Birth Preparedness Class Pilot Manual
List of Acronyms

ANC  Antenatal Clinic
BPC  Birth Preparedness Class
CBO  Community Based Organization
CHV  Community Health Volunteer
CPR  Contraceptive Prevalence Rate
DFID  Department for International Development
FBO  Faith-Based Organization
FCC  Female community Champions
IEC  Information, Education and Communication
IPC  Inter-personal Communication
MCH  Maternal and Child Health (Clinic)
MCPR  Modern Method Use
MOH  Ministry of Health
MOHD  The Ministry of Health Development
PSI  Population Services International
SAHAN  Somali Advocates for Health and Nutrition
SBCC  Social Behavior Change Communication
SGC  Small Group Communication
SHINE  Somali Health and Nutrition programme
TBA  Traditional Birth Attendant
TOT  Trainer of Trainers
INTRODUCTION

The Ministry of Health Development (MOHD), with the Support of Population Services International (PSI), is implementing the Somali Advocates for Health and Nutrition (SAHAN) Programme. SAHAN is the Demand Creation for Health Services component of DFID-funded Somali Health and Nutrition Programme (SHINE) programme. Under this programme, PSI aims to increase access to and utilisation of reproductive, nutrition, child, and maternal health services and to promote healthy behaviour change.

PSI is using an adaptive, evidence-based, participatory design to better understand the persistent barriers to uptake of health services and health-seeking behaviour and develop and test innovations in demand creation that target the external factors which influence individual behaviour to improve the health of Somali women and children. We look to the Availability, Accessibility, Acceptability and Quality (AAAQ) framework to understand the barriers to achieving the right to health that describe these external factors.

Somalia has some of the highest infant, child, and maternal mortality rates in the world.

Maternal mortality was 732 out of 100,000 live births in 2015.

Under-five mortality was 137 out of 1,000 live births.

1 in 12 women die in pregnancy or at childbirth in Somalia.

Furthermore, CPR remains at 4.3% in 2012 and only increased to 5.1% in 2016.

The causes of maternal mortality in this context include low literacy levels, poor coverage and limited access to quality health care products and services, poor nutrition, poverty and a range of myths and misconceptions about modern health care, health facilities and the health care providers.
THE BPC STORY

BPC was first conceptualized in a co-creation workshop with women of reproductive age selected from the statehouse IDPs. The design challenge, was based on insights from the first round of immersive research where first-time mothers shared reasons they do not give birth in the health facility.

These reasons included fear of complications and labour pain and the misconception that such pain and complications are better managed using local methods and in the comfort of their homes.

<table>
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<tr>
<th>Insight</th>
<th>Justification for current behaviour and barriers to health services utilization</th>
<th>Potential triggers for behaviour change</th>
<th>Design challenge</th>
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<tbody>
<tr>
<td>Pregnancy and child birth are the stages where Amina is emotionally weakest and needs comfort, familiarity, support, and empathy</td>
<td>TBA’s have a compelling emotional offer and are trusted to have the experience and skill (even though are unable to handle some complications) MCHs lack adequate psycho-social support</td>
<td>Birth complications that TBA can’t handle Death/ disability out of birth complications is not the will of God (individual has degree of responsibility)</td>
<td>How do we leverage the TBA in encouraging ANC and facility delivery behaviour? How do we empower WRA to seek services at MCH’s despite current challenges there? How do we improve Amina’s experience at the MCH?</td>
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Discussions in the co-creation workshop revealed that the fear of labour pain was actually due to inadequate information on the natural methods of labour pain management and the lack of adequate birth preparedness by women/spouses, leading to unexpected delivery days and labour occurring in the home or out in the fields with high risk of complications.

The BPC aims to increase the level of awareness among mothers in the community, on Pregnancy, 4 ANC visits and facility delivery by providing free, fun and informative afternoon session, along with skill building on natural labour pain relief methods as well as knowledge required to welcome a new baby, and care for baby post-delivery.
The Initial BPC Class
The first classes took place at one rural and one urban maternal child health clinic (MCH). In total, 43 mothers attended the classes, indicating some level of interest.

Key Learnings
Exit interviews revealed that labour pain management resonated well, particularly with urban women, who were primarily first-time mothers.

Insights emerging from the first round of testing corroborated immersive research findings, revealing that pregnant women are highly vulnerable during pregnancy and need emotional and psychosocial support.

Clients attend ANC clinic but still patronise home delivery services. The provider has insufficient time to attend to the high number of ANC clients that require attention within the short operating hours (7am – 12noon).

Key learnings informed further iterations of the BPC curriculum which include:
- Incorporating emerging topics of interest for the pregnant women.
- Adjustments made to the time of the day during which BPC classes were to be held.
- Re-designing the sessions to be joyful, practical, fun and engaging
- Building in a tour of the labour room to dispel misconceptions associated with facility delivery, (Necessitating minor upgrade of the delivery room, to include dignity curtains and renovation of the toilets) and making the activity fun and engaging.

Second Round of Testing
Overall of 60 pregnant women attended the birth preparedness classes, over a period of 3 months (from July to September 2018). Classes took place at three MCH clinic; two of them located at IDP centers (Abdiidan MCH and Mohamed Mooge MCH). The third, was Guryasamo MCH.

Community mobilisation was carried out by IPC's/FCC's, to reach pregnant mothers at different stages of pregnancy.

In this iteration, traditional birth attendants (TBA’s) were invited as guests in order to equip the TBA with the skill to pass on critical health information and refer cases with possible complications. Further the presence of the TBA's acknowledged the preference of pregnant women, to deliver at home, due to prevailing customs or practical reasons like the distance to the nearest health facility.

Out of the 60 mothers 33 were on 3rd trimester and 27 were on 1st and 2nd trimester. Only 17 of them could merely mention at least one danger sign of pregnancy however, the remaining 48 mothers had no clue about danger signs of pregnancy.

Iteration Phases
Phase 1: The first BPC class was held in Guryasamo MCH and the team leader was assigned to mobilize the community. However, classes had low attendance and as a result, we decided to use the IPC’s to mobilize for us. (currently referred as FCC)

Phase 2: The 2nd BPC class was held in Abdi-idan MCH. This clase faced challenged with the timing of sessions. The initial plan was to start the class from 3 pm to 6 pm. However, this was not optimal because it’s quite hot in the early afternoon and clients had no means of transportation, and as such they would often be late to class. Timing into 4:30 to 5:30 and this worked well.

Phase 3: The 3rd BPC class was held in Mohamed Mooge MCH and we intentionally invited more non-users of ANC or facility delivery? then users compared to Guryasamo and Abdiidan MCH.

Suggestion: if we aim to invite mothers or non-users in very hard to reach area; I think we should consider providing transportation. In one of the MCH’s a client mentioned that she walked about 30 minutes to participate the class.
INTRODUCING BPC
Introducing BPC
The Birth Preparedness class is a series of two classes that will be held each MCH once every week, four times a month. The first class will be scheduled on Sunday afternoon’s, between 4:30pm – 6:00pm for the first cohort (1st and 2nd trimester). The second class will be scheduled on Wednesday’s between 4:30pm – 6:00pm, for the second cohort (3rd trimester). Alternative dates can be selected depending on health facility activity schedule. These classes are labelled “special afternoon sessions” where 12-20 women gather to be taken through an adapted curriculum by a trained nurse or midwife in a Joyful and informative, activity, suitable for adult learners. It will help expectant women to celebrate childbirth as a unique moment in their lives. The class is designed to increase the compliance with the basic requirement of at least 4 ANC visits and facility delivery.

Fun in Learning
Fun activities integrated into the Birth Spacing class include: singing, and prayer sessions, as well as the Henna Body Art, an affordable temporary body pigmentation of the skin. Henna is an affordable temporary pigmentation of the skin for beauty purposes, beauty herb worn by Somali women on their hands, and feet for festive occasions. Practicing different designs application methods is an activity that Somali women often enjoy.

This idea has been well accepted since it was infused into the class during once on the co-creation activities. The purpose of using this material at the BPC is to keep the audience mothers attentive, engaged as well as to create a relaxed environment where they can learn and at the same time prepare themselves to celebrate the childbirth experience as a unique moment.

Theoretical Base for Birth Preparedness Class (BPC)
The Birth Preparedness class interventions is a social behaviour change communication approach that is anchored in sound theory. Each session is designed to be audience centred and participatory. Some of the Behavioural models informing this intervention include:

Using the socioecological model

The socioecological model provides a behavioural framework, which takes into account multifaceted and interactive effects of personal and environmental factors that support behaviour adoption, including as in this case, the need for women to have support groups with their peers or other women with whom they can share their experiences and empathize with each other. This enables them form social networks and social support systems that can influence their individual behaviours and the choices they make.
This intervention is also designed to impact the institutional/organizational level because directly addresses access to services at the health facility, including requiring midwives to work in the afternoon, which is currently reserved for skeletal emergency services, thus initiating a shift in institutional norms to favour women of reproductive age.

**Theory of Reasoned Action**

This theory states that the intention of a person to adopt a recommended behaviour is determined by:

- A person’s subjective beliefs, that is, his or her own attitudes towards this behaviour and his or her beliefs about the consequences of the behaviour. For example, a young woman who thinks that using contraception will have positive results for her will have a positive attitude towards contraceptive use.

- A person’s normative beliefs, that is, how a person’s view is shaped by the norms and standards of his or her society and by whether people important to him or her approve or disapprove of the behaviour.

- This concept is relevant because young people’s attitudes are highly influenced by their perception of what their peers do and think. Also, young people may be motivated by the expectations of respected peer educators.

**Social Learning Theory**

This theory is largely based upon the work of psychologist Albert Bandura. He states that people learn:

- Through direct experience.

- Indirectly, by observing and modelling the behaviour of others with whom the person identifies (for example, how women see their peers behaving).

- Through training that leads to confidence in being able to carry out behaviour. This specific condition is called self-efficacy, which includes the ability to overcome any barriers to performing the behaviour. For example, using role plays to practice how and when to introduce contraception can be important in developing the self-confidence to talk about safer sex methods with a partner.

**Theory of Participatory Education**

This theory states that empowerment and full participation of the people affected by a given problem is a key to behaviour change. This implies that many advocates of peer education believe that the process of peers talking among themselves and determining a course of action is key to the success of a behaviour change education project.

**Health Belief Model**

The health belief model was developed in the early 1950s by social psychologists Godfrey Hochbaum, Stephen Kegels, and Irwin Rosenstock. It was used to explain and predict health behaviour, mainly through perceived susceptibility, perceived barriers, and perceived benefits. This model suggests that if a person has a desire to avoid illness or to get well (value) and the belief that a specific health action would prevent illness (expectancy), then a positive behavioural action would be taken with regards to that behaviour. In this regard, a perceived barrier could be reduced through reassurance, correction of misinformation, incentives, and assistance. For example, if a woman does not seek health care in the local clinic because she feels that her confidentiality is not respected, the facilitator may provide more information on a friendly and confidential service, thus helping to overcome the barrier to accessing proper health care.

**IMBR Model:**

Information, motivation, behavioural skills, and resources. The IMBR model addresses health-related behaviour in a way that can be applied to and across different cultures. It focuses largely on the information (the ‘what’), the motivation (the ‘why’), the behavioural skills (the ‘how’), and the resources (the ‘where’) that can be used to target at-risk behaviours. For example, if a woman knows that using contraceptives properly may prevent an unwanted pregnancy, she may be motivated to use them correctly, but may not be able to purchase or find them. Thus, the concept of resources is important to this model. This implies that a programme of this nature should include comprehensive approach of all four IMBR concepts to ensure availability of the essential components for reducing risky behaviour and promoting healthier lifestyles.
**BPC in Practice**

**Experiential Learning**

“Tell me … I forget, show me … I remember, involve me … I understand”. Ancient Proverb

‘Involving’ participants in a class in an active way that incorporates their own experience is essential to the success of BPC. Such experiential learning gives the participants an opportunity to begin developing their skills and to receive immediate feedback. It also gives them the opportunity to participate in many of the class exercises and techniques first-hand. The model includes the four elements: participation, reflection on the experience, generalization.

**PARTICIPATION**
- Brainstorming, Roleplays, Group discussions, Storytelling Case Studies, games and drawing pictures

**REFLECTION**
- Answering questions, sharing reactions to activity, identifying key results
- Presenting results of discussions or findings and drawing conclusions

**APPLICATION**
- How the knowledge/skills can be useful to their lives. How to overcome difficulty in using the knowledge and skills.
- Plan follow-up on knowledge and skills

**GENERALIZATIONS**
- Drawing inferences of how knowledge and skills can be applied to improve knowledge and skills

**Delivery**

The BPC session shall take the form of a facilitated peer group discussion. In this context, peer education refers to the process whereby a well-trained and motivated woman undertakes an informal or organized educational activity with her peers (those similar to themselves in age, background, or interests).

These activities, occurring over an extended period of time, are aimed at developing the woman’s knowledge, attitudes, beliefs, and skills and at enabling them to be responsible for and to protect their own health. This form of group discussions have a strong influence on the way people behave. This is true of both risky and safe behaviours. Not surprisingly, women get a great deal of information from their peers on issues that are especially sensitive or culturally taboo. BPC intends to leverage peer influence in a positive way.

The facilitator for the BPC will have a detailed curriculum and a job aid to assist her if facilitating the discussions. She is expected to internalize the curriculum prior to the sessions and the job aid which contain only key messages and calls to action during the session.

**Messages**

Health area messages are delivered depending on the gestation age of the mother attending the Class. The BPC class messages is divided into 2 modules to specifically target mothers in their first and second trimester and mothers in their 3rd trimester respectively. Find curriculum and Job aid in annexes.

**Format/Setting**

These group sessions will take place within the hospital premises in the initial stage but can also hold in any location within the community that the mothers find convenient such as schools, markets, workplaces, neighbourhood meeting points, IDP camps, or wherever women gather. In the health centre, the women and the facilitator will sit on mats or benches depending on the facilities available to make them as comfortable as possible to practice their henna application while the discussions are ongoing.
Objectives of BPC

1. Ensure that pregnant women who attend BPC classes, complete 4 ANC visits and to give birth at a health facility.
2. Guide pregnant women, their spouses and families, on how best to prepare for the delivery of the baby and steps to be taken when unexpected complications occur during pregnancy.
3. To alleviate the fear of facility delivery by providing ample information about maternal health and natural pain relief during labour and delivery available at the facility.

Exposure Management

This intervention benefits from the existence of the Hooyo-ku Hooyo community demand creation activities. Through this intervention, pregnant women, especially those who are not yet users of MCH services, identified during home visits, are linked to the health facility for ANC and subsequently encouraged to join the birth preparedness class by the provider depending on how far along they are in their pregnancy. This also allows for continuous follow up of these clients, up to delivery and even for post-natal care. The providers are also expected to encourage walk-in clients, to return for the BPC.

Scope of BPC

Below are 6 topical issues that concerns the expectant mothers;

<table>
<thead>
<tr>
<th>Class</th>
<th>Trimester</th>
<th>Topics</th>
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| 1     | 1st / 2nd Trimester | Importance of ANC  
Nutrition during pregnancy  
Advance birth preparedness  
Danger signs of pregnancy  
Risk of delivering at home/benefits of delivering at a facility  
Importance of breast milk (breastfeeding) |
| 2     | 3rd Trimester | Advance birth preparedness  
Danger sign of pregnancy  
Recognizing signs of labor  
Risk of delivering at home/benefits of delivering at a facility  
Labor pain management (breathing exercise-video demo)  
Importance of PNC and family planning.  
Tour of the labor room |

NOTE: BPC is NOT a substitute for the current ANC classes but an additional innovation to help increase ANC attendance and facility delivery. A pregnant woman would only be required to attend 2 sessions throughout her pregnancy and will be contacted to attend the second class within her last trimester by the facilitators.

Educational Take-Home Materials

The women are given the ‘Hayaan Hooyo’ Booklet during their class. This is a take-home educational material. The content of the booklet include the need for 4 ANC visits, nutrition during pregnancy, breathing exercise, danger signs of pregnancy and advance on birth preparedness. These topics are elaborated during the classes. At the same time, this booklet is intended to give the client a sense of ownership because her name and her husband’s name are labelled on the first page of the booklet. The booklet will also be used to track her ANC attendance and her next BPC appointment.
An educational wall sticker (A3) which highlights the danger signs in pregnancy is given to each client; the purpose is that the client will take it home and stick it to somewhere in her house so that her spouse and/or immediate family have access to observe it and learn from it too. This is an indirect method of involving husbands and other men in Amina’s journey during pregnancy.

Find samples of IEC materials in annexes.

Other Material used in the Class
- Comfort cushions
- Chairs
- Banner (one banner used for all classes)
- Refreshments
- Henna
- Floor mat
- LG flat screen (owned by the MCH) for the video demo.

Renovating the Delivery Room
Delivery rooms in the MCH’s are sometimes the most neglected space in maternity in terms of ambiance or privacy. It’s usually perceived as the least important room because women in labour do not get an opportunity to inspect the room because of the intense pain, they are going through diverts their attention.

Prior to the intervention, we noticed that most delivery rooms lacked privacy, often with three or more delivery beds adjacent to each other with no privacy screen to protect the dignity of the mothers. Attention to the aesthetic as well as toilet facilities was also required.

Renovation is a key aspect of the BPC because at the end of each class, clients will have an opportunity to take a tour of the delivery room to demystify any myths and misconceptions they may have about facility delivery. Therefore, where required, a facelift of the delivery room is recommended with friendly colours that are pleasing and reassuring to the pregnant mother.

After the tour, with some explanations of the procedure, the mothers will give their feedback through a survey at the exit door by ticking a happy or an unhappy emoji to represent how they feel about giving birth in the delivery room.
Methodology

On job training was given to the facilitator prior to commencement of the BPC class at the MCH. These were usually the team leaders at the MCH or a recommended midwife. Since these categories of providers are usually responsible for the ANC sessions and are familiar with the health areas, the training session usually takes about 30 minutes to walk them through the session guide and activities.

A curriculum/facilitators guide has been developed and can be found in the annexes.

Verbatim Quotation (Abdiidan MCH):

Note: Prior to the class, baseline questionnaire was collected from all the participants with a formal consent. The questionnaire focused on different areas including number of children below 5 years, gestational period, place of delivery (last child), current plan of place to give birth, pre-ANC visit, knowledge of danger signs of pregnancy and knowledge about nutritious food.

Best Practice

Aspects of the BPC Participants Liked and Why

1. The Afternoon session.
   
   Reason: (All 20-hand voted) because we are free in the afternoon they said.

2. The mini booklet
   
   Reason: (esp. the schedule of ANC visit per trimester and the actual advance birth preparedness)

3. The adhesive poster.
   
   Reason: “because it will educate our spouses and the rest of our families about when to seek medical attention”.

   
   Reason: “because we did not know the breastfeeding latch and how it’s important for the baby to cover the areola and the nipple together to get enough milk”.

5. The delivery tours.
   
   Reason: “because of the private screen which is covering between two adjacent delivery bed to maintain the privacy of the mother, also the hygiene of the room plus the space. In addition, the delivery room will be a familiar place to give birth”.

Cost Value:

Find in annexes.