Listening to Community Voices:
Effective program design with nomadic pastoralists

Save the Children.

Background

Wajir and Mandera counties have the highest total fertility rate (TFR) and the lowest modern contraceptive prevalence rate (mCPR) in Kenya; the modern contraceptive prevalence rates are 2.3 in Wajir and 1.9 in Mandera.[1] This low use of family planning is attributable to a weak health system, policy, resource environment, and strong socio-cultural and religious norms opposed to the use of FP.[2] Save the Children, with funding from the Bill & Melinda Gates Foundation, partnered with the London School of Hygiene and Tropical Medicine and the Centre for Behaviour Change Communication on the four-year (December 2017-April 2022) Nomadic Health Project (NHP) to increase use of quality family planning (FP) services among nomadic and semi-nomadic pastoralist populations in Kenya.

Nomadic and semi-nomadic pastoralists have been largely missed by government and NGO-led implementation. As such, key to any success was to ensure the population's comfort and trust in the activity. This brief describes how a phased approach including formative research, a facility assessment, and consultation with leaders and community members was used to inform the design and implementation of the Nomadic Health Project model.

Phase 1: Formative Research

Phase 1 of the Nomadic Health Project focused on formative research and gathering information needed to design the project. Formative research explored the social norms influencing FP use and a health facility assessment was conducted to inform design of facility-based interventions. Stakeholder consultations were also held, and key documents were consulted.

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[1] Kenya National Bureau of Statistics (2015). Kenya Demographic and Health Survey (KDHS) 2014. https://dhsprogram.com/pubs/pdf/FR308/FR308.pdf

[2] Leah Kenny, et al. (2021). Improving provision of family planning among pastoralists in Kenya: Perspectives from health care providers, community and religious leaders, Global Public Health, DOI: 10.1080/17441692.2021.1944263

Formative Research to Explore Social Norms

Formative research explored the social norms and other key factors that influence decision-making and uptake of FP (number and timing of children) among nomadic and semi-nomadic communities in Wajir and Mandera counties. The formative research sought to understand the social norms and beliefs that influence FP use, including those around gender roles and responsibilities, family formation, family structure and family planning. The research also explored social reference groups with the greatest impact on FP decision-making, barriers and facilitators to accessing FP, and identified which social norms could be targeted by a community-based intervention to improve demand for FP. The study found that there were norms around use of FP, particularly modern hormonal methods; and barriers identified included religion, that God decides when and how many children couples may have. The ideal family has many children, as it is a sign of prosperity, wealth and community connection, and modern FP is used by 'others'. In addition, husbands are seen as key decision makers in issues relating to reproductive health and have to give consent for use of FP. There were also some misconceptions on the effect of modern FP among women and men. Cost and distance to the limited number of health centers which supply modern FP was also highlighted. Through this formative research, it was clear that the nomadic and semi-nomadic pastoralists had extreme need for health services, beyond FP, and a recommendation that encouraged an integrated approach.

Identified Social Norms:

Family formation
- Women must marry young

Family structure
- Real men have many children
- Women must give birth immediately after marriage
- Child spacing using natural methods is acceptable
- Child spacing should be discussed in private

Family planning
- Natural FP methods are acceptable
- Men must provide consent for reproductive health decisions
- No one uses modern FP methods

Key Stakeholder Consultations

To inform program design, the project sought to identify stakeholders using a four-quadrant voice of the stakeholder analysis. The following stakeholders were identified for consultation and ongoing engagement at the county, sub-county and local level: county government and county/sub-county health management teams; health workers; health partners including Kenya Red Cross Society, World Vision, Amref Health Africa, and UNICEF; Kadhi Office (responsible for jurisdiction over determination of questions of Muslim law); religious leaders; reproductive health technical working group (RHTWG); division of family health; chiefs; ward representatives; and community elders. Consultations were to define the existing health problems and set priorities for the community.

Health Facility Assessment

NHP also conducted a health facility assessment to assess the availability of services and readiness to provide FP services in static health facilities along the migratory pathway. Recognizing community health volunteers (CHVs) and mobile outreach only provided short-term methods of FP, NHP sought to strengthen the skills of health workers in these facilities along the migratory pathway. The assessment included a structured facility inventory tool for facility-in-charges and semi-structured interviews with facility staff and county/sub-county health managers. This assessed their attitude toward provision of FP services to a pastoralist population and their perspectives on potential services to support adequate service provision among pastoralist populations. The assessments revealed major challenges to quality service provision, including gaps in staff numbers and capacity, inadequate commodity supplies, infrastructural challenges that hamper provision of FP, and identified some training needs of health workers in these facilities. Additionally, recognizing that health workers in these

facilities were often not from these counties, NHP added values clarification and attitude transformation (VCAT) activities, to begin to address some biases displayed by facility staff serving nomadic and semi-nomadic pastoralists. The facility assessment revealed the need to increase the number of health facilities that required support to 53, up from the 25 originally forecasted.

Phase 2: Design of Project

The second phase of the project utilised the data gathered through formative research, assessments, consultations, and past implementation experience to inform program design. Sustainability and scale-up were key considerations in the design of the model. As such, the project team was guided by the Government of Kenya's Community Health Strategy (CHS) and aimed to operationalize the strategy to serve nomadic and semi-nomadic pastoralists. The team also relied on the ExpandNet framework to inform sustainable scale-up. For stakeholders in Kenya to be interested in the model, the team had to ensure that the project model incorporated attributes of innovations that have been successfully scaled including: credible, observable, relevant, relative advantage, easy to install, compatible, and testable.[3]

After the formative research and facility assessment, the project team held several design activities that started with a participatory design workshop that included representatives from the project team and partners. During the workshop, preliminary findings from the formative research and facility assessment were presented and used to develop the project theory of change, identify primary and secondary audiences, determine the project name, and design of the key project components (service delivery, social and behaviour change, and stakeholder engagement). After the initial design workshop, validation meetings were held in each county with representatives from county and sub-county health management teams, religious leaders, elders and community members.

Development of Project's Theory of Change

NHP sought to develop a Theory of Change, to address many of the challenges highlighted by the assessments and activities. Key barriers identified through formative research include cultural and religious barriers, misconceptions about FP, and structural barriers including the cost of travel and distance to health centers that may influence health-seeking behaviour. The Theory of Change includes increasing the engagement of religious and traditional leaders to promote child spacing (emphasis on men); increasing CHV and health worker skills to effectively address women's access, informational and motivational needs; and increasing community social support for child spacing as part of the SBC strategy. These increases will better serve women's MNCH and FP needs, leading to increased child spacing and healthier mothers and children.

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[3] Save the Children (2019). Assessing barriers, facilitators, and opportunities for inclusion of nomadic and semi-nomadic populations in health policy formulation, implementation and monitoring and evaluation: A case study of Wajir and Mandera Counties in Northern Kenya. Nairobi: Kenya

Levels of Influence | Inputs | Intermediate Outcomes | Outcomes | Impact
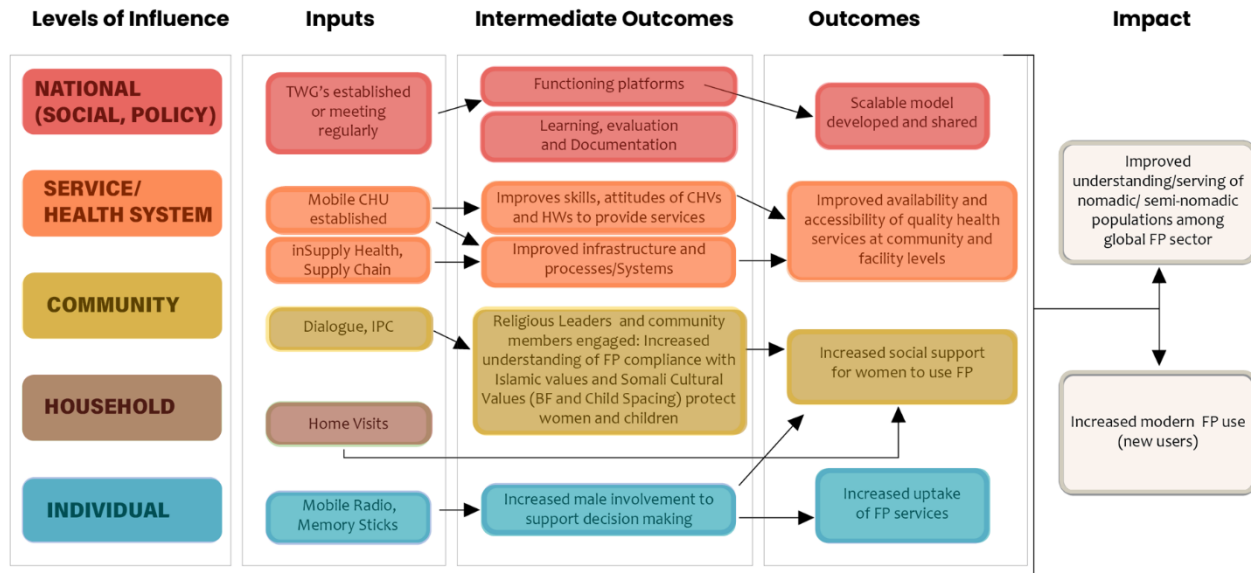
Naming the Project

Members of the county and sub-county health management teams and community and religious leaders were consulted to identify the project name. The Nomadic Health Project was identified as a locally and contextually appropriate name. The name also reflects the expansion of the project from a focus on family planning to a more integrated health project. In consultation with the Bill & Melinda Gates Foundation, NHP implemented this more integrated approach and developed a strong visual branding which tested well with the audiences.

Design of Project Interventions

Based on the theory of change, the project team designed NHP with three main components: social and behaviour change (SBC), health service delivery, and stakeholder engagement – as seen in the diagram below:
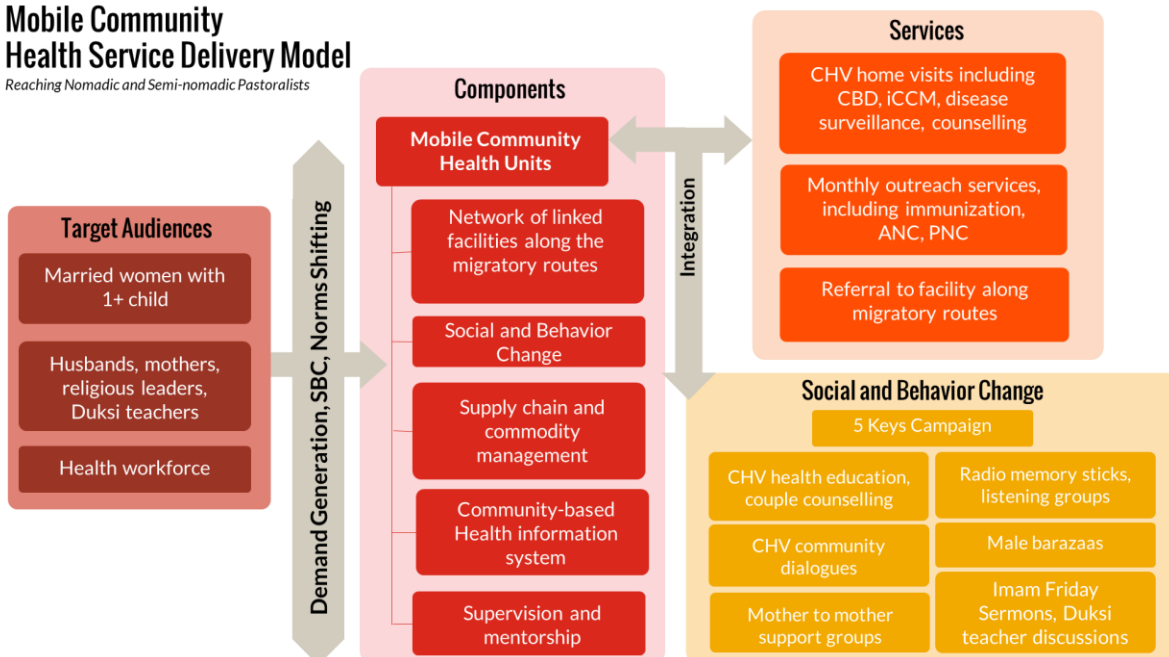
Social and Behavior Change

Project partners participated in a workshop to review formative research findings and then design an integrated and multi-pronged SBC strategy that sought to reduce restrictive social and gender norms that influence the use of FP. Audiences identified included directly affected (married women non-users, with one or two children, nomadic and semi-nomadic), directly influencing (husbands, mothers of married women, co-wives, and female peers, religious leaders, and village elders), and finally indirectly influencing (service providers and advocacy audiences). After audiences were identified, the design team identified desired behaviors, barriers including norms and access issues, measurable SBC objectives to address such barriers, and explored an effective channel mix in almost media and signal dark districts in order to reach audiences with sufficient intensity. As the SBC strategy was drafted, validation workshops were held in both counties with county and sub-county management teams and with nomadic and semi-nomadic pastoralists. Feedback and inputs were solicited from these key stakeholders before the SBC strategy was finalized. Communities in the target areas were reached through Friday sermons, male *barazas*, round table discussions with *Duksi* teachers, CHVs holding dialogues in the community, and mother-to-mother support groups that involved young women and mothers-in-law and held interactive talk shows with religious leaders and health workers on Local Radio FMs. A variety of SBC materials supported both religious leaders and CHVs to engage with community members, including the *Five Keys* Reference Booklets for Religious leaders (Arabic and English), *Five Keys* Community Health Volunteer Guide (Somali and Borana), *Five Keys* Parents Booklet (Somali and Borana), 20 radio drama episodes covering *Five Keys* topics for broadcast on local FM and distributed on memory sticks for portable solar radios (Somali and Borana), audio sermons for Religious Leaders (memory sticks for portable solar radios) in Arabic.

Service Delivery

NHP worked with the county departments of health to introduce a comprehensive package of community-based health services – including reproductive, maternal, newborn, child health, and family planning services to nomadic and semi-nomadic pastoralist populations. Fifteen mobile community health units (CHUs), each covering a population of 2,500 and linked to the nearest primary health facility along their migratory path, were established in six sub-counties in Wajir and Mandera. Nine CHUs were established in Wajir and six in Mandera. CHVs were selected by community members, using agreed upon criteria, in collaboration with key stakeholders and providers were trained to deliver basic health services at the community level. In collaboration with the MOH, the project developed a supervision plan that included mapping of community health assistants (CHAs) and development of checklists. Fifty-three CHAs from linked facilities along the migratory routes in both counties provided supportive supervision to the migrating CHUs. In addition, NHP collaborated with inSupply Health through the SCALE project to support the availability of FP commodities to meet demand through community-based distribution of FP. Led by inSupply Health, human-centred design (HCD) was used by the SCALE project with CHVs and health workers to design a mobile platform called cStock that was user-friendly and responsive to their needs. cStock is a digital supply chain strengthening approach through which CHVs use a mobile app to report their health supplies stock levels.

Phase 3: Implementation of the Model

As implementation proceeded, several activities ensured the project team received feedback from the community to further refine the model. At the community level, quarterly feedback sessions were held to solicit feedback on the NHP interventions, including additions or changes needed to respond to community needs. Through these quarterly meetings, the community identified a problem they were seeing with children having watery diarrhoea. As a result, NHP decided to train CHVs in integrated community case management (iCCM),

including training on the administration of oral rehydration salts, which is estimated to prevent 70-90 percent of deaths due to acute watery diarrhoea.

Continued engagement with the RHTWG provided the project an opportunity to keep other key stakeholders updated on project activities and troubleshoot challenges. For example, the RHTWG was consulted on adjustments for the rollout strategy for community-based distribution of FP, in particular training on intramuscular depo-medroxyprogesterone acetate (DMPA-IM), as challenges initially emerged with CHV competencies.

The project conducted a developmental evaluation (DE) in collaboration with inSupply Health and HealthRight International, focusing on activities and outcomes to generate evidence and learnings about sustainable and scalable models that can increase utilization of community health services (including family planning) in arid and semi-arid lands. A DE collects and analyses real-time data to support design and implementation by providing relevant evidence for ongoing informed decision-making.[4] The DE was conducted in three waves (January 2020, August 2020 and August 2021), and focused on:

- CHV recruitment, roles (including optimal and scalable package of CHV services), motivation, mentoring and supervision;
- community-based distribution (CBD) of health commodities;
- policy and other modifications needed for the Community Health Strategy to be responsive to community health needs;
- effective communication channels for peer-to-peer learning and collective problem-solving to support c-Stock implementation; and
- the effect of COVID-19 on communities.

The figure below outlines some key examples of findings from the DE and subsequent adaptations that were made in real-time during implementation.

Examples of DE Findings and Real-time Adaptations

	Finding	
Finding	Successful capacity building programs for CHVs must consider literacy levels of CHVs, incorporating pictures, practice exercises and role play.	Continuous training and retraining to build CHV competencies for all aspects of CBD, including frequent training and refresher training as well as targeted mentorship at community level. The training content should be customized to low-literate CHVs and there is a need to develop and utilize innovation approaches in training these CHVs like including visual aids to suit the literacy level. The training should include some sessions to help build CHVs' capacity to maintain confidentiality for their clients.
Adaptation	While NHP identified literacy challenges prior to the DE, the DE reinforced the need. Adaptations to the training included: use of brainstorming and group discussions, videos and pictorials, role plays, and exposure to the clinical environment to practice counseling and assessments.	A cohort-based training approach for training of CHVs on DMPA-IM was used to respond to COVID-19, but also allowed for smaller in-person training. Initially a two-week clinical placement was used to allow for CHVs to practice injection techniques. This clinical placement was extended to four weeks to allow for more time to practice and resulted in significant increase in skill levels displayed by CHVs.

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[4] inSupply Health. Developmental Evaluation of Community Health Models in ASAL Counties in Kenya.
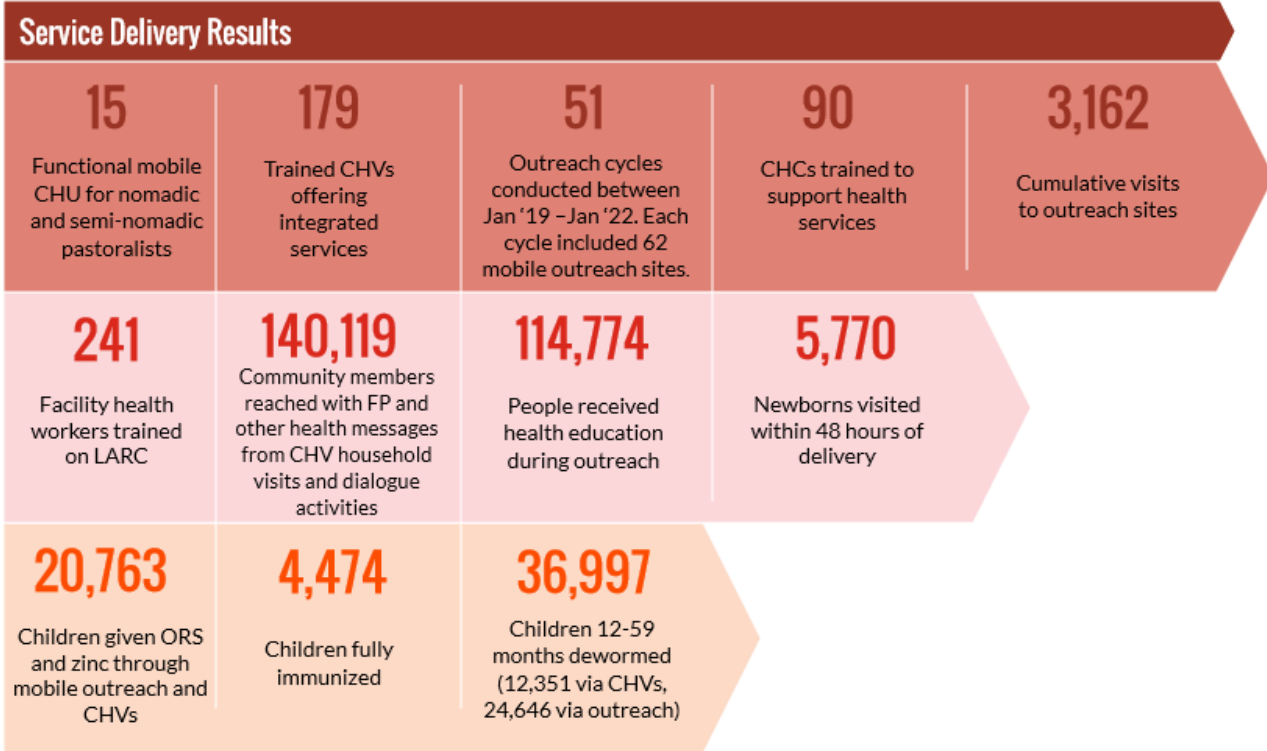
Evaluation activities conducted during NHP included a developmental evaluation, outcome harvesting, and an SBC assessment. In addition, regular project monitoring and data collection contributed to project results.

Outcome Harvesting

Toward the end of the project an outcome harvesting exercise was conducted. Outcome harvesting is a complexity awareness evaluation process that collects evidence of what has changed and then, working backwards, determines whether and how an intervention has contributed to these changes. Implemented from June to September 2021, the outcome harvesting activity was designed to collect evidence of change from NHP from project stakeholders with the guiding question: what approaches implemented by NHP proved promising and should be prioritized for future community health interventions for semi nomadic and nomadic populations?

After outcomes were identified, the project team categorized the outcomes into four areas of strength: effective program design, provider capacity strengthening and task shifting, sustainable service access, and social and behaviour change. This was an effective process in part due to the participatory design and implementation of the project, which engaged and solicited input from community members. The outcome harvesting process further increased stakeholder engagement and buy-in to the model at all levels, fostered community cohesion and highlighted important results of the project from the perspective of the community.

Key Results

Service Delivery Results

15	**179**	**51**	**90**	**3,162**
Functional mobile CHU for nomadic and semi-nomadic pastoralists	Trained CHVs offering integrated services	Outreach cycles conducted between Jan '19 –Jan '22. Each cycle included 62 mobile outreach sites.	CHCs trained to support health services	Cumulative visits to outreach sites
241	**140,119**	**114,774**	**5,770**	
Facility health workers trained on LARC	Community members reached with FP and other health messages from CHV household visits and dialogue activities	People received health education during outreach	Newborns visited within 48 hours of delivery	
20,763	**4,474**	**36,997**		
Children given ORS and zinc through mobile outreach and CHVs	Children fully immunized	Children 12-59 months dewormed (12,351 via CHVs, 24,646 via outreach)		

Social and Behavior Change Results

7,500 Women adopted FP during the life of the project (Nov 17- Feb 22)	**19%** Average monthly increase of new FP users	**89%** of respondents support continued increased access to FP information and services	**98%** of respondents believe their spouse is supportive of their use of FP for child spacing
418 Radio programs aired	**374,000** Community members reached by radio programs	**75** Religious leaders oriented on FP through religious leader discussions/activities	**97%** of religious leaders interviewed pledged support for FP

Conclusions and Recommendations

NHP has shown that working on demand and supply-side FP programming in an environment with restrictive social norms on the use of FP can be done when the community is approached with respect and engaged meaningfully in program design and implementation. Based on key project results, below is a list of recommendations for future implementation and scale-up of the project model.

- Regular community engagement and feedback meetings throughout implementation creates opportunities for projects to respond to issues in real-time. Through regular feedback meetings, NHP learned of increasing reports of watery diarrhea and added training of CHVs on iCCM of childhood illness. Maintaining regular engagement from design through evaluation can strengthen the responsiveness of your program to local needs.
- When involvement of community members is not feasible (e.g., NHP's initial design workshop), holding validation workshops in several localities, with diverse stakeholders, provides an opportunity to validate findings, soliciting feedback and inputs to make adjustments as required.
- Developmental evaluations provide opportunities for projects in complex settings to gather insight into some of the challenges facing implementation and offer recommendations for adaptation in real time.

NHP has been able to demonstrate promising approaches to generating demand for use of FP and other health services and to increase reach and access to health services.