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Breakthrough RESEARCH

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A Structural and Provider Behavior Change Approach to Enhancing Respectful, Integrative, Responsive Care for Hospitalized Young Children (0–24 Months) in Kenya

The quality of newborn and pediatric care is tied to parents' experiences participating in their young children's care, including the sense of respect, and emotional support communicated by health professionals. Despite the growing body of evidence around family-centered approaches to caring for newborn and young children in higher-income settings, little is known about the feasibility and effectiveness of implementing institutional and provider behavior change interventions in low resource settings.

To address this, Breakthrough RESEARCH, led by Population Council, tested a set of interventions that promote a positive experience of care for hospitalized newborns and young children 0–24 months and their parents in Kenya. The approach was informed by a review of the existing intervention literature¹ and formative research.^{2–4} This was followed by two co-creation workshops held in early 2020 with providers, parents, and child health stakeholders that validated the global literature review and formative research findings and identified solutions that resonate in the Kenyan context.

Co-creation Process to Develop the Intervention Approach

The co-creation followed a two-part process convening co-design workshops facilitated by Population Council. Part 1 included parents and providers from Nairobi and Bungoma counties (February 3–4, 2020), and Part 2 included program and policy level stakeholders, including Ministry of Health, USAID, UNICEF, White Ribbon Alliance, Save the Children, and professional associations (Kenya Pediatrics Association, Kenya Midwives Association) at county and national levels (February 6–7, 2020).

The participatory consultations involved presentations, plenary reflection, and group work. Validation of the formative work through deliberation enabled

This brief describes a co-creation process and a resulting provider behavior change intervention approach that can be adapted to similar low- and middle-income hospital contexts. It offers policy and program managers details around each intervention component, linking to an accompanying provider orientation PowerPoint and other training materials/job aids. Finally, it recommends a few lessons to guide those interested in engaging in a similar co-creation and implementation approach.



Participants discussing experience of care and intervention approach (from top left, clockwise): Mothers, fathers, health care providers, and policy/program stakeholders.

cross-perspective consensus around the experience of care for sick young children and their parents in Kenya, including manifestations and drivers of mistreatment as well as parent-provider interactions and involvement in the neonatal integrative developmental care model and responsive care practices. Identification of solutions emerged out of reflections on these findings, discussions around program integration within specific facility contexts, existing national guidelines, and consideration of family-centered care and the neonatal integrative developmental care model approaches identified in the global literature review. The co-creation process allowed for a refinement of our theory of change (see Figure 1) that emphasized a structural and behavior change approach to enhancing respectful, integrative, responsive care for sick young children (0–24 months). The solutions identified during the co-creation formed the basis for our intervention approach in relation to our theory of change.

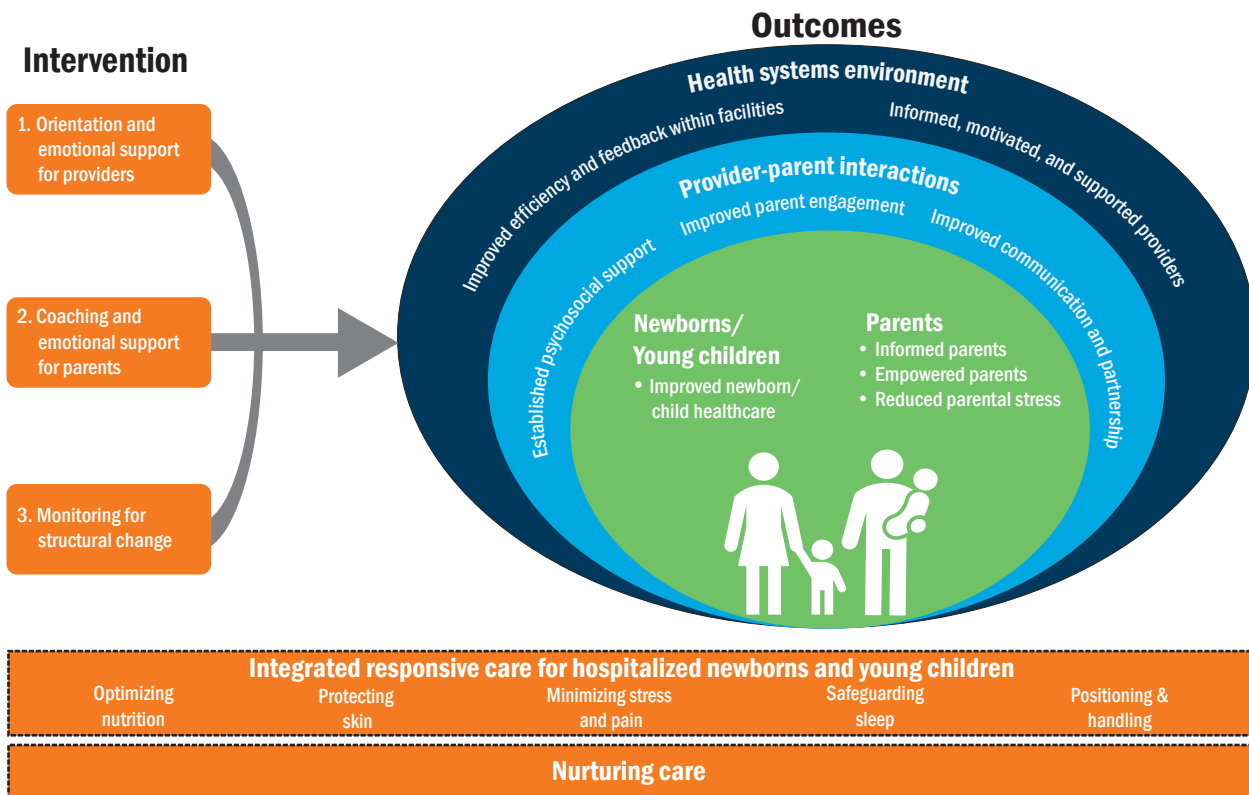
Intervention Approach

The intervention approach aimed to improve provider practice norms and provider-parent interactions to enhance the experiences of parents and their sick young children. It integrated elements of the neonatal integrative developmental care model and responsive care guidelines developed by WHO⁵ and emphasized aspects of the Research and Learning Agenda for Advancing Provider Behavior Change Programming, developed by Breakthrough RESEARCH, that focuses on addressing provider attitudes, norms, and biases that shape provider behaviors during their interactions with parents of hospitalized young children.⁶ The intervention approach included (1) orientation and emotional support for providers, (2) coaching and emotional support for parents vis-à-vis skilled providers, and (3) monitoring for structural change such as physical and/or distributional aspects of changing the environment in which care is provided.

The interventions were implemented in collaboration with the Kenya Ministry of Health (MoH), County Health Management Teams and managers and providers in five

FIGURE 1 THEORY OF CHANGE FOR A STRUCTURAL AND PROVIDER BEHAVIOR CHANGE INTERVENTION TO IMPROVE EXPERIENCE OF CARE FOR HOSPITALIZED NEWBORNS/ YOUNG CHILDREN AND THEIR PARENTS

Enhancing respectful, nurturing, and responsive care for sick young children (0–24 months)



*parent denotes family caregivers, guardians, members of extended family

hospitals in Nairobi and Bungoma counties between November 2020 and August 2021. Given that the intervention commenced six months into the COVID-19 pandemic, implementation was adapted to enable virtual capacity building and limited in-person activities to heed MoH restrictions to prevent COVID-19 spread and protect providers.

1: Orientation and emotional support for providers—building provider capacity

A virtual orientation for facility-based mentors was followed by mentor-led continuous professional development (CPD) sessions to build provider knowledge and capacity.

The orientation package consists of seven modules:

- 1. Introduction of the overall intervention approach**, which adapted the neonatal integrative developmental care model and nurturing care framework. This approach includes partnering with families, optimizing nutrition, minimizing pain and stress, positioning and handling, safeguarding sleep, and protecting skin within a healing environment, with emphasis on respectful, and positive experience of care. This was adapted into an existing WHO/MoH Kenya, Care for Development Child, guide for clinical practice. In addition, we reviewed and discussed formative study findings on mistreatment of women and newborns in Kenya.
- 2. Exploring possible intervention challenges and solutions** posed by COVID-19 pandemic through review of MOH COVID-19 guidelines for newborns and children up to five years of age.
- 3. Understanding how organizational structures and provider behavior affects the care** that is provided, and the interaction between providers and parents. Discuss hospital policies and operations, including how providers and facility managers can engage to create a positive experience for parents and children. Unpack provider values, beliefs and attitudes, and stressors to shift behaviors.
- 4. Coaching parents to facilitate positive provider-parent engagement and communication** in caring for a sick child with a focus on how providers can coach mothers, adopt a team approach that accounts for parents' needs, and involve fathers and other male relatives.
- 5. Promote awareness and implementation of neonatal integrative developmental care** model and nurturing care components, including optimizing nutrition, protecting skin, minimizing stress and pain, safeguarding

sleep, positioning and handling; and early childhood physical and cognitive development for sick newborns and young children.

- 6. Build provider capacity for emotional support**—for themselves and parents—and how to operationalize two global emotional support tools adapted for Kenya's context.
- 7. Foster an enhanced facility environment** to improve experience of care through intervention monitoring focused on quality improvement and routine feedback mechanisms.

Conducting virtual orientation for mentors

The study team identified three to four mentors per facility from both the newborn and pediatric units in collaboration with facility management and peer providers. A preliminary meeting was held with identified mentors and trainers (including MoH and Nairobi Metropolitan Services colleagues) to discuss the orientation objectives and expectations. A virtual five-day orientation workshop with 21 mentors took place between November 2020 and January 2021 due to COVID-19 restrictions. In addition to the seven modules, the mentors were trained on mentoring principles and skills to prepare them to build capacity of the providers in their respective facilities. These include delineating roles and responsibilities of mentors and mentees (providers) and discussing how to build mutual respect between them to ensure mentees learning. The mentors developed continuous professional development schedules and action plans in consultation with facility management and providers.

CPD sessions at facility level

Mentors used various strategies—both in-person and virtual—to build provider capacity using the seven modules between November 2020 and July 2021. A total of 20 CPD sessions were held at the facilities with an average of 22 providers attending each session from both the newborn unit (NBU) and pediatric wards. Mentors led facility-based 1- to 3-hour orientation sessions targeting a cohort of providers, used combinations of standardized slide decks, discussed print and video-based job aids (Table 3), and engaged in one-to-one mentoring/on-the-job training. At the end of each CPD session and during on-going mentoring, mentors and providers discussed how to translate the knowledge to practice. Some illustrative highlights include:

- How to start advocating for facility policy change on admission/discharge processes, visitation, service fees, feeding and treatment times, and amenities for parents as part of facility changes to ensure hospitalized young

children and parents centred services and resources available.

- How to use values clarification and attitude change tools to recognize the influence of provider attitudes and behaviors on parent's/children's experience of care, on the one hand and shift their behavior on the other. How to adhere MoH's infection prevention including the COVID-19 Child Health National guidelines on assessing, triaging, and treating sick children with upper respiratory infection/pneumonia, including displaying a wall-chart protocol.
- How to use job aids to strengthen their interactions and communication with parents of hospitalized young children.

Job aids and tools used

The project staff in collaboration with MoH, study sites mentors and providers developed/adapted and pretested four job aids for training and support intervention implementation. The existing MOH Training Manual and Clinical Guide on Early Childhood Development and the MoH COVID-19 Guidelines for Newborns and Young Children up to five years Table 2 (page 5).

As COVID-19 restrictions eased, in-person facility-based meetings/ and training among providers, (peers), providers, mentors, and project staff were conducted using the orientation PowerPoint on all the intervention modules to ensure standards across sites. The project staff supported learning virtually or in-person where appropriate. This was complemented by weekly virtual meetings (via telephone/ WhatsApp) during which the mentors and providers reviewed progress learning, use of job aids, and overall intervention. All job aids were disseminated and sent through WhatsApp and/or printed for use as described above. Where possible, each of the facility teams was encouraged to review the videos together and discuss lessons learned and the potential transferability of some techniques where the video only focused on the newborn to the older children (29 days–24 months). A total of 289 providers were trained across the five study sites during the intervention period.

Emotional support for providers

Existing literature, formative results findings and the co-creation process identified that provider behavior is affected by work-related stress and burnout due to heavy workload, poor working conditions, and a lack of supportive supervision and psychosocial support.^{7–9} To address this, mentors and providers were trained on an adapted **Provider Emotional Wellness tool** that promotes

'Awareness, Balance and Connection' and helps to identify and cope with stress. This tool offers strategies for provider self-care, reflection on one's stressors, and promotes work/life balance and interpersonal connection as a way of coping and reducing burn-out. Providers were also trained on how to support parent's emotional wellness using an **adapted Distress-Emotional-Partnership (D-E-P) Guide**, that was adapted from Distress-Emotional-Family (D-E-F) Protocol for Trauma-Informed Pediatric Care.¹⁰ Additionally, the study supported facility-based counsellors to offer debriefing sessions to support provider emotional well-being; this was later complemented with sessions facilitated by an external counsellor. Staff debriefed on a wide range of work and personal stressors and how these affected their day-to-day provision of care. Providers who required longer-term counselling were linked to external psychological support beyond the study timeline.

2: Coaching and emotional support to parents at facilities

Coaching parents: translating knowledge into practice

Providers drew on all seven modules to adapt their coaching styles and enhance their interactions with parents. Several job aids and training materials were used to support providers coaching styles to both promote the neonatal integrative developmental care model and nurturing care and provide emotional support to parents (Table 2). Many of these materials were developed or adapted for the intervention, from global or regionally applied tools through an iterative process between the project team and key stakeholders. Providers coached parents on the neonatal integrative developmental care model components and encouraged them to ask questions and voice their opinions or concerns for shared decision-making about their young child's care while in hospital. Each facility displayed job aids, including adapted wallcharts and protocols for the neonatal integrative developmental care model; in some cases, facilities played videos on televisions in common areas within the NBU and pediatric wards. Targeted messaging and posters on how fathers can participate in the neonatal integrative developmental care model and nurturing care were posted within pediatric wards, NBUs, waiting areas and at home.

Emotional support for parents

Providers were encouraged to use **Parents' Emotional Wellness Guide** that emphasizes distress recognition, emotional support, and partnership (DEP) guide to identify parents exhibiting signs of stress to counsel and offer emotional support daily. The guide assisted providers in i)

TABLE 2 JOB AIDS/TOOLS USED

All job aids were displayed on a wall in the NBU/pediatric ward at points accessible to provider and parents. They were availed electronically through WhatsApp to parents when possible.

JOB AID	USE
A guide for communication during hospitalization	Adapted to provide guidance on communication between parents and providers during procedures and care of sick newborns and young children within hospital settings.
Male engagement poster for involving fathers	A brochure developed to educate and empower male partners to be involved in care of their sick and well children during hospitalization and at home.
The Distress-Emotional-Partnership (D-E-P) Guide for Trauma Informed Pediatric Care	A practical three-step process which provides resources to help families cope with pediatric illness and injury was adapted to guide both provider and parents on how to recognise and manage stress in sick newborns and young children during hospitalization. It also helps parents identify when they are stressed, when selfcare could benefit them, or seek support from providers to manage their stress.
Provider’s Emotional Wellness	A three-step guide referred to as the Awareness, Balance, and Connection (ABC) guide to help providers be aware when stressed, possible stress triggers, how to balance work and life to avoid stress, and how to connect with others, family, or counsellors to manage stress.
The MOH Training Manual and Clinical Guide on Early Childhood Development, 2018	The manual was used to integrate/adapt elements of nurturing care into the neonatal integrative developmental care model for sick young infants up to two years of age.
Neonatal integrative developmental care model and nurturing care components*	Videos used (All videos were made available through facility mentors and mentees WhatsApp platforms in each study facility)
1. Optimizing nutrition	<ul style="list-style-type: none"> - Helping a breastfeeding mother (Swahili) - Complementary feeding (6–12 months) - Tips on how to feed your child (1–2 years) - Understanding what your child should eat (6–24 months)
2. Protecting skin	<ul style="list-style-type: none"> - Keeping the baby warm (Swahili) - Carrying baby skin to skin (Swahili) - Chlorhexidine for newborns (Swahili)
3. Safeguarding sleep	<ul style="list-style-type: none"> - Carrying baby skin to skin (Swahili) - Nesting for newborns
4. Minimizing stress and pain	<ul style="list-style-type: none"> - How to assess pain and stress for babies in NBU - Non-pharmacological measures for soothing pain
5. Positioning and handling	<ul style="list-style-type: none"> - Early childhood development (Swahili)
6. Healing environment, COVID-19 IPC	<ul style="list-style-type: none"> - Healing environment for pre-term and sick infants - Handwashing in hospitals
7. Provider communication	<ul style="list-style-type: none"> - Communicating with parents/delivering bad news - How to communicate a disappointing outcome

identifying sources of anxiety, worries, fears, and concern; ii) providing emotional support, and iii) engaging with parents and family to mitigate stressors, including bereavement. Parents were also encouraged to share their worries and concerns with other parents if they felt comfortable doing so. The most reported sources of stress among parents included fear of the outcome for their sick child, critical illness, bereavement, limited visits due to COVID-19, fear of contracting COVID-19, and hospital machines (incubators, phototherapy machines, and oxygen therapy gadgets).

3: Monitoring for structural change

To integrate parent and provider feedback into quality improvement mechanisms, we incorporated two routine monitoring and feedback tools (designed for the intervention) into regular meetings at each facility. These tools documented providers' and parents' experiences of the interventions and contributed to wider monitoring of structural changes in facility, NBU, and pediatric departments.

1. Parent exit feedback: one short form was administered to parents on exit, and a slightly longer one within 14 days after discharge between March and June 2021 conducted through phone at home. Parents were asked about their perceptions of hospital/ward environment, experiences during their child's hospital stay, views on communication and interaction with providers, including provider coaching on integrative nurturing and responsive care. They were also asked about sources of stress or emotional support received.
2. Provider self-administered peer feedback: hosted electronically on a Kobo platform⁹ where providers were asked about their own and peer providers' experiences and perceptions of the intervention and job aids. This included reporting on the emotional wellness tools and psychological debriefing sessions on their and their peers' behaviors, and the psychological support they provided to parents. However, many providers did not fill in the feedback forms preferring to discuss their issues during review meetings with project staff or counsellor.

Facility-based quality improvement teams (QITs) at NBU and pediatric ward levels met periodically during

⁹KoBo Toolbox is a suite of tools for field data collection for use in challenging environments. It is free and open source. It was developed by teams of developers and researchers based in Cambridge, MA and many other places around the world. It helps with collecting quick and reliable data online or remotely. For more information, see <https://www.kobotoolbox.org/>

the implementation period. As part of the intervention approach, Breakthrough RESEARCH supported virtual monthly meetings lasting 1 to 1.5 hours for facility managers, mentors, and providers, and county or sub-county managers to share experiences and implementation challenges encouraging cross-learning between the five study facilities. The feedback received from the facility QITs meetings, monthly meetings, and provider and parent interviews supported the identification of specific facility-designed and implemented solutions for structural change.

Lessons Learned

This brief presents the intervention development and implementation process initiated before and during the COVID-19 context. Several important lessons emerged:

1. It is important to engage in formative work to inform a provider behavior intervention or contextualise the evidence to individual and community factors relevant to a particular group (societal, ethnic, cultural) and geography, as well as any institutional factors.
2. Involving key stakeholders, including providers and parents, throughout the formative, co-creation workshops, intervention development, implementation and evaluation is critical to helping both providers and parents of young children feel ownership and desire to sustain the work beyond the life of a project.
3. Stakeholder involvement using a co-creation process in defining what intervention activities resonated in Kenya and how to implement and measure progress was integral to the final design. Using a bottom-up approach through the co-creation workshops—speaking to parents and frontline providers before policy/program stakeholders—was particularly useful in drawing out sensitive power-laden issues that affected both provision and experience of care. These participatory sessions strengthened our theory of change and concurrence on intervention activities.
4. Important to tread carefully to ensure parents' voices do not get muted in the presence of any provider who may have treated them or their young child prior to the co-creation workshop. We countered this concern by having separate groups for discussion so that everyone was able to voice their opinion—i.e., mothers of young babies in one group, fathers in another, and frontline providers in another.
5. Incorporate providers' and parents' reflection throughout the implementation of the intervention—iteration

and feedback of job aids by parents, providers, and facility managers enhanced their overall quality and relevance.

6. Flexibility in adapting to virtual learning for both orientation and monitoring of the interventions is needed. Contextual issues such as provider strikes, and the COVID-19 pandemic posed challenges to intervention implementation.
7. Despite virtual adaptations, there is a need for face-to-face provider training for clinical aspects of the neonatal integrative developmental care model, communication and interaction, demonstrations/role plays, emotional support, nurturing care, and behavior change activities.

Conclusion

Using a co-creation process with parents, providers, and policymakers to determine challenges and solutions to improve the quality of newborn and pediatric care was critical in developing a contextualized approach in Kenya. Involving providers throughout led to flexible ways to use adapted and newly developed job aids—virtually and in-person—given the COVID-19 pandemic context. This also fosters a sense of ownership to providers on the interventions’ modifications or usefulness. The localized participatory process is low-cost and adaptable for newborn and child health policy and program stakeholders to align their strategies with parents’ experiences and needs.

References

1. Ndwiga, C. et al. 2022. “Experience of care of hospitalized newborns and young children and their parents: A scoping review,” *PLoS ONE* 17(8): e0272912. doi: 10.1371/journal.pone.0272912
2. Abuya, T. et al. 2022. “Manifestations, and drivers of mistreatment of sick newborns and young infants and their parents in health facilities in Kenya,” *PLoS ONE* 17(2): e0262637. doi: 10.1371/journal.pone.0262637
3. Breakthrough RESEARCH. 2020. “Understanding provider and parent experiences in caring for hospitalized young children: Summary findings from a formative study in Kenya,” *Programmatic Research Brief*. https://breakthroughactionandresearch.org/wp-content/uploads/2020/12/BR_Kenya_Newborn_Form_Brief.pdf.
4. Okondo, C. et al. 2022. “You can’t even ask a question about your child”: Examining experiences of parents or caregivers during hospitalization of their sick young children in Kenya: a qualitative study,” *Frontiers in Health Services* 2: 947334. doi: 10.3389/frhs.2022.947334
5. World Health Organization. 2020. “Improving early childhood development: WHO guideline.” <https://www.urban.org/research/publication/improving-early-childhood-development-policies-and-practices>.
6. Breakthrough RESEARCH. 2019. “Advancing provider behavior change programming,” *Research and Learning Agenda*. Washington, DC: Population Council. <https://breakthroughactionandresearch.org/wp-content/uploads/2019/02/RLA-Provider-Behavior-Change.pdf>.
7. Dugani, S. et al. 2018. “Prevalence and factors associated with burnout among frontline primary health care providers in low- and middle-income countries: A systematic review,” *Gates Open Research* 2:4. doi: 10.12688/gatesopenres.12779.3.
8. Ndwiga, C. et al. 2017. “Exploring provider perspectives on respectful maternity care in Kenya: “Work with what you have,” *Reprod Health [Internet]*. 14(1): 99. Available from: <http://reproductive-health-journal.biomedcentral.com/articles/10.1186/s12978-017-0364-8>
9. Afulani, P. A. et al. 2020. “Providers’ perceptions of disrespect and abuse during childbirth: A mixed-methods study in Kenya,” *Health Policy Planning* 35(5): 577–586. doi: 10.1093/heapol/czaa009
10. O’Brien, K. et al. 2020. *The Children’s Hospital of Philadelphia. Healthcare Toolbox*. <https://www.healthcare-toolbox.org/>. Accessed 12 Jun 2020.

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