MOH Best Practices Validation Visit to Garissa County on 31st May 2016

MOH Visiting Team Members

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County Team Interviewed

1. Dr. Farah Amin - County Director of Health
2. Mr. Shale Abdi- Head of Division of Policy, Planning, Monitoring and Evaluation
3. Ms Habon G. Abdi – Head Division of Family Health Services
4. Dr. Hussein Iman - Medical Superintendent Iftin Sub County Hospital
5. Ms. Purity Mwembia –Nurse in Charge Nanighi Community Unit
6. Ms Irene Kilonzo Nurse in Charge Kamuthe Community Unit
7. Lucy Wamutere - Nursing Staff Kamuthe Community Unit

Introduction

Strengthening service delivery is crucial to the achievement of the health-related Sustainable Development Goals (SDGs)- 3.1 targeting a reduction of maternal mortality to 70/100,000 births by 2030. Strengthened service delivery includes the delivery of interventions to reduce maternal mortality among others. Maternal mortality is one of the indicators of reproductive health status of the population. Efforts to reduce maternal deaths have for decades been a focal point of international agreements and a priority for women's rights and health groups throughout the world.

Garissa county's landscape is mostly arid - desert terrain, with inhabitants being mainly nomads. The county is ranked among the top 15 counties with high maternal mortality ratios. This could be attributed to their nomadic culture making access to health facilities a challenge. Most mothers deliver at home by the assistance of traditional birth attendants. Over the years, maternal mortality has remained high, while the skilled deliveries have been on a constant low.

Best Practices

The county decided to look for ways of bringing the mothers to the facility in order to increase utilization, thus reduce maternal mortality. Three facilities were visited: Nanighi

Community Unit, Iftin Sub County Hospital and Kamuthe Community Unit. Several strategies were put in place:

Introduction of the MAMA Kit which is a kit that contains the basic essentials post-delivery, funded by free maternity funds.

Other Best practices were

1. Maternal shelters at locations close to the health facilities, to host pregnant mothers from far, who are close to delivering to enable them access health services easily. This acts as a home away from home.
2. Whatsapp messaging which connects the facilities to the county team in case of stock outs and need for referral.
3. Incentivizing *(Gacan maris)* the traditional birth attendants with KSh. 200 for every mother they bring in to deliver. These TBAs are allowed to be there during delivery of the mother for moral support, and in some occasions, allowed to deliver the mother in the facility together with the skilled worker.
4. Incorporating RMNCH with CRVS by providing mothers who deliver at a health facility with birth certificates for their babies after completion of the measles vaccination.
5. Incentivising the community health extension workers with KSh. 200 for every woman they bring to the facility. These CHEWs are assigned to 20 households each, whom they know very well thus are able to tell when one of them is pregnant, sick etc. The CHEWs are connected to the chiefs, who provide security during referral.
6. Tickler boxes to track defaulters of immunization. These are boxes with 12 slots each representing a month of the year. Once a baby is vaccinated, their card is put into the tickler slot of the month of the next vaccination. This way, any child defaulting can be known and traced either by calling or through the CHEWs.
7. Enhanced referral system with 2 ambulances per sub county and motor bikes for the CHEWs to pick those who cannot make it to the facility.
8. Introduction of alternative birthing through birth cushions, which is the traditional Somali way of birthing by squatting.

Result

The MAMA Kits were in use in all the 3 facilities visited, from the community units, to sub-county and county facilities. These Kits contained a basin, mosquito net, cup, bar soap, , baby

powder, (baby shawl and mothers leso in some facilities), antiseptic for cord care (chlorhexidine), at a cost of 300-1000. In Nanighi community unit, the kits were introduced in October. Records from October show an increase in deliveries at the facility from around 3 to 8-10 per month, and has been constantly increasing. All mothers who deliver at the facilities are guaranteed a MAMA Kit. In situations where they are out of stock, their names and contacts are taken, and mothers are contacted once the kits are made available.

There has been a lot of support from the leaders. In April 2014, the Governor, CEC, Director and CHMT committed to reducing maternal mortality. This is monitored through quarterly RMNCAH specific M&E.

As a result, many mothers who deliver to the facility are entitled to a mama kit package and also receive information about family planning which contributes to the overall improvement of maternal and child health in Garissa County.

Challenges

The main challenge faced in the county as whole in the implementation of their best practice is inconsistence in funding to purchase the Kits and many are the times they lack the Mama Kits and are forced to promise the mothers to get them during their post-natal or Child immunization schedules

Access to the health facilities by the pregnant mothers was cited to be an overarching challenge that mostly inhibit mothers from seeking skilled delivery services from the facilities contributed by existing long distances to the facility.

Feedback to County Director of Health

After site visit, the team gave feedback to Dr. Farah Amin the County Director of Health Garissa County on the observations made and challenges. He showed a strong commitment to the practice and highlighted that Her Excellency the First Lady Margaret Kenyatta offered support on improvement of maternal health in the county after she was impressed by the motivation and innovations they had in the roadmap for Universal Health Coverage and were in the process of proposal development for the same. The county however offered their leadership role to other counties which may consider domesticating their innovations by sharing their challenges and strategies.

Conclusions

These particular methods have proven to be quite effective, efficient and relevant to the people in this community. Sustainability is questionable especially with inconsistent funding, sustaining the TBA and CHEWs incentives of KSh 200 per delivery each mother brought to the facility, and purchase of the kits can be a challenge without other sources of funding, yet it is a method that has had a great impact on increasing the number of skilled deliveries. However, with increased knowledge of the services offered, mothers attended to previously at a facility may not need to be motivated by the CHEWs and TBAs again, since they will have experienced the delivery at the facility.

Given that there were notable increase after implementation of Mama Kits on skilled delivery in the county, the practice is worthwhile and require support both from the county leaders and the national government especially in providing alternative funding and a coordinated mechanism that needs to be strengthened and streamlined in the efforts of achieving the SDGs targets towards maternal and child health.

Recommendations

Such practices are worth supporting and replicating in all communities especially in nomadic areas and places with poor access to health facilities.

Representatives from this counties should offer to guide others in similar situation ie nomadic communities and difficult to access areas on these practices.

Alternative funding to the Mama kit is very crucial as far as sustainability of the practice and maximum utilization of maternity services in County.

Due to existing long distances from the facility, a transport voucher refund system can be used, where mothers who use their own means of transport can be refunded. However, this could have sustainability challenges.