

AFYA KWA UKOO

POLICY BRIEF
JULY 2019

Engaging cultural institutions and culturally-sensitive facility-based delivery on maternal and newborn health service utilization in Garissa

Governments across the globe have committed to achieving the Sustainable Development Goals by the year 2030, by putting in place systems that safeguard the well-being of all. Of note are Articles 3.1 and 3.2 (under Goal No.3), which seek to reduce global maternal mortality and end preventable deaths of newborns.

Over the period of Millennium Development Goals (MDGs), which preceded the SDGs, trends showed some improvements in maternal and child health. However, a lot remains to be done. In Kenya, the number of women who die of pregnancy related causes remain relatively high.

According to the 2014 Kenya Demographic and Health Survey, for every 1,000 live- births 362 mothers died. This is in comparison to 520 mothers for every 1,000 births within a similar survey period as recorded in the 2008 national survey.

On the other hand, child mortality showed more marked improvement and corresponding increase in uptake of key services such as child immunization, prevention of vertical transmission of HIV, and treatment of childhood illnesses. Like most of the North Eastern region of Kenya, Garissa County has been under-served by social services such as healthcare.

Issues such as inadequate staffing, poor infrastructure facilities (both in quantity and quality and sporadic insecurity, are among the factors



that have contributed to the low levels of health services utilization. In addition to these systemic challenges are individual and community social and cultural norms and values that compound the situation, such as female circumcision and early marriages.

With the advent of the devolved system of government in Kenya, there have been many investments in maternal and child health at different levels including the provision of free maternity care across the country, and the decentralization of primary healthcare for more focused and contextualized services.

Fig 1: Map of Kenya and Garissa County

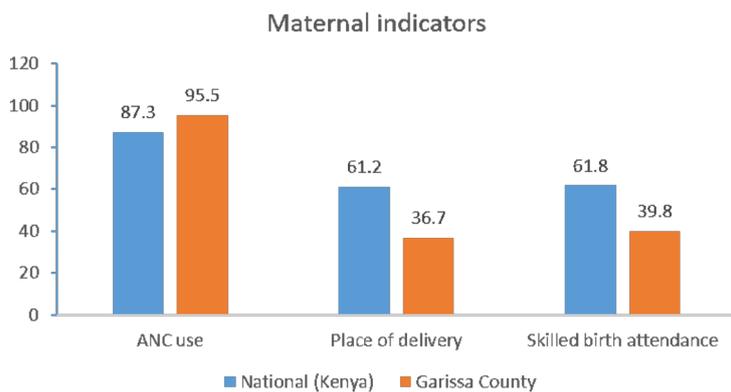


Source: Kenya Demographic Health Survey, 2014

The Afya Kwa Ukoo project was developed with the aim of tackling long-standing social and cultural barriers that prevent women from using maternal newborn and child health (MNCH) services through community mobilization and education (working with Community Health Volunteers); social change advocacy by local social influencers (Imams, clan leaders, male champions and youth leaders) and; bridging relationships between the community and local health service providers through fora such as the Maternal and Perinatal Death Surveillance and Response (MPDSR) committees.

In anticipation of the rise in demand, minor infrastructural upgrades were made and new equipment purchased for the two participating health facilities- Iftin and SIMAHO. Staff were also trained on culturally acceptable and sensitive services (CASS).

Figure 2: National and Garissa maternal health indicators¹



¹ Source: Kenya Demographic and Health Survey (2014)

Key findings

1) Most mothers are aware of the availability and make at least one antenatal care clinic (ANC) visit. Before the intervention, 91% reported making at least one ANC visit and at endline this stood at 93%.

2) Women often start attending ANC clinics later into their pregnancies. About 17% had their first ANC visit in their first trimester (at baseline) and 22% at endline. Very few pregnant women make all the four recommended ANC visits (Fig. 3).

3) Delivery in health facility increased by 25% in intervention site and 11% in control site. Overall increase attributable to intervention is 14%.

4) Skilled birth attendance (SBA) increased by 25% in intervention site and 12% in control site. Overall increase attributable to intervention is 13%.

5) Postnatal care use increased by 23% in intervention site and 13% in control site. Overall increase attributable to intervention is 10% (Fig. 4).

6) BCG immunization (tuberculosis vaccine) increased in both sites to almost 100% from 62% in the intervention and 45% in control site. Similarly DPT (diphtheria, whooping cough and tetanus vaccine) coverage increased from 49% to 81% in control site and 25% to 74% in control site. The change seems not related to the intervention as it happened in both sites.

7) Breastfeeding initiation in first one hour after delivery increased by 28% in intervention site and 5% decrease in the control site hence overall increase attributable to intervention is about 33%.

8) There was an increase of 14% in exclusive breastfeeding in intervention site and 4% increase in exclusive breastfeeding in intervention site and increase attributable to intervention of about 10%.

10) Overall- positive service user experience: 91% of women and 95% men at the intervention site perceived quality to be good or excellent compared to 67% and 75% respectively at the control site.

Figure 3: Place of delivery and skilled birth attendance

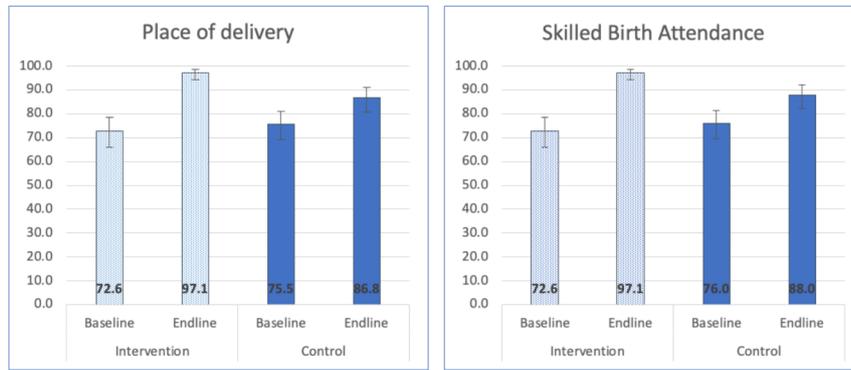


Figure 4: Post natal care use

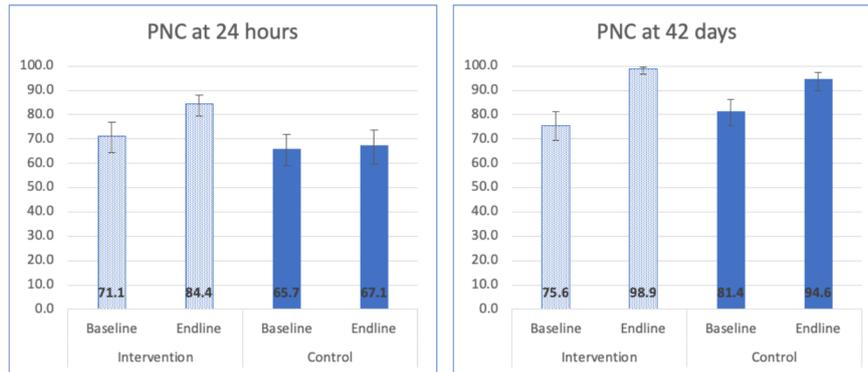


Figure 5: Breastfeeding initiation and exclusive breast feeding

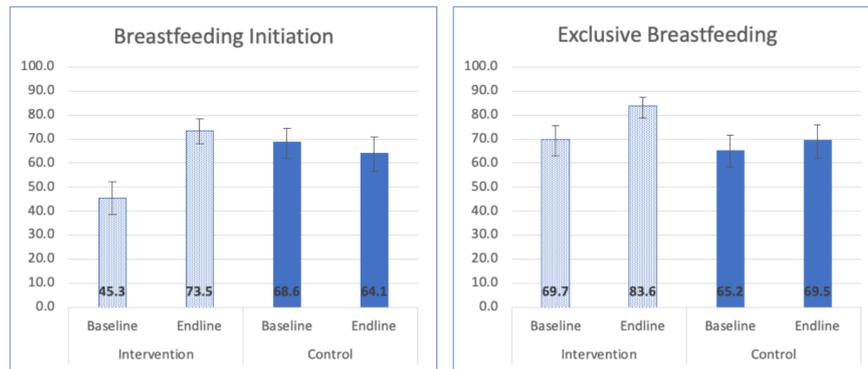


Photo: A group of women listening to the deliberations during a public meeting at Ifin Hospital, Garissa.

Cultural, social and contextual barriers to services

Barriers to accessing and using maternity and child health services, as reported by service users, community leaders and service providers, are many and some are deeply entrenched. These include:

a) **Gender of service provider**- Many women and men expressed disapproval with expectant women being attended to by male service providers based on cultural and religious norms. This is a concern the County has started addressing through Affirmative Action in the recruitment process, that is, more of the subsequent medical hires are female.

b) **Distance to health facilities**- While the study was carried out in a majorly peri-urban area, lack of transport especially in cases of emergencies was reported as a key issue.

c) **Poverty**- Poverty is rampant and for some a choice between seeking health and meeting basic needs has to be made. This is critical in a situation where means of production and income generating activities are dominated by males who have to give authority for expenses to be made.

d) **Lack of information on key health issues**- Basic information on health including prevention, health risks, and knowledge of places to access care is low especially among young women. This has a bearing on health care seeking.

e) **Poor attitude of service providers**- This is repeatedly been reported as a reason why women especially those in labor avoid going to mainstream health facilities and opt to be attended by traditional birth attendants.

f) **Cultural norms**- High fertility has a direct impact on maternal and child health outcomes. Uptake of modern contraceptive methods has been very slow in this region owing to traditional perspectives on family planning.

g) **Quality of maternity care**- The perceived quality of a health facility and the skill of personnel greatly affect decision of health care seeking. Availability of medicines, quality of services offered at facilities and the attitude of staff greatly impact acceptability and the use of these services by community members.

Call to Action

- **Defining and implementing Culturally Acceptable and Sensitive Services (CASS) for maternity and other healthcare services in Garissa.**

- Culturally sensitive services are those that take into consideration non-harmful norms and values, thereby making them socially unacceptable to the potential users.

Defining and delivering a culturally acceptable service entails knowing the issues that are important to the community with regard to a given service. Critical issues were identified, a training guide developed and culturally acceptable and sensitive services implemented in Garissa sub-County.

We recommend that the training on CASS be implemented as a norm whereby all providers are trained on cultural competence. Whenever possible, the County and private providers should deploy female service providers, with priority given to maternity units. CASS elements include:

i) Allow spouse /trusted associates including traditional birth attendants (TBAs) and CHVs to be present for the mother during labor and delivery.

ii) Allow other the mother labour and deliver in other safe positions.

iii) Allow traditional practices such as massages and accompanied walks.

iv) Accommodating traditional and religious rituals such as allowing the sheikh to make “dua” (prayer) for the mother during labor and after delivery.

v) Provide audio and visual privacy during labor and delivery.

vi) Make more familiar and comforting to mothers by for example incorporating local prints and materials in the decor of the delivery rooms.

vii) Advocate for more female health workers attend to mothers in labor and delivery, whenever possible.

viii) Train service providers on respect for clients/mothers. New staff, especially from other regions, need to be oriented on how to provide culturally acceptable and sensitive services as a way of ensuring quality of care. This will make health facility deliveries and Antenatal care clinics more appealing to the mothers (and their families), thereby increasing service uptake.

- **Quality assurance**

Perceived poor quality was mentioned severally as one of the reasons why mothers avoid using health services. This encompasses many factors such as hygiene of facilities, staff technical skills, equipment, emergency transport, privacy, and respect for clients.

- **Recognition of community health volunteers as an integral part of the health system**

Community Health Volunteers (CHVs) play a crucial role in the provision of care and support to under-served populations, particularly in areas experiencing acute human and financial resource challenges.

They provide health education and promotion as well as referral of those suspected to be in need of care. They are often trusted and know the people they serve including knowing critical events such as births and deaths. Their engagement and supervision has been adhoc and weak. To enable CHVs be more effective and efficient, there is need for a formal engagement and recognition of CHVs, training, involvement in community mobilization, and assessment of health-related issues in the community as well as supervision including regular reporting on their activities.

- **Create and maintain mutual community-service provider accountability**

The inter-linkages between the community (service users, TBA, male champions and CHVs), the health services providers and managers need to be strengthened for better mutual accountability. We noted responsiveness from the community through engagement with the social influencers and CHVs on one hand and service providers on the other through engagement with the MPDSR committees and Influencers' Forum. The County Health department needs to maintain and strengthen these inter-linkages.





APHRC Campus, Kitisuru

P.O. Box 10787-00100, Nairobi, Kenya

Tel: +254 20 4001000

Email: info@aphrc.org

Twitter: [@aphrc](https://twitter.com/aphrc)

www.aphrc.org