC groups in your zone, you are sure that they have all of the information about reproductive health. They can also provide information about the health system and delivery at a hospital, which permits mothers to then process information and make educated decisions. Now that the CVACs have started this work, it will never stop.”

Mbemba
Community Health Worker in Kolda district
IMPLICATIONS FOR SUSTAINABILITY
This case study describes best practices from Kakamega County, Afar and Kolda, but projects are intended to be adapted and used in similar contexts within Africa and other countries to improve maternal and newborn health.

The UN Sustainable Development Goal 3 has a target of achieving universal health coverage for all, including access to quality essential healthcare services. We know that the health, nutritional status, and general well-being of mothers have a profound impact on a child, especially during the 10 crucial months between conception and delivery. When mothers have the support of their communities, there is a better chance that they—and their children—will survive pregnancy and birth. A recent review showed that mobilizing the community through participatory learning and action groups can reduce maternal mortality by 37% and newborn mortality by 23%.

Each demonstration project was designed to be community-led, even when non-government organizations and governments were involved. We believe this focus on community involvement is the key to sustainability, as it gives communities a sense of ownership, as well as the tools and experience they need to continue the activities long after the conclusion of the project.

Throughout this five-year project, we encountered a variety of successes and challenges. Considerations when implementing the discussed interventions, and mobilizing communities to prioritize nutrition interventions, follows.

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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This project was funded by the Government of Canada, through Global Affairs Canada.