

# Empowering Communities to Address Malaria in Pregnancy

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# Malaria in Pregnancy: Behaviors to Promote

All women of reproductive age (including adolescents) in malaria endemic areas:

- Sleep under an insecticide treated net every night of the year

All pregnant women in malaria endemic areas:

- Attend ANC starting in the first trimester
- Obtain at least three doses of IPTp spaced at least one month apart starting in the 13th week of pregnancy

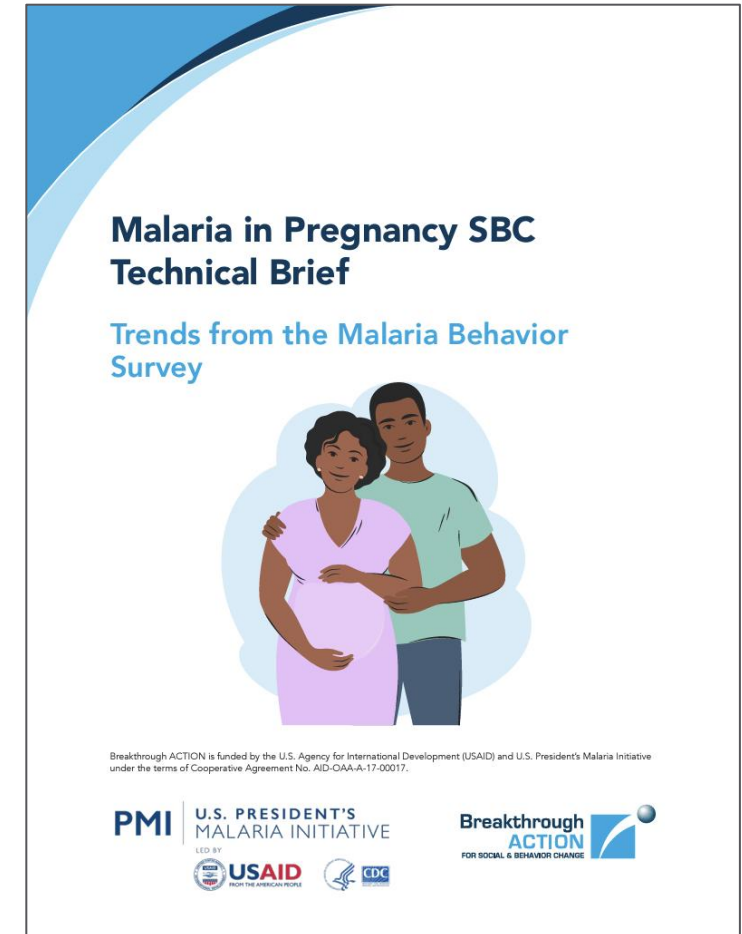
Antenatal health care providers:

- Ensure that every eligible woman is offered IPTp at every possible visit
- Treat women with respect, encouraging repeated attendance

# Common Barriers for MiP-related Behaviors

Across data sources and experiences, common barriers include:

- **Financial Constraints:** Lack of money for ANC and/or transport.
- **Logistical Challenges:** Time and distance affecting access to ANC services.
- **Social Norms:** Issues around early pregnancy disclosure and lack of privacy in ANC.
- **Psychosocial Factors:** Intention to attend ANC influenced by various psychosocial factors, like importance of spousal support and shared decision-making about going to ANC.



# Social and Behavior Change

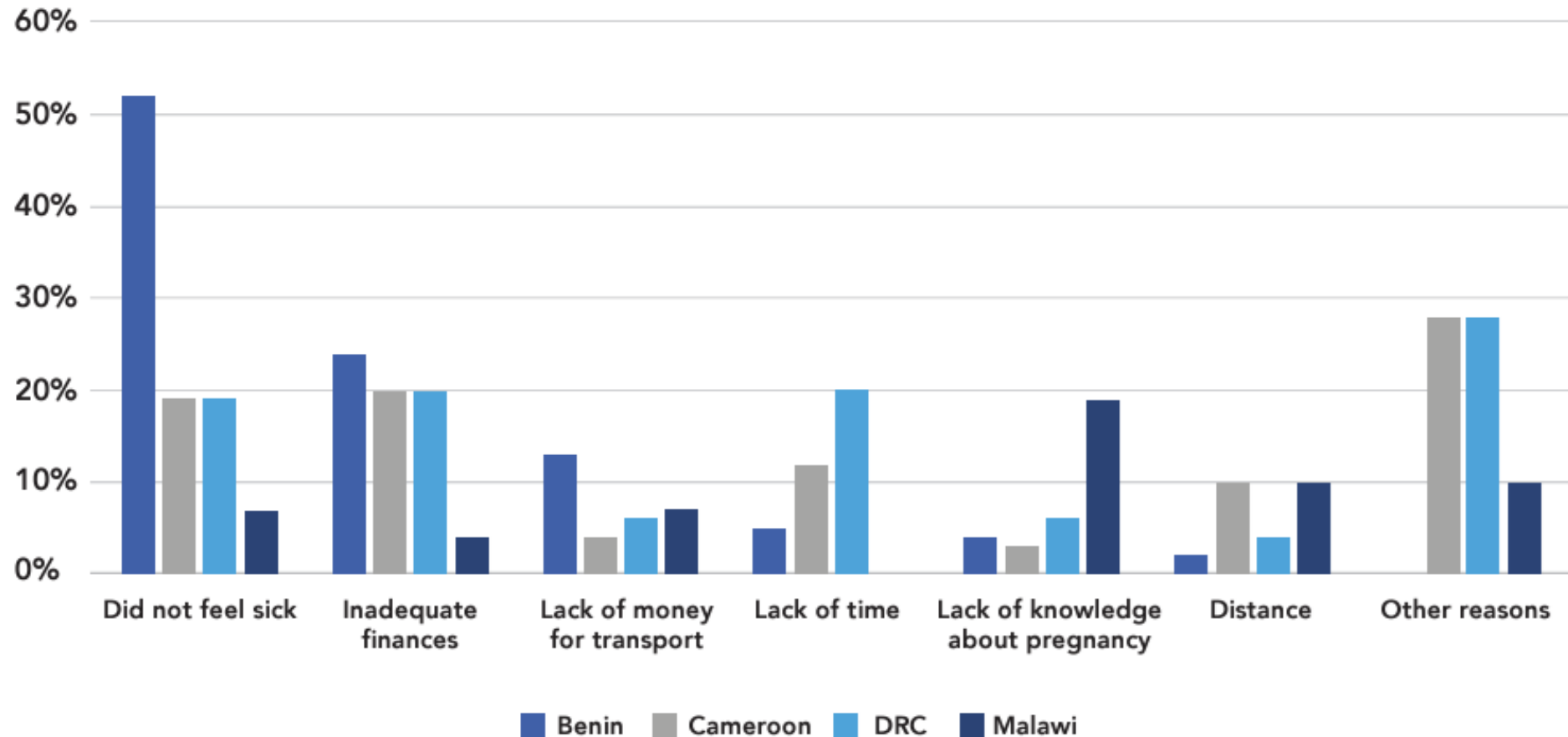
- SBC is a systematic, evidence-based approach that aims to improve and sustain changes in behaviors and social norms.
- It addresses individual, social, and structural factors by using insights from fields like behavioral science, communication, and psychology.
- SBC interventions extend beyond communication and include a wide set of activities and approaches that influence MIP behaviors
  - **Health system:** Non-communication interventions can include collaborating with service delivery partners to automate pregnancy screening and referrals
  - **Health provider:** Reducing provider rationing of SP even when health facility stock is adequate
  - **Community:** Making ANC or IPTp services more accessible (logistically, financially) to pregnant women

# Four Key MIP Behavioral Challenges

1. Early ANC - Initiation of ANC in the first trimester
  - **Challenge:** Many pregnant women initiate ANC late in pregnancy, reducing their opportunities to obtain at least 3 doses of IPTp
2. ANC Retention - Make a minimum of 4 ANC visits
  - **Challenge:** Less than 4 visits may be insufficient to obtain 3 doses of IPTp
3. Community IPTp SBC Considerations
  - **Challenge:** For cIPTp to be successful we must ensure that CHWs/CHVs have sufficient supplies, and that pregnant women seek out care from CHWs at the recommended times.
4. Provider Behaviors that Impact ANC/IPTp Uptake
  - **Challenge:** We continue to see gaps in both ANC attendance and in delivery of IPTp to women at ANC. What are the provider behaviors that contribute and how can we address them?



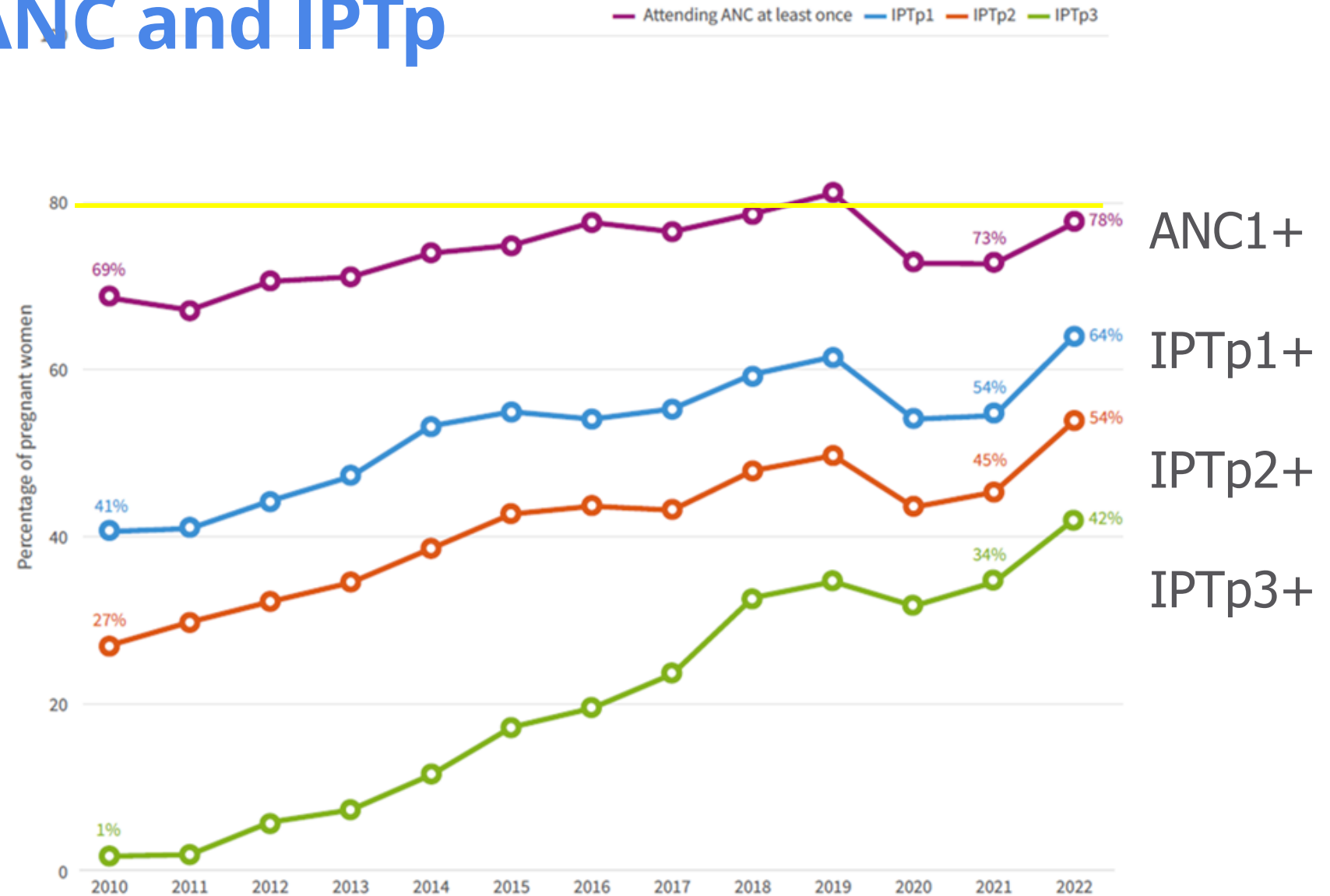
# Malaria Behavior Survey from 4 Countries



Online data! Go to: [www.malariabehaviorsurvey.org](http://www.malariabehaviorsurvey.org) for more SBC data and recommendations

# Coverage of ANC and IPTp

While IPTp3+ coverage is improving, it continues to lag well below target.



ANC: antenatal care; CDC: United States Centers for Disease Control and Prevention; IPTp: intermittent preventive treatment in pregnancy; IPTp1: first dose of IPTp; IPTp2: second dose of IPTp; IPTp3: third dose of IPTp; NMP: national malaria programme; SP: sulfadoxine-pyrimethamine; WHO: World Health Organization.

# Factors Associated with Poor Uptake of IPTp

## **Pregnant women**

- Inadequate knowledge
- Poor attendance
- Refusal of IPTp-SP

## **Healthcare Provider**

- Inadequate knowledge, confusion perception of SP resistance
- Disrespectful treatment of pregnant women

## **Health facility factors**

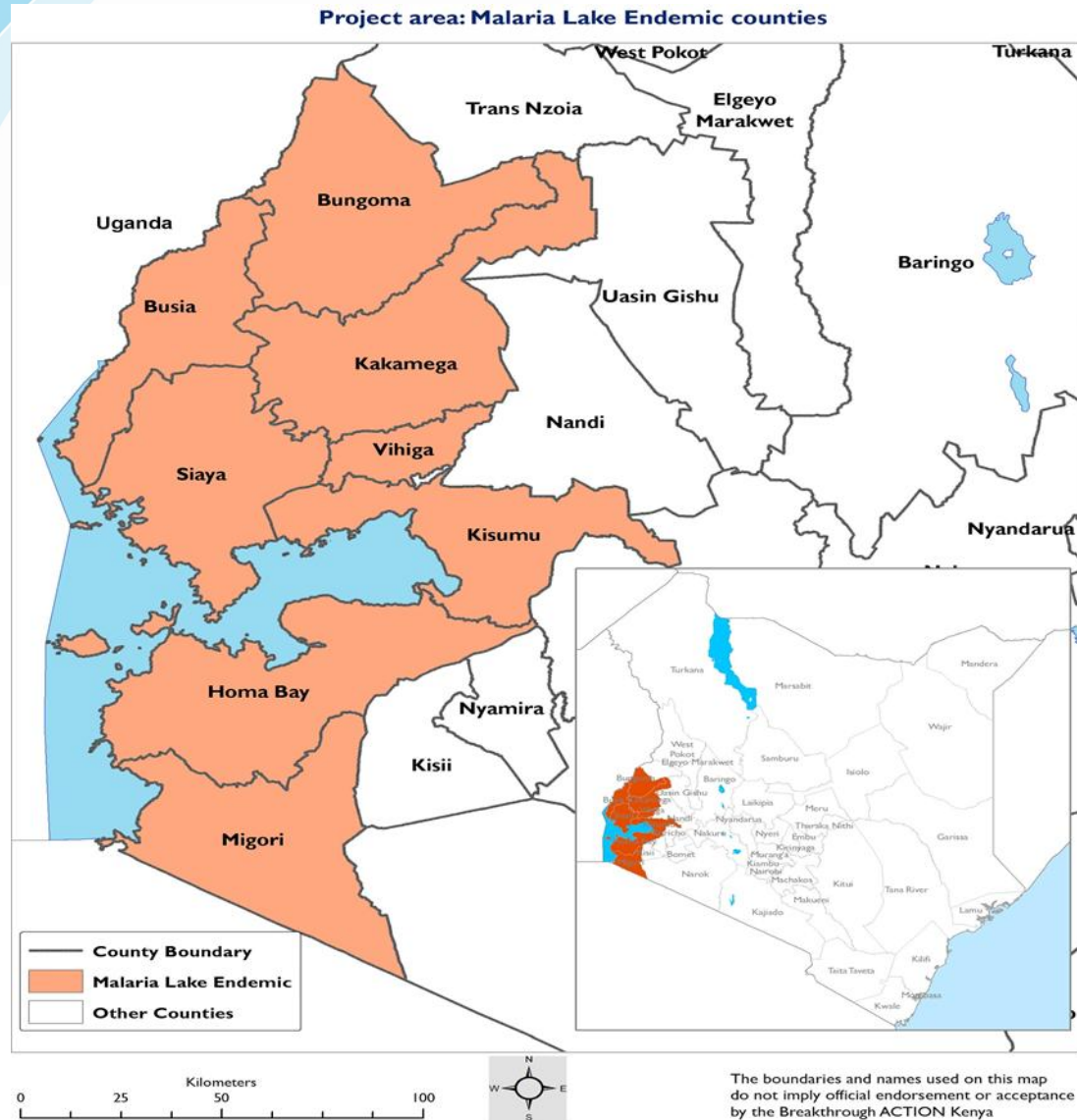
- SP stock-outs
- DOT supplies unavailable
- Insufficient staffing



# Community IPTp Considerations for SBC

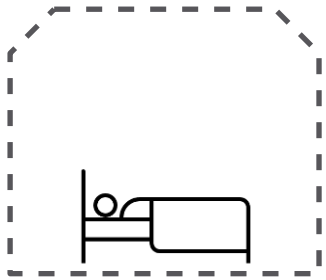
- As a new intervention, we need to consider how to ensure that cIPTp is successful
- This requires both ensuring that CHWs have **sufficient supplies**, and that pregnant women seek out care from CHWs
- It is important to understand **community perceptions** of the care provided by CHWs to understand whether women will feel comfortable seeking IPTp from them, and whether there are social/family issues which need to be addressed
  - These may be related to perception of quality of care as well as to gender
- Additionally, the **perception of Health facility workers** regarding having CHWs deliver IPTp must be assessed, as CHWs are monitored but also supplied by the health facilities

# Breakthrough ACTION Kenya Malaria Project



- **Goal:** To encourage Kenyans to adopt preventive and care-seeking behaviors around malaria and enable positive social norms
- **Location:** 8 counties in the Lake endemic region of Kenya
- **Key results Areas**
  - Community
  - Health Worker
  - National

# Key Behaviors to influence



Increase use of long-lasting insecticide-treated nets (LLINs)



Increase prompt care-seeking for fever



Increase uptake of early and frequent antenatal care (ANC) visits



Increased uptake of malaria in pregnancy (MiP) interventions, specifically intermittent preventive treatment in pregnancy (IPTp)



# Intermediate Result 1: Community-level focus

## Community Engagement Approach Implementation



CHVs Capacity Building



Community Engagement



Engagements through  
Non-Health Actors

# Intermediate Result 2

## Improved health worker behaviors supportive of effective malaria service delivery



Health Care  
Providers/mentors  
interpersonal  
communication and  
Counselling training



Strengthen Community  
Facility linkages through  
Fishbowl Approach



Facility check in with  
Health Care Providers



Whole Site Orientation



Community Health Providers  
Support Supervision



# Establishing Community Action Groups

- In collaboration with county and sub-county MOH teams, **Community Action Groups** were established to increase the uptake of key household and community behaviors
- The Community Action Groups members comprised of;
  - **Health actors** (facility health care workers, community health assistants and promoters)
  - **Non-health actors** (assistant chief, religious leaders)
- Community Action Groups members were trained to implement the **Community Action Cycle**



Community Action Group Planning



# Developing Community Action Plans

- The **community action groups** conducted dialogues using the problem tree methodology.
- Barriers and solutions also derived from a **Human Centered Design** process
- These barriers informed development of **community-led action plans**
- Designed **Tailored Interventions**



Community Action Group during community exploration

# Implementation of the Community Action Plans

- Community-led engagement/dialogue sessions
- Open-air meetings (“barazas”), boda boda sheds, religious forums, and community events, youth champions, peer to peer in school, magnet theatre
- **Tailored messages** addressing specific community barriers
- Events **built social support** for the health issues by engaging influential leaders and speaking about issues more openly





# Strengthened Male Engagement

- Intentional reach to boda boda stands, quarry, abattoir
- Key messages aimed at increasing male involvement to improve ANC attendance and IPTp uptake of their partners.
  - Benefits of early ANC attendance
  - Benefits of SP uptake
  - Importance of enabling spouse to attend clinic



# Strengthening Client-Provider Dialogue through the Fishbowl Approach



- **Foster Empathy and Understanding:** The fishbowl approach enables community members and health providers to share experiences, enhancing mutual understanding.
- **Improve Communication and Accountability:** This method addresses institutional barriers and strengthens collaboration to enhance malaria service provision.



# Monitoring and Reporting

- Quarterly review meetings
- Monthly reporting tool tracked:
  - # of community engagement sessions,
  - # of community members engaged in collective action
  - #of community-led activities.
- ANC visits, IPTp uptake, cases of malaria in pregnancy were recorded in the ANC registers and entered in the Kenya Health Information System (KHIS)



# End of End of Cycle Review Meetings

- Improvement in **ANC attendance and IPTp uptake**
- Improvement in prompt care seeking for fever, ITN use
- Improved **TBA referrals** for pregnant women
- Revival of **community health promoters** manned desks that helped fast track patient flow
- **Increased male involvement** in reproductive health activities – boda boda operators, abattoir workers.
- Community action teams advocated and established;
- Outreach clinics for hard-to-reach pops
- Establishment of a lab with staffing
- Provision of microscopes
- Installation of water tank/safe water
- Staff quarters
- Increased cohesion between the facility team, community team and community health promoters

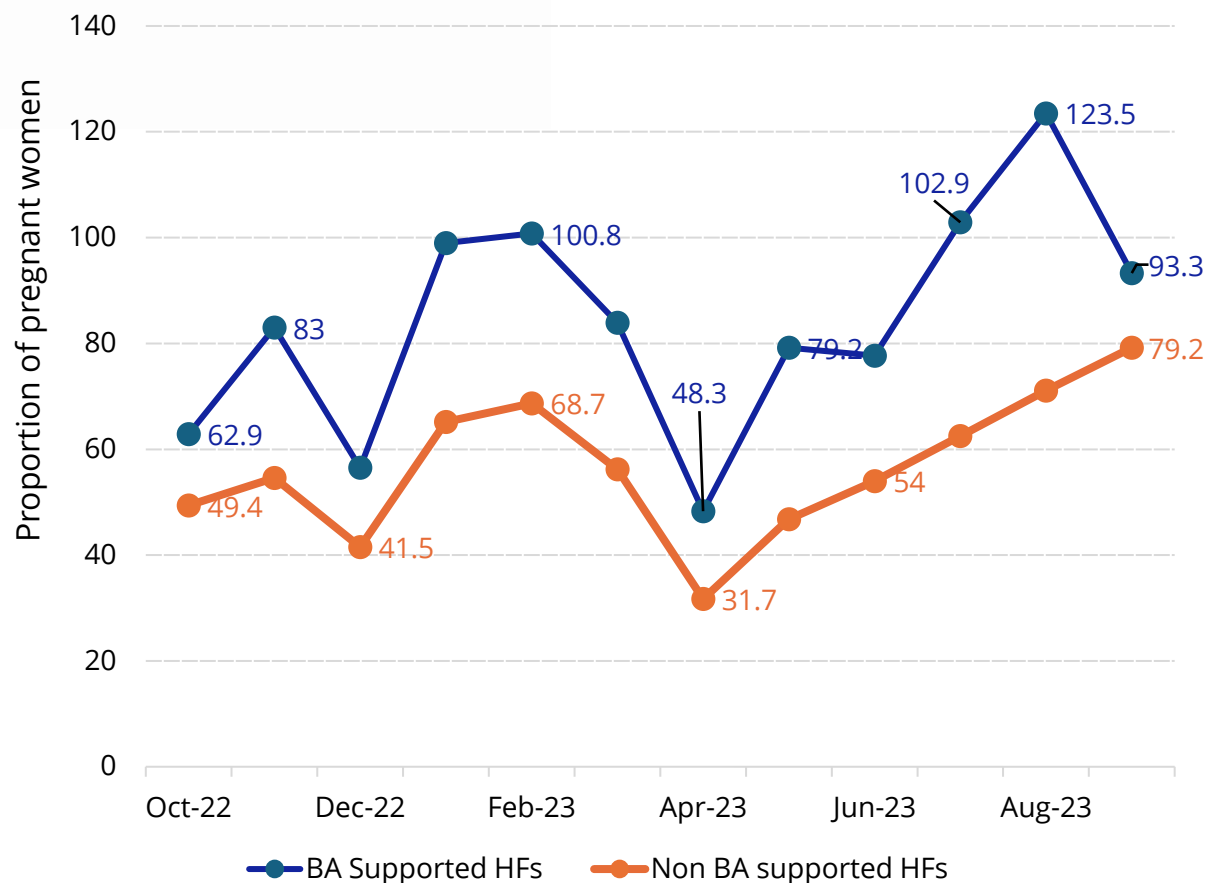




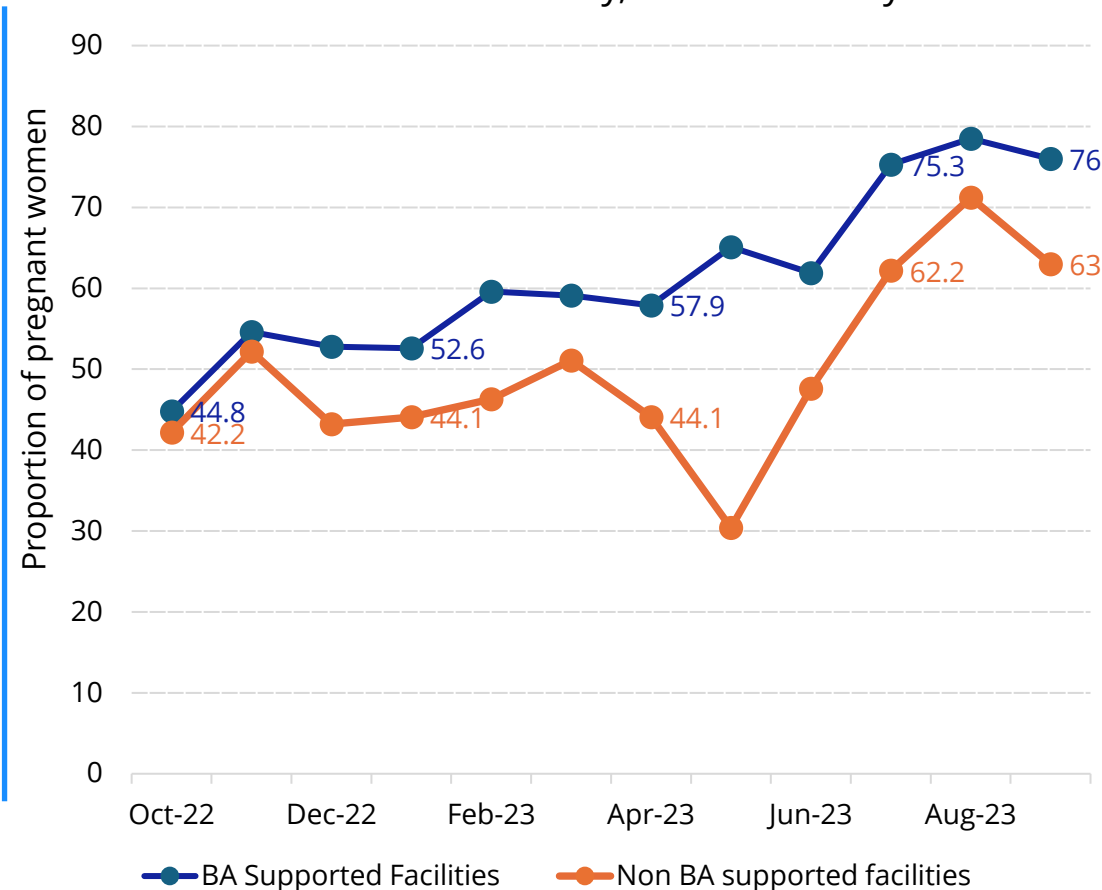
# Key Results

# Improved Health Facility Performance

IPTp3 Uptake among ANC attending women in Hamisi Sub county, Vihiga County

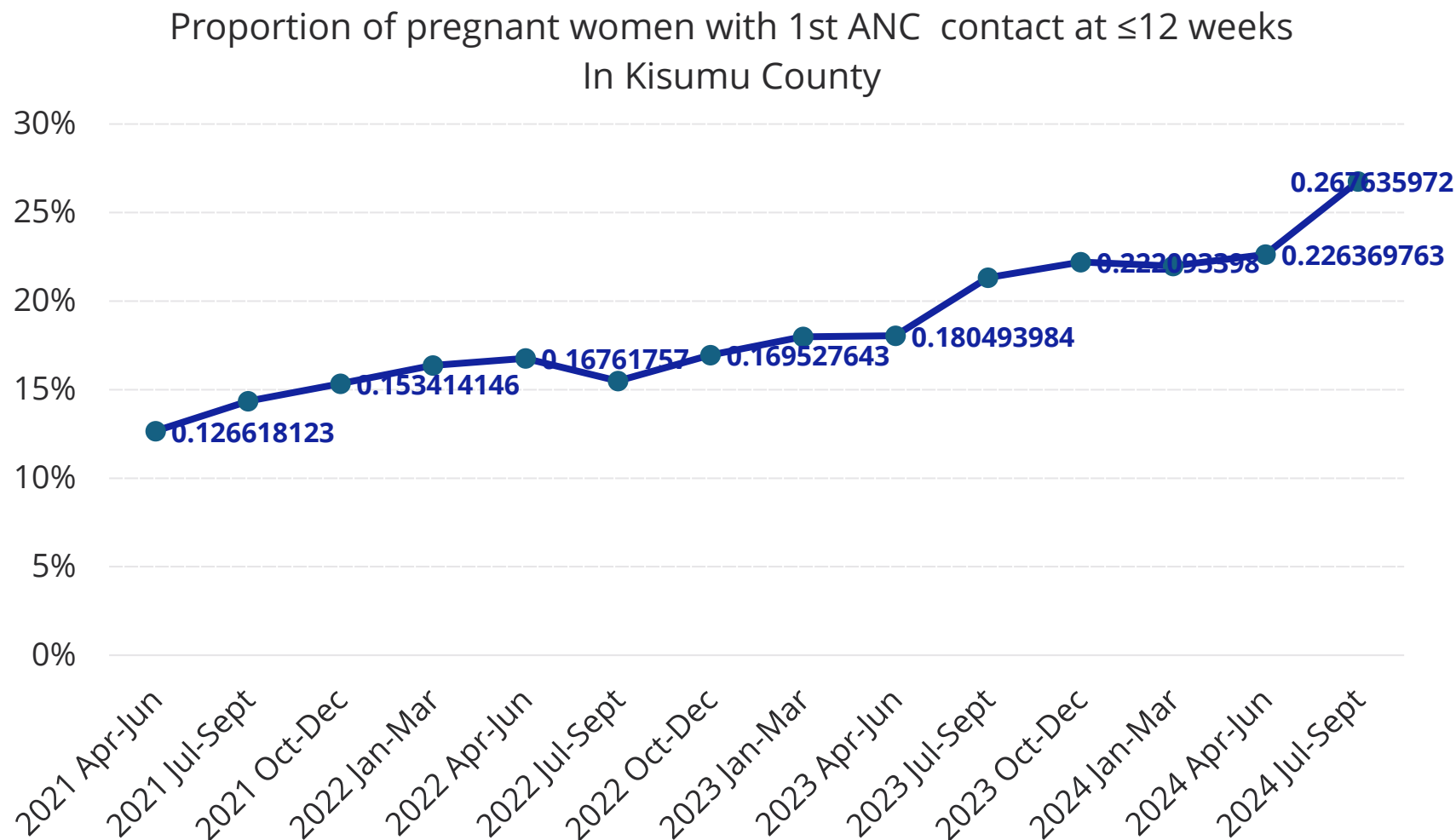


IPTp3 Uptake among ANC attending women in Kisumu East Sub county, Kisumu County



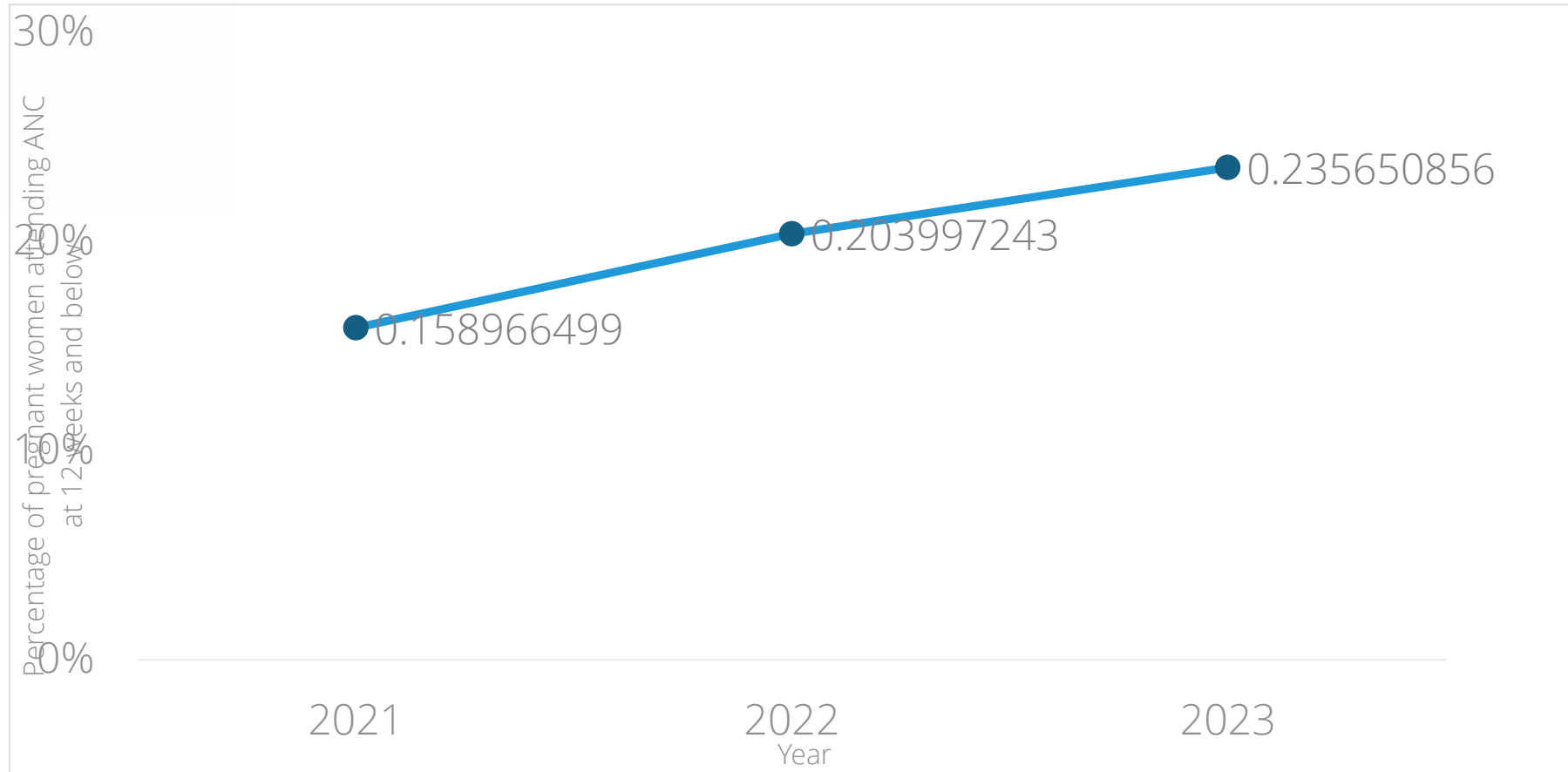
# Trends in Timely ANC Initiation Among New ANC Clients in Kisumu County

The proportion of pregnant women initiating antenatal care in Kisumu County doubled since the project began implementation in April 2021.



Source: KHIS2

# Comparison of Early ANC Initiation between 2021 – 2023 (Homa Bay County Project supported sites)



# Common challenges

- Attrition/turnover of county team and Community Action Group members
- Not all replacement Community Action Group members are trained
- Competing tasks at all levels
- Expansive area to be covered
- High community expectations
- Low male engagement



# Strategies for overcoming these challenges



- Continuous engagement and adaptability
- **Retraining** new community action group members – expensive but necessary
- Work with the MOH teams to plan around existing activities
- **Synergy** with other MOH and other partner activities
- Working through the MOH Health Promotion and **Community Strategy structures** to cover larger areas.
- Non health actors help in mobilizing men and the general population. More importantly, **“going to the men”**.
- Using MOH structures and involving community members reduces high expectations



# Reflections

- Community engagement through dialogues increased early and frequent ANC attendance and IPTp uptake by:
  - Raising awareness
  - Encouraging positive behavior
  - Increasing male involvement
  - Enhancing the role of non-state actors – Religious leaders, local administration
- Health system strengthening interventions further supported ANC attendance through:
  - Improved provider attitudes through interpersonal communication training and creating a more welcoming and supportive environment for expectant mothers through improving facility–client relationships e.g. Fishbowl approach
  - Commodity availability ensuring consistent access to essential commodities sulphadoxine pyrimethamine (SP)



**Thank You**

# Acknowledgement

We extend our heartfelt appreciation to our valued partners for their unwavering support and collaboration

- USAID/PMI
- Other PMI Implementing Partners
- National Malaria Control Program
- Department of Family Health
- Division of Health Promotion
- The 8 counties in Western region of Kenya - CHMT and community members
- The Breakthrough ACTION team
- The RBM Partnership to End Malaria: SBC Working Group and MIP Working Group