Pregnancy Support Groups 2019-2022 Kenya

TEAM MUM'S PREGNANT WOMEN'S GROUPS

End of project review

CHILD .ORG


Team mum
I'M IN
#Team
FYA YA MAMA, UBORA

REPORT SUMMARY

Our work in Meru, Kenya

Team Mum's Pregnant Women's Groups are designed to bring pregnant women together into groups to provide life-changing and life-saving information on how women can keep themselves and their babies safe during pregnancy, birth and beyond.

Pregnant Women's Groups have a strong evidence base behind them, but there are limited data to demonstrate effectiveness in Kenya. Across three years (2019-2022), Child.org worked closely with County and Sub-County health teams to deliver community-based pregnancy support groups and improve the quality of care for pregnant women in Igembe Central, Meru County, Kenya.

Working with 6,238 women across 827 groups, Child.org's Pregnant Women's Groups have sparked real improvements in life-saving behaviours and provided direct interventions in clinical care for at-risk pregnancies. The results speak for themselves (see to the right).

Team Mum exceeded our own expectations; in bridging the gap between communities and formal healthcare services, we also received fantastic feedback from the county government, and have been invited back to develop Pregnant Women's Groups and roll them out across the whole of the county.

Child.org's Team Mum Pregnant Women's Groups (PWGs) in Meru, Kenya, was our first ever UK Aid funded project.

Through a successful UK Aid Match Campaign in 2018, Child.org raised £502,952.10 from our partners and supporters. £260,540.95 was matched by the UK government to fund community-based pregnancy support groups (Pregnant Women's Groups).

This report contains a summary of the project successes and challenges along with our ambitious plans for the future.

Results

6,238 women attended groups

2,816 men engaged in our male partner sessions

2,655 pregnant women referred to facilities for further care

1 MILLION+ community members listened to our radio

"

benefitted a lot by joining the group; I learnt so many things such as recognising danger signs when pregnant, what to eat and the importance of safe, skilled deli very.

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Cherio Onacha
Programme Manager

Martina Gant CEO

Jacob Chege
Project Officer

Thomas Omoko
Project Field Supervisor

Faith Ngatha
Project Support Assistant

KEY SUCCESSES

The numbers

6,238 women attended our pregnancy support groups (9% above our 5,700 target)

2,816 men engaged in our male partner sessions (33.5% above our 2,109 target)

of Pregnant Women's Groups

86.5% newborns received safe umbilical cord care thereby re ducing the risk of infection; a 70% increase from our baseline survey

1,478 men demonstrated supportive behaviours during their partner's pregnancy

65.5% of women could identify five out of 7 of the danger signs during pregnancy, up from 17.4% at baseline

2,655 women referred to a health facility

The success of the programme is further reinforced by data from the District Health Information System (DHIS)1. Between the dates the programme was delivered (2019-2022), the following changes were noted by the Ministry of Health in Meru:

Deliveries conducted by skilled birth attendents in Meru County dropped from 78.9% to 69.9%. However, in Igembe Central this **increased from 67% to 79.4%.** This was the only sub-county in Meru to see an increase between 2019 and 2022.

76.4% of women in Meru county attended at least one antenatal care session in 2022, compared to 93.5% in Igembe Central

24.8% of women in Igembe Central attended four antenatal sessions, up from 19.1%.

What are Pregnant Women's Groups?

Pregnant women's groups (PWGs) have emerged as a popular and effective approach for improving maternal and neonatal health outcomes in low- and middle-income countries. PWGs are community-based interventions that bring pregnant women together in regular meetings to share experiences, knowledge, and to support each other.

Women are invited to attend six sessions that cover topics including: your body during pregnancy, maternal nutrition, the importance of antenatal and postnatal care, what to expect during delivery and caring for your newborn.

Ideally groups meet at local clinics so that women can also access antenatal care services but where communities are remote, this is not always possible.

The participants are also encouraged to support one another after the sessions have ended. In some cases we saw women's groups changing function and becoming 'chamas' - groups where women support one another financially by providing loans to members.

HEALTH CLINICS

We provide training, improve referral processes and identify small but impactful quality of care improvements (like providing curtains to make sure labouring women have privacy).

CHV SUPPORT

We work with health workers and provide training and tools on caring for mothers during pregnancy, birth and in the early days of parenthood. We facilitate shared learning and peer to peer exchange.

MALE PARTNERS

We host male partner sessions, train and support Gender Champions and lead community dialogues.

INCENTIVES FOR MUMS

We provided milk and bread for mums at every session, plus a 'Baby Pack' on completion of all six sessions, including a baby hat, weighing bag, reusable nappies and a Team Mum leso (shawl).

WHAT'S A CHV?

Community Health Volunteers (CHVs) are community-based health workers who in Kenya are unpaid and 'unskilled' (in the sense that they are unlikely to have had any formal health worker training). CHVs are really important because they bridge the gap between the community and health services. They are an under-utilised resource - often they are well respected community members and command authority over other community members - people listen to them! They are organised by Community Health Assistants (CHAs) who are trained and paid by government.

WHY INVOLVE MEN ON A PROJECT ABOUT PREGNANT WOMEN?

Whilst it may seem obvious to include men on a project about pregnant women and newborn babies, it's not actually a common activity in this region. Pregnancy is seen as 'women's business' meaning many men are reluctant to engage with the subject, despite being key-decision makers in topics such as medical expenses. Many projects have tried and failed to engage men effectively but we have demonstrated that it can be done!

WHAT IS ANC IN HEALTH CLINICS?

Antenatal Care (ANC) is the care that a woman receives while pregnant. In Kenya ANC should be free for pregnant women (along with delivery and postnatal services), but the reality is that many clinics are under resourced because of various challenges within the health system. This means that many clinics need to charge for services like routine checks and laboratory tests to be able to pay their staff. Sometimes services that should be available cannot be provided, meaning women have to travel long distances to access the healthcare they need during pregnancy.

WHY DID WE GIVE INCENTIVES TO MUMS?

Baby packs were included in Team Mum because pregnant women's groups were a new concept for women in Igembe Central. By offering incentives, women were more likely to participate in the groups at the start, until the value of the groups was established. By the end of this project, we had stopped offering incentives and women kept joining, so future projects may not include incentives.

Delivery

At its core, Team Mum is a project about disseminating vital information to pregnant women who might not otherwise have access to it, allowing women to understand what's happening to their bodies, what's normal and what isn't. The project is designed to encourage women to seek the care they are entitled to, and to help them identify when they might need additional support.

However, improving women's knowledge and understanding of pregnancy and birth is not enough to see changes happen within a community. To ensure women and babies are better supported, they need more support within the home, and access to quality and consistent health care.

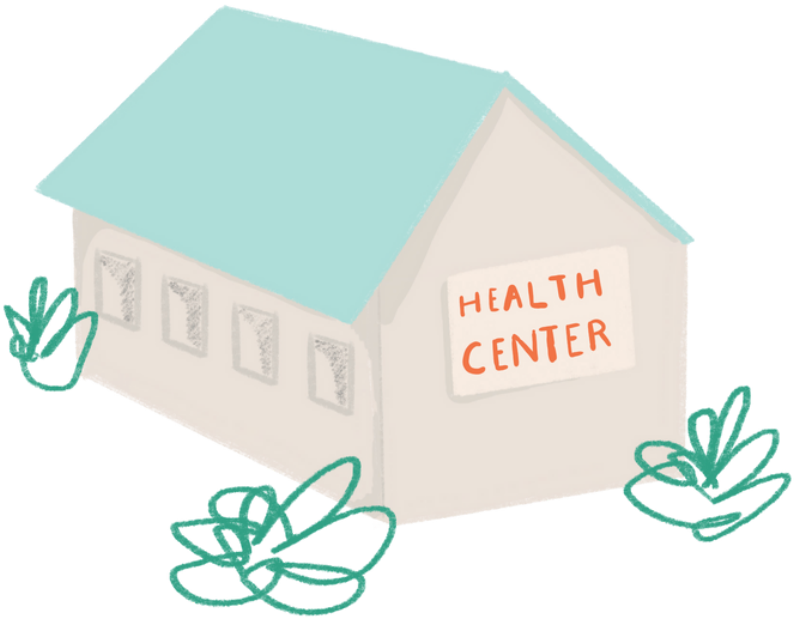
Team Mum works towards improving support through three core strategies:

1 Individual: Improve women's knowledge about their bodies and encourage them to seek care.

2 **Quality of care: Improve the** consistency & quality of care by improving service delivery of ante-natal, delivery and postnatal care.

3 Community: To strengthen support for pregnant women within the community and within the home by working with male partners.

A continuum of care approach means the holistic needs of a pregnant woman are more likely to be met. She is more likely to seek care because she knows when she needs it and what should be available; she is more likely to get better care when she seeks it; and she's more likely to have support and the resources she needs, including financial, physical and emotional support within the community.




Team
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The Goal

“5700 women and their babies in Meru are safer and better supported during pregnancy, delivery and early infancy”

To measure our progress against this outcome, we used three key indicators:

1 Percentage of newborns receiving cord care that minimises risk of umbilical infection

This indicator was designed to measure the behaviour change behind a practice that can lead to poor health outcomes for newborns. Neonatal sepsis is the cause of 29.3% of neonatal deaths in Kenya. One of the causes of sepsis is poor management of the umbilical cord stump. In many parts of Kenya, traditional practices can lead to parents putting water (which can be unclean), ash, or even dung on their baby’s stump which can lead to infection.

In our baseline survey 16.6% of parents were practising safe cord care (following WHO guidelines of doing nothing to the cord stump or putting on chlorhexidine as prescribed by a health worker).

In our endline survey, 86.5% of parents reported practising safe cord care: an increase of 69.9% among parents participating on the project.

Throughout the project we tracked progress against this indicator and in year two noticed a reduction in safe cord care practices. We could then track where respondents were receiving incorrect information.

Team Mum saw a need and worked with the Sub-County Health Management Team to deliver training to health workers in that clinic on cord care. This filtered down to the community and contributed to the success on this indicator, potentially saving babies lives on this project and for years to come.

2Number of women who attend one antenatal care clinic during their first four months of pregnancy

In Kenya only 58% of women attend the WHO recommended four antenatal care (ANC) clinics. Early ANC visits mean pregnant women are more likely to attend further ANC appointments throughout their pregnancy, and issues can be identified much earlier. Therefore, Team Mum aimed not only to increase the number of care visits women received, but also to encourage women to seek care earlier.

Our target for this indicator was 25% of participants going for ANC within the first four months of their pregnancy. By the end of the project, 65.5% of women were seeking early care.

We also saw changes to women's understanding of how many visits they should be attending. 57.6% of women at baseline knew they were advised to attend four or more ANC clinics in the course of their pregnancy. This increased to 78% at the endline.

65.5%

of women went for ANC within the first four months of their pregnancy

1,478

men demonstrated at least three out of five supportive behaviours

3Number of male partners that demonstrate three or more out of five supportive behaviours

We recognise that male partners play an important supporting role during pregnancy; to improve support for pregnant women we identified five 'supportive behaviours' (detailed on p. 20) and asked pregnant women how many of the behaviours their partners demonstrated. We had a target of 1,476 men demonstrating at least three out of five supportive behaviours, as reported by women. We hit the target, with 1,478 men demonstrating three of five behaviours, but faced real challenges in reaching this indicator. See p. 24-25 for details on the challenges we faced in engaging male partners.

MEET MERCY

Mercy has five children but she only joined Child.org's Pregnant Women's Groups during her last pregnancy.

The practical advice she learnt helped to save her life.

"Before I did not plan what I was going to do around birth, but this time I planned everything: I brought some food, I saved some money for transport, and I had also identified a vehicle that would take me to hospital." However, Mercy's baby came early and she had to give birth at home.

"I had prepared everything through, and this was so important because imediately after delivering, I was taken to hospital. I lost a lot of blood and my haemoglobin levels had gone down. I had to have a transfusion quickly. If I didn't go to hospital I probably would have died. Thanks to Child.org and Team Mum I knew the importance of going to hospital."

“

If I didn’t go to hospital I probably would have died. Thanks to Child.org and Team Mum I knew the importance of going to hospital

Mercy, mum of five

Activities

We organised Team Mum's project activities under three key outputs:

15700 pregnant women from Meru are connected & have knowledge to protect maternal and neonatal health & recognise when care is required

Activities for this output included running pregnant women's groups and developing tools and training Community Health Volunteers (CHVs) to facilitate sessions.

Our target was to work with 5700 pregnant women in groups over three years. Despite delays at the start of the project and the barriers that the COVID-19 pandemic posed, we exceeded that target and worked with 6,238 pregnant women in 827 different groups.

To understand the impact of Team Mum, we surveyed women about their knowledge of the sessions, with a particular focus on the core danger signs during pregnancy: vaginal bleeding, no foetal movement, fever, severe abdominal pain, severe headache, paleness and convulsion. We obtained baseline data, then followed up with participants in exit surveys so that we could monitor the change in knowledge after participation in the groups.

In our baseline, 17.4% of women surveyed could identify five danger signs. By the end of the project, that figure had risen to 65.5% exceeding our target of 60%. By providing women with the knowledge of what danger signs look like in pregnancy, we increased the likelihood of women being able to identify when their health or the health of their baby's is at risk. This then increased the potential for women seeking care much earlier than they otherwise would have.

Handbook & Facilitation Guide

We developed our PWG Handbook and Facilitation Guide using the Government of Kenya's Community Health training materials. They combine core messages as identified by the Kenyan Government along with evidence-based information, visual references and suggested activities to facilitate running sessions and learning. We then trained Community Health Workers on the content and how to facilitate group sessions.

2Sustainable community processes and capaci

Team Mum works within, and is reliant We held 25 community dialogues and
on, community health structures. We engaged 30 established women's group
recognised there were weaknesses leaders to refer women to the project.
within that structure in Igembe Central. This brought our total community
We therefore developed ways to stakeholder reach to 211, exceeding our
strengthen the capacity of Community target by 31%. Community dialogues
Health Workers, and improve links were an integral part of Team Mum; they
between communities and clinics.created awareness of issues faced by
We engaged community leaders (Chiefs women during pregnancy while creating
and Assistant Chiefs), health workers a platform to find local solutions to
(Community Health Volunteers and health some of the challenges. They improved
facility staff) and government staff (from communication pathways between
the County and Sub-County Ministry women, the community and Sub-County
of Health), who participated in training, and County health structures.
sensitisation and community events.

> We held 25 community dialogue sessions,
> engaged 30 women's group leaders and 211
> community stakeholders in total

The project also aimed to improve referral pathways by strengthening the process for Community Health Volunteers (CHVs) to refer women to a health facility to receive further care. Initially, we had planned to create our own referral tool but the team soon realised that an existing government tool, the MOH100 form, would work effectively. However, this tool was not readily available due to government blockages so we printed and provided this tool to each CHV.

Women who needed antenatal care (ANC) were referred for routine appointments and women experiencing danger signs in their pregnancy, such as bleeding or reduced foetal movement, were also referred to further care.

We had aimed to see at least 560 referrals through the Team Mum project, but by the end of year three our numbers were substantially higher: 2,655 pregnant women were referred using the MOH100 tool to further care, where they were seen by a health worker at a government clinic. These figures don't include women who chose to visit private clinics, rather than public clinics, and therefore the total number of women prompted to seek care as a result of attending Team Mum's Pregnant Women's Groups is likely to be even higher.

We expected 560 ANC referrals and by the end of Team Mum saw

2,655

32,109 male partners of pregnant women part

and support for pregnant women within the family

In this region of Kenya, pregnancy is seen as 'women's business' and male partners (husband/boyfriends) are rarely involved in activities to support their pregnant partners. To encourage active participation in the pregnancy of their child(ren), we engaged with male partners separately in 'male partner sessions'.

Initially, we were also encouraging partners to be present at the birth of their child, but upon discussions with pregnant women it was clear that women did not want men to accompany them during delivery, so emphasis was shifted to get to clinics and pay for any costs associated with the birth.

The purpose of the groups was to dispel myths around pregnancy and to encourage 'supportive behaviours'. These behaviours included encouraging male partners to attend at least one antenatal care (ANC) session, supporting their partners in attending multiple ANC sessions and emphasising the importance of regular visits, saving money for the birth, organising transport to the hospital and allowing time for recovery postpartum by helping with chores and childcare (or arranging others to support).

"We've seen really positive changes since engaging male partners; the Pregnant Women's Groups have reported back that men are now fully engaged in supporting their pregnant partners.

Isaiah, CHA

Along with the male partner sessions, the project identified 'Gender Champions'. These were men who recognised the discriminatory cultural norms that existed in the community and had the drive to cause change. We used these men as agents of change to reinforce messages around support for women during pregnancy and early days after delivery.

We also collaborated with the County and Sub-County Health Promotion Teams, introducing TV and radio sessions as additional messaging channels to promote male involvement in maternal and child health. The sessions enabled the project to indirectly reach over one million people in the project's wider area of work (across the whole of Meru County). The radio and TV sessions increased awareness of the project and disseminated our key messages on male involvement in maternal and child health.

This activity got off to a slow start (see pages 24-25 for details) but by the end of year three 2,816 men had participated in sessions, which was 34% above our target. To assess the value of these sessions and the impact they had on supportive behaviours, we surveyed male partners pre- and post-sessions and asked for their opinions on their role and the types of supportive behaviours we encourage. At baseline, 77.9% of the men agreed that it was their responsibility to support their partner by accompanying them to ANC clinics, by the endline this had increased to 90%.

2,816 men participated in male partner engagment sessions; **34%** above target

KEY AREAS OF LEARNING

As with all projects, we faced challenges and learning opportunities throughout the implementation of Team Mum's Pregnant Women Groups (PWGs). Working through these challenges helped shape Team Mum and our learnings have made us, and the Team Mum methodology, stronger.

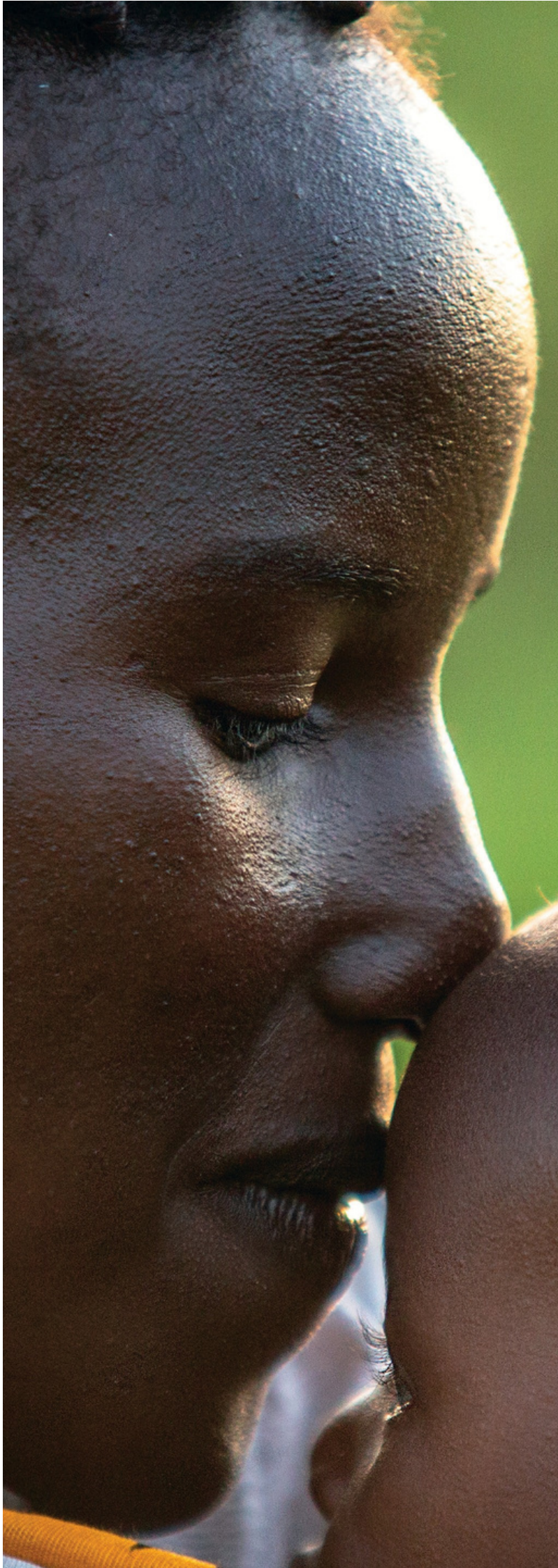
Delivery partners

The first challenge was that our initial delivery partner could not work to the requirements of the donor and it was agreed mutually to terminate the partnership. Whilst this was disappointing, we saw an opportunity to deliver Team Mum directly. We took over the management of the team that we had helped recruit originally and the Sub-County Health Management Team offered us office space at the principal health facility in Igembe Central, Kangeta Clinic. This meant we had a physical presence within the Ministry of Health (MoH) facility and were able to work closely with Sub-County Health Management.

The COVID-19 pandemic

We started the rollout of Team Mum in September 2019 and started forming groups at the start of 2020. Almost as soon as the team got into the swing of delivering PWGs, COVID-19 restrictions meant that groups could not get together.

The team adjusted quickly and looked into alternative opportunities for meeting pregnant women. We trained our Community Health Volunteers (CHVs) on COVID-safe practices like sanitation and social distancing, and facilitated community-based visits where they advocated on the importance of keeping up with clinical visits and antenatal care appointments in pregnancy.



We provided PPE to CHVs and health workers and advocated nationally and internationally for COVID-19 restrictions to exempt pregnant women.

During this period we quickly pivoted to working with an SMS platform called Mama Tips which shared antenatal care information, similar to what we were sharing through groups, to expectant mothers via text messages. The platform provided women with important information and allowed them to ask questions in response.

This approach was well received but did not have the same reach as in-person contact, particularly in the more rural regions. As soon as restrictions eased, in-person activities resumed with social distancing measures in place.

Asha - CHV in Kwale

Male partner involvement

A key element of Team Mum was to encourage male participation in pregnancy by working with male partners and encouraging supportive behaviours. We had several engagement strategies, including group sessions, using Gender Champions as agents of change, community outreach sessions and media campaigns on TV and radio.

Our first year was extremely slow; only 16 men participated in sessions. This was partly due to the pandemic where our priority focused on ensuring we were still engaging pregnant women. Despite this, we found that men were reluctant to participate in sessions if it interrupted paid employment, and this was compounded by cultural shame associated with admitting that their partners were pregnant.

Pregnancy in the community is seen as a private woman's affair; for a man to talk about their pregnant partner in public was perceived as a sign of weakness. This caused us to rethink our approach and adapt our activity; we started meeting men at their places of work and recreational spaces like sports grounds.

We worked closely with community influencers like religious leaders, chiefs and the council of elders who helped us in both the mobilisation process and sensitisation.

We also learned that there was resistance from men to accompany their partners to ANC and delivery because community infrastructure was not supportive of male involvement: men were not allowed in examination and delivery rooms. To navigate this, we held advocacy meetings with the County and Sub-County Health Management Teams (SCHMT) to advocate for improvements to the health facility environment that would increase men's confidence to go to health facilities.

As a result, the Ministry of Health introduced several initiatives to facilitate male partner involvement, such as making health workers aware of the importance of male participation in pregnancy or allowing men into examination rooms. The SCHMT also created more space in the main health facility where men could sit as they waited for their partners.

Meru County, and Igembe Central, is a heavily patriarchal region, and we saw a pushback within the community against investment into women's needs. The Gender Champions introduced us to a group called MAWE (Men Against Women Empowerment) whose main agenda was to disempower the women in their lives and their community in every way possible by ensuring women did not grow economically and that men retained full control of their wives'/ partners' finances. MAWE sees women empowerment as a threat to the authoritative position men hold in the community but through engagement and sensitisation meetings we were able to work with them, and in turn they helped us mobilise men to take part in male partner sessions.

We also broadened our messaging to include gender issues that have long-term implications on maternal health such as gender based violence, female genital mutilation and family planning.

MEET IMA & DERIC

Ima and her partner Deric have two children. During her first pregnancy, Ima did not receive a lot of support from Deric: "My first pregnancy was difficult. I worked hard to go to antenatal clinics on my own but I wasn't being supported enough by my husband. This is often the case for other women in my community: we lack basic needs and support so we can't go to antenatal clinics. It's also hard for us because here in Igembe, women are forced to participate in laborious tasks like working on the farms even when we're pregnant."

Ima joined a Team Mum pregnancy support group for her second pregnancy. "What was most important for me was learning about danger signs. Many women in my community lose their lives, and those of their unborn babies, because they don't recognise danger signs."

Ima would tell Deric about what she learnt at the sessions which, alongside Team Mum's male partner engagement work, helped Deric become a more supportive partner: "I learnt about the importance of remembering Ima's clinic dates, what a healthy diet looks like for a pregnant woman and also that it is not safe for pregnant women to do strenuous jobs like working on the farm."

"Most pregnant women in this community lack moral support from their partners. Men won't walk with their pregnant partner in public and even refuse to admit that the unborn child is theirs. I had to work harder and take on more responsibility after learning from Team Mum, but now I help Ima take care of our baby and I am happy to be a supportive husband and father because this baby is a blessing for me and my family."

> "I had to work harder and take on more responsibility after learning from Team Mum
>
> **Deric, father of two**

COST

This project was funded in most part by the UK Government through UK Aid Match Funding. In early 2019, Child.org conducted our largest ever campaign, with a target of £150,000. Thanks to our supporters and partners, we exceeded that target raising a total of £260,540. The UK Government matched the money raised, enabling Team Mum to be launched in August 2019.

Many thanks to the UK Government, our supporters and partners for this support for this project.

Matching your donations with UKaid

Total cost of the project: £294,948.32

Total UK Aid Match spend: £260,540.95

Total Child.org spend: £34,407.37

Total cost per woman: £47.28

Staff (including CHVs): £23.12

Training materials & baby packs*: £12.46

Admin & overheads: £5.89

Learning & research: £5.81

*see p. 30 for more information about baby packs.

Total cost of activities: £294,948.32

Staff costs: £144,191.33

Includes all operational and management staff contributions, including full time Project Officers and Field Supervisors plus CHV contributions. Part time contributions for Programmes Manager, Technical Advisor, CEO, Finance and M&E support

Project activities: £77,714.54

Includes training materials, baby packs, Mama Tips platform, all set up meetings and CHV training, quality of care improvements at health facilities, male partner sessions, community dialogues

Monitoring, evaluation and learning: £36,263.72

Includes baseline survey, project & quarterly monitoring reviews, travel to Meru, international travel

Administration: £27,892.96

Includes overheads in Kenya and UK, office expenses, t-shirts and bags for CHVs, stationary

Capital expenditure: £8,885.77

Includes motorbikes. laptops, camera, printer

Baby packs

We included baby packs as an incentive to join Team Mum because Pregnant Women's Groups were a new concept for women in Igembe Central. By offering incentives, women were more likely to participate in groups. Packs included:

- Milk and bread for mums at every session
- A leso (used for carrying babies and wrapping mums)
- A baby hat & reusable nappies
- Weighing bags (to weigh babies at check ups)

We had budgeted for 5,700 baby packs (based on our target participation). Once we'd reached this target, we had to stop providing incentives but by this point, in the project's final year, the value of the groups was established and a further 538 women joined groups without incentivisation.

The packs were the least sustainable element of the project and scale-up plans do not include provision of these items, apart from in regions of food insecurity where we hope to be able to provide nutritional support to women vulnerable to maternal malnutrition.

WHY PREGNANT WOMEN'S GROUPS?

"Women's groups practising participatory learning and action led to substantial reductions in neonatal and maternal mortalities in rural, low-resource settings."2

Pregnant women's groups (PWGs) are proven to have a positive impact on maternal and neonatal health, as evidenced by studies in Nepal, Bolivia and Malawi. Our PWG project is the first of its kind in Meru County and the results we have seen reinforce the potential for participatory antenatal care (ANC) as part of maternal and neonatal health strategies.

Participatory learning PWGs are a cost effective2 and impactful strategy to decrease neonatal and maternal mortality in low-resource settings3. In multiple contexts, participatory learning groups led to significant increases in the uptake of ANC services and increases in deliveries in clinical settings, as well as having positive impacts on healthy behaviours like improved sanitation and breastfeeding practices2,3.

Where food has been provided alongside these groups, like in our project, average birth weights of babies born to the participants have been significantly higher than of babies born to women not provided with food4. Babies born with low birth weight are about 20 times more likely to die than heavier babies5.

Since the start of our project, other studies have looked at the potential of group ANC in Kenya with positive results on ANC attendance rates, and for strengthened social support for pregnant women in Kenya6,7,8.

Group ANC differs from PWGs in that it brings women together with trained healthcare workers, for sessions that will cover clinical checks as well as provide information. PWGs are led by 'untrained' (in the sense that they are not given clinical training) Community Health Workers who run participatory sessions, and refer women to clinics for personalised ANC consultations.

When Team Mum launched in Igembe Central, the national recommendation for ANC was at least four consultations with a trained healthcare professional during pregnancy. In Kenya, only 66% of women are achieving this target9 and it's even lower in rural locations. At the start of Team Mum, 19.1% of women in Igembe Central attended four ANC clinics - by the end this rose to 24.8%1. In 2022, the national recommendation for ANC visits rose from four to eight, despite many regions struggling to reach the lower target.

Both group ANC and PWG approaches have great potential to improve maternal and neonatal health outcomes in Kenya, and to increase uptake for ANC services. However, the health system has critical weaknesses that compromise the quality and availability of trained healthcare workers and the quality of care available. By strengthening community health systems and supporting Community Health Volunteers through training and the provision of teaching tools, there is an opportunity to relieve some of the burden on trained health workers.

MEET DORIS

Doris is a Community Health Volunteer (CHV) in Igembe East Ward, Kenya. Doris is passionate about supporting women from Meru through their pregnancy journey.

"At first it was hard trying to mobilize pregnant women in this community. However, we had faith and approached each conversation with understanding, support and respect. This meant that the women we worked with respected us back and listened to what we had to say."

When Doris started working with Team Mum, she found that local pregnant women were experiencing many challenges, such as limited financial and emotional support from their male partners and a lack of awareness about how to look after themselves during pregnancy. Many women were not attending enough antenatal care clinics which put themselves and their babies at risk, as they would continue to drink alcohol or deliver their babies at home without a skilled birth attendant present.

Doris and other CHVs were able to tackle some of these challenges by working with Team Mum's pregnancy support groups.

Doris remembers one particular success story about a pregnant woman who experienced vaginal bleeding. Her mother had told her that it was a normal part of pregnancy but the CHVs advised the woman to go to hospital and she told the doctor how she had learnt that vaginal bleeding was a danger sign. She went on to deliver a healthy baby.

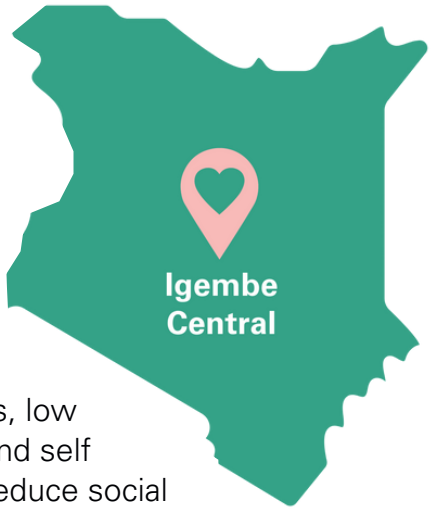
Doris is proud to be a CHV working with Team Mum to support women in her community. "I would like to thank all Team Mum staff for supporting us here in Igembe Central. I learnt so much and I will continue helping others because I love this work. Whatever happens with Team Mum in the future, we will continue working with and supporting women in this way."

Doris (CHV) & Meeme (CHV)

WHY IGEMBE CENTRAL IN MERU?

We delivered Pregnant Women's Groups in Igembe Central, a rural and remote sub-county of Meru County in Kenya. Igembe Central was selected as the project location because whilst Meru had been performing relatively well in terms of maternal and neonatal health indicators prior to the project launch, Igembe Central did not reflect any positive gains. In 2022, 66% of pregnant women in Kenya were achieving the target of four ANC visits9. In Meru in the same year, only 45% of women were achieving the four visits9. Our baseline indicated that in Igembe Central, only 21%of women were achieving the recommended number of four care visits with a qualified health worker10.

The status of women in the region is low, with little say in the control of local resources and little personal agency in issues such as their own healthcare seeking or that of their children. Traditional practices and damaging social gender norms are prevalent. 31% of adolescent girls in Meru have undergone Female Genital Mutilation (FGM)11, bringing additional risks in delivery. Early marriage remains normalised and is synonymous with early conceptions, reflected in the 42% of pregnancies in the sub-county being to adolescent women and girls.



Entrenched patriarchal social structures, low gender status and self determination reduce social connectivity and support, particularly for young women, hindering women's mental and physical health whilst increasing avoidable risks during pregnancy and childbirth.

WHO IS CHILD.ORG

Child.org is a data-driven charity working to champion perinatal health in Kenya, where neonatal mortality rates have barely changed in the last five years. We work with parents, communities and government in Kenya to provide life-saving antenatal and postnatal health information, connect at-risk mums and babies with the healthcare services they need and work with local health authorities to advocate for and improve the quality of perinatal care.

Child.org International Kenya, Child.org's registered Kenyan Entity delivered this project. Child.org Kenya operated as a local delivery partner and a team, working directly for Child.org, was recruited and positioned in Igembe Central.

The local Ministry of Health (MoH) kindly provided office space for the team at Kangeta Health Facility, one of the key project sites, meaning the team had a physical presence with MoH teams and a close working relationship was facilitated.

WHAT'S NEXT?

We have big ambitions for this project. We are already scaling Team Mum to cover the whole of Meru County and then we plan to develop Team Mum further, across the whole of Kenya.

We have proved that the Pregnant Women's Groups (PWGs) approach works in improving maternal health outcomes. However, to achieve the scale we're aiming for we need to adapt the way we deliver PWGs and teach county and sub-county health teams to manage the delivery of PWGs themselves. The new project design is taking a more sustainable, affordable approach. To keep costs low, we are removing incentives such as baby packs and instead focusing on training health teams, providing more training materials and providing mentorship and support for community health teams.

The ambition:

- In 2023 we are scaling from one sub-county in Meru to all 11 sub-counties, where we intend to reach 20,000 women in groups by the end of 2024.
- We also intend to roll out to a new county in Kenya, ideally Narok county, where 70.1% of births are attended by a skilled birth attendant (compared to a national average of 89.3%), and 55.3% of pregnant women attend four antental care sessions (compared to a national average of 66%)9.
- By the end of 2023 we will have scoped a new third county, in an arid or semi-arid region of Kenya, where pregnant women are particularly vulnerable to food insecurity during droughts like the one being experienced in East Africa this year.

Why is Team Mum the right project?

PWGs increase women's attendance to life changing and life saving antenatal care. Kenya recently increased the recommended number of ANC appointments for pregnant women from four to eight care visits. Given that many counties are struggling to reach the previous target of four sessions, a new approach is needed. These group sessions will fill that gap and allow women to attend many more sessions, thereby increasing their access to trained health workers.

What you can do

If you are interested in helping to achieve the ambitions we've highlighted above, we want to talk to you! We are always open to collaborating with government bodies, delivery partners and academic institutions to improve the impact and reach of our work.

We also need to fund the scale up! If you or someone you know might be interested in helping us to reach more women and to improve the chances of healthy babies and mothers, please get in touch.

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WITH THANKS TO

Thanks to the FCDO UK Aid Match fund for making Team Mum possible and to our Grant Managers at Manion-Daniels for their continued support. Thanks to all of our wonderful supporters and Team Mum partners who helped us to raise well over our original target.

Thank you for every contribution, from your hard earned money to every like and share during and after the campaign.

Thanks to the Child.org team that looked very different at the start of Team Mum, who helped us to design and shape this project.

Thanks to Emma Douglas at Awakening Creative Co. for her excellent illustrations in this report and in our training tools.

REFERENCES

[1]

[2]Kenyan District Health Information System, 2022.

Prost, A., Colbourn, T., Seward, N., Azad, K. et al. Women's groups practising participatory learning and action to improve maternal and newborn health in low-resource settings: a systematic review and meta-analysis. The Lancet, 2013;381(9879):1736-1746.

[3]

Fottrell, E., Azad, K., Kuddus, A. et al. The effect of increased coverage of participatory women's groups on neonatal mortality in Bangladesh: a cluster randomized trial. JAMA Pediatrics, 2013;167(9):816-825.

[4]

Saville, N., Shrestha, B., Style, S. et al. Impact on birth weight and child growth of Participatory Learning and Action women's groups with and without transfers of food or cash during pregnancy: findings of the low birth weight South Asia cluster-randomised controlled trial (LBWSAT) in Nepal. PLoS One, 2018;13(5):1-29:e0194064. Accessed April 14, 2023. https://doi.org/10.1371/journal.pone.0194064.

[5]

Nutrition Landscape Information System (NLiS) Nutrition Landscape Information System (NLiS) country profile indicators: interpretation guide. World Health Organisation, 2019;2.

[6]

Grenier, L., Onguti, B., Whiting-Collins, L. et al. Transforming women's and providers' experience of care for improved outcomes: A theory of change for group antenatal care in Kenya and Nigeria. PloS One, 2022;17(5):e0265174. Accessed April 14, 2023. https://doi.org/10.1371/journal.pone.0265174

[7]

Grenier, L., Suhowatsky, S., Kabue, M. et al. Impact of group antenatal care (G-ANC) versus individual antenatal care (ANC) on quality of care, ANC attendance and facility-based delivery: A pragmatic cluster-randomized controlled trial in Kenya and Nigeria. PloS One, 2019;14(10): e0222177. Accessed April 14, 2023. https://doi.org/10.1371/journal.pone.0222177.

[8]

Somji, A., Ramsey, K., Dryer, S. et al. "Taking care of your pregnancy": a mixed-methods study of group antenatal care in Kakamega County, Kenya. BMC Health Services Research, 2022;22(969). Accessed April 14, 2023. https://doi.org/10.1186/s12913-022-08200-1.

[9]

Kenya National Bureau of Statistics, Kenya Ministry of Health & The DHS Program, ICF. Demographic and Health Survey 2022: Key Indicators Report. Kenya National Bureau of Statistics, 2023. Accessed April 14, 2023. https://dhsprogram.com/pubs/pdf/PR143/PR143.pdf

[10]

End-line evaluation report on the impact of the pregnant women's group project in Igembe *Central, in Kenya. Smart Health Equas Consultants Limited Company; 2022.*

[11]

United Nations Children's Fund. A Profile of Female Genital Mutilation in Kenya. UNICEF; 2020.

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.ORG