RMHC

Keeping families close

RMHC Maternal and Child Grantees
Three-Year Summary Report

General Information:

- **Organization:** Curamericas Global
- **Project Title Based on the Initial Grant Proposal:** Saving lives of mothers and children through Community Based Birthing Centers: taking the Casa Materna global and testing it in new contexts in Guatemala, Kenya and Sierra Leone.
- **Contact:** Andrew Herrera, andrew@curamericas.org, 919-510-8787 (office); 919-801-0612

Project Description:

Be clear and concise. Include the unmet need you were seeking to meet/address based on the initial proposal. Add information that helps demonstrate the impact.

The global tragedy of preventable maternal and neonatal mortality persists: the world is not on track to meet the Sustainable Development Goal (SDG) of reducing the global maternal mortality ratio (MMR) to less than 70 maternal deaths per 100,000 births by 2030. The epicenters of these tragedies include sub-Saharan Africa, South Asia, and parts of the Americas, especially the indigenous population of Guatemala. High maternal mortality signals a systemic failure of the health system, often manifesting as racist exclusion of indigenous peoples from health services. Furthermore, health facilities are often too distant or too costly for poor rural people to access and operate on limited hours and provide disrespectful, even abusive, and low-quality care. Given these barriers, poor rural women continue to deliver and die in their dirt-floored homes.

Our project aims to address this challenge by scaling-up and validating our revolutionary Ronald McDonald House Charities Community Birthing Center/"Casa Materna" model for reducing maternal and neonatal mortality. This model builds and strengthens the local health system by providing community-owned or -advised obstetric facilities that are culturally appropriate, accessible, and affordable to local populations. The facilities are staffed by indigenous health workers who provide 24/7, respectful, high-quality routine and emergency obstetric care.

In the last 3 years, we have deployed 7 new Community Birthing Centers (CBCs) for a total of 10, dramatically expanding our reach in Guatemala and replicating the RMHC CBC model in Kenya. We have also shown that in order to make significant, sustainable gains in the health of mothers and children, change must be driven by the communities themselves. In our projects, change is led by community health committees, community health workers, trained traditional midwives and the mothers themselves, who educate and support each other in practicing healthy behaviors. Engaging so many community actors has allowed us to bring life-saving health education to every doorstep, change behaviors at the household level, and create demand for CBC services. Most importantly, the model creates a culture and focus on the importance of health – particularly the health of mothers and children.

In addition to the programs outlined above, Curamericas implemented an innovative sexual and

reproductive health curriculum for adolescents in local schools. Pregnancy and childbirth are the leading cause of death among girls aged 15–19 years globally. Many of these pregnancies are unwanted, unplanned and result in birth complications or botched, illegal abortions. Education on sexual and reproductive health in schools is often nonexistent. Curamericas' curriculum goes beyond traditional "sex ed" to include additional lessons on emotional intelligence and responsible decision-making.

To sustain our CBC model, we nurtured partnerships with the communities, civil society, Ministries of Health (MOH) and local governments, massively leveraging RMHC resources to increase reach and impact. In addition, to replicate our model, we established a Center of Excellence with Curamericas Guatemala at their headquarters, a site where practitioners can come to observe and learn, and then bring the model home.

We feel that we were hugely successful in this ambitious endeavor. In Guatemala, we expanded the reach of our project seven-fold, from a pilot catchment of only 8,100 to a population totaling 55,637, spread over five municipalities in two Departments. During this process, we not only strengthened the services of our 3 existing Casas Maternas but also built and launched 4 more Casas Maternas. During the 3 years of this project these 7 Casas attended 1,233 deliveries, including 332 potentially fatal obstetric complications. As a result, in our project catchment, maternal mortality decreased by 79%, from 4 deaths/year, a maternal mortality ratio (MMR) of 602, to only 1 maternal death in 2020, an MMR of 142. Neonatal mortality declined 36%. In addition, our innovative sexual/reproductive health curriculum reached 2,253 adolescents. Our MOH, municipal government and community partners now support 2/3 of the personnel and operating costs of the Casas Maternas, ensuring their sustainability. In addition, our Kenyan MOH partners received training at our Center of Excellence in Guatemala, enabling their successful replication of the model in their home country.

In Kenya, we are proud to report that we successfully adapted and replicated our model on African soil, working in close partnership with the Kisii County MOH. The Kenya project serves three rural catchments totaling 35,960 population. Unlike Guatemala, here there were three existing MOH clinics, however they were grossly underutilized due to stockouts, lack of infrastructure, and lack of 24/7, culturally sensitive services. Utilizing our *Community Birthing Center Manual* and its Rapid CBC Assessment Tool, we partnered with the communities and the MOH to adapt these clinics to the CBC model, adding nursing staff to enable 24/7 services, creating woman-friendly birthing spaces to the communities' specifications, and installing battery-backed solar panels to ensure 24/7 electricity. As in Guatemala, we mobilized the communities to deploy health committees, community health volunteers, and mother peer educators bringing health education to every doorstep.

The result – maternal mortality decreased from 9 maternal deaths/year, an MMR of 1,122, to 0 deaths in 2020, a reduction of 100%. Neonatal mortality declined 42%. In addition, our innovative sexual/reproductive health curriculum reached 470 young adolescents. While the ending of RMHC funding has required a scale-back of some aspects of the project, the MOH is sustaining the CBCs, whose life-saving work continues.

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Goals and Objectives:

Please be consistent with the original proposal. Include a summary of all adjustments you made throughout the course of the three-year period, including changes made as a result of COVID-19, or others. We have approved changes to the program delivery and the direction of funds over the years. Describe what you learned and why the adjustments were important (what new information or external changes occurred causing you to pause and reassess).

The original project goals were to reduce maternal/neonatal mortality and improve child nutrition among women and children in high-mortality regions of Kenya, Sierra Leone and Guatemala. Our goals were to serve populations totaling 215,000, including 46,120 children and 58,800 mothers. Objectives included: Increase health facility deliveries with professional birth attendants to 65%; increase attention to obstetric emergencies to 70%; increase health facility deliveries that were respectful and culturally-appropriate to 75%; increase the percentage of women who can recognize obstetric and newborn danger signs to 70%; reduce stunting to 40% in Guatemala, 30% in Sierra Leone and 17% in Kenya; and reduce maternal mortality by 50% and neonatal mortality by 35%.

Our first major adjustment occurred early in the project. Following our hallmark best practices, in Program Year 1 we executed the most thorough formative research efforts ever done in our prospective new catchments in both Kenya and Guatemala. The research utilized household surveys, mortality censuses, a comprehensive assessment of the Kenya clinics using our proprietary Rapid-CBC Assessment (R-CBCA) tool, and extensive interviews and focus group discussions with beneficiaries, MOH staff, and community leaders. The results were staggering and sent shock waves through the Ministries of Health of both Kenya and Guatemala: the situation on the ground was far worse than anyone expected, with maternal and neonatal mortality three times the expected levels and appallingly high levels of unsafe home deliveries. In Kenya, the clinics to become CBCs were so lacking in staff and reliable infrastructure that they were rarely used for maternal/newborn care by the population they were meant to serve. In Guatemala, the region was passing through a crisis of poverty, violence and food insecurity, contributing to a mass exodus of Mayans seeking asylum in the U.S.

Meeting our original project goals would require more resources than we would have at our disposal. We concluded that the quality of execution was a far higher priority than the quantity of people served. So as to not overwhelm our implementing partners and to focus on the effective replication and improvement of the model, we proposed to reduce the populations and beneficiaries served and adjust the end-of-project outcome indicator goals, changes which RMHC graciously approved. Regrettably, this entailed postponing the replication of our work in Sierra Leone.

What we learned: this experience validated our meticulous formative research process, which enables us to discover the reality on the ground, to not only execute proper project planning but to also inform the local MOH, who more often than not are “flying blind” with unreliable data. We feel that the successes we achieved validated this assessment, that quality of execution superseded quantity of production, and we greatly appreciate RMHC’s support of our assessment.

The other significant adjustment was to the COVID-19 pandemic. When the pandemic hit, our

Guatemala and Kenya projects embarked on comprehensive public awareness and mitigation campaigns that required profound adjustments. During this time, project staff effectively leveraged the trust and social capital they had cultivated in the communities to execute extensive education campaigns at the community and household level. Care Groups and routine home visitations by staff and mother peer educators continued and reached mothers with direct education and support on coronavirus prevention utilizing our new COVID-19-themed Care Group lessons which we pioneered and have since been disseminated globally (https://www.fsnnetwork.org/resource/curamericas-care-group-lessons-covid-19). Field staff created visual aids to leave with families for further reference. Staff also utilized WhatsApp to reinforce health messages and to check on the health of families between visits. In Kenya, a project beneficiary and her husband, a local tailor, made over 2,000 masks at cost, enabling us to provide a mask to every mother and community health worker in the Kenya program. Also, in Kenya, our Village Health Committees successfully petitioned the local Kisii County administration to allow pregnant women to legally travel after curfew in order to deliver safely in our Community Birthing Centers. In Guatemala, staff created engaging radio COVID prevention lessons that were widely broadcast in the local Mayan languages.

Project staff also made enormous efforts to ensure that maternal/newborn health services and education continued despite the pandemic, with zero diminishing of services. In fact, Guatemala staff reported that the demand for health services at the Casas Maternas actually increased by 20%. On August 23, 2020, in mid-pandemic, the first baby was born in the newest Casa Materna in Sichivilá. Most of the construction of the new Casa Materna occurred amidst the fear and uncertainty brought on by the pandemic, and was achieved through a sustained, collaborative effort of community members, the MOH, and Curamericas Guatemala, and stands as a tangible symbol of partnership between the Maya people and the government.

In addition, Curamericas Global and our implementation partners supported the creation of a *Home-based Care Guide* for people with COVID-19 or its symptoms in low-resource areas. This Guide is available on CORE Group's website and has been shared around the world though Curamericas' partners, with the document already translated into 6 languages.

The lesson learned: Curamericas' exemplary pandemic response was enabled 1) by leveraging our empowered community health networks, which have allowed us to quickly and efficiently reach every family with education and support and tap into the communities' initiative; and 2) by our partners' dedicated staff, who were able to readily redirect their hard-won maternal and newborn care professional skills to prevent the spread of COVID-19.

Outcomes:

What tangible outcomes/results did you meet -for example: # of babies delivered over the three years, # of mothers whose births were attended over the three years, mortality rates changed over the three years, # of people served over the three years through all program efforts? Please complete the attached Excel worksheets for 2020 metrics as well as summary metrics for 2017-20.

How does this position you for the future?
What partnerships did you develop?
What attitudes/knowledge/behaviors did you influence or change?
What key learnings did you realize? Did these challenge your initial assumptions, reshape your thinking, reinforce your original approach?

We are proud to report that despite the challenges, including a devastating global pandemic, we have attained or exceeded nearly all our adjusted end-of-project goals:

Table 1 – Project outcome indicators

Outcome Indicator	End of Project Result	Goal
Number of Community Birthing Centers operational	10	10
Percentage of women with health facility deliveries	74%	55%
Percentage of obstetric emergencies attended in a health facility	80%	65%
Percentage of deliveries with respectful/culturally appropriate care	48%	55%
Percentage of women who can recognize 3 danger signs in pregnancy	70%	55%
Percentage of women who can recognize 3 danger signs in delivery	54%	50%
Percentage of women who can recognize 3 danger signs post-partum	56%	55%
Percentage of women who can recognize 3 danger signs in newborn	40%	55%

Table 2 Mortality impact

Maternal mortality	**Baseline**			**Final**			**% Change**	**End of Project Goal**
	Deaths	Live births	Maternal Mortality Ratio	Deaths	Live births	Maternal Mortality Ratio		
Kenya	9	802	1122	0	519	0	-100%	-38%
Guatemala	4	664	602	1	780	128	-79%	-38%
Combined	13	1466	887	1	1299	77	-91%	-38%
Neonatal mortality	**Baseline**			**Final**			**% Change**	**End of Project Goal**
	Deaths	Live births	Neonatal Mortality Rate	Deaths	Live births	Neonatal Mortality Rate		
Kenya	37	802	46	14	519	27	-42%	-35%
Guatemala	16	664	24	12	780	15	-36%	-35%
Combined	53	1466	36	26	1299	20	-45%	-35%

Our Casas/Community Birthing Centers managed 2,612 deliveries over the course of the project. For the project as a whole, maternal mortality declined 91% (vs. a goal of -38%) and neonatal mortality declined 45% (vs. a goal of -35%). Maternal deaths decreased from 13 annually to only 1; neonatal deaths decreased from 53 annually to only 26.

As the data show, crucial knowledge and behavior change at the household level was associated with the significant reductions in maternal and neonatal mortality. Increases were notable in attention to obstetric emergencies (where every minute counts), the number of mothers able to immediately recognize obstetric and newborn danger signs, and the number of safe deliveries, particularly in Kenya, where nearly all mothers (95%) gave birth at a health facility. Women now actively seek antenatal care, safe health facility deliveries, and timely post-partum care, helping ensure optimal maternal/newborn outcomes.

Our model recognizes that no one partner, not even the MOH, possesses sufficient resources to impact maternal and child mortality. Substantial, long term impact can only be brought about through collective, coordinated action at local and regional levels. Therefore, a key achievement of this project was the solidification of strong and durable partnerships. In Guatemala, we established a new partnership with the San Marcos Department MOH, evidenced through the construction of three new Casa Maternas, significant cost-sharing, and collaboration on daily activities with MOH staff.

We are proud to report that as of October 2020, the MOH and local governments will cover the salaries of 14 auxiliary nurses across 6 Casa Maternas (an annual contribution valued at $94,000). The MOH also provides medicines, drugs and medical supplies to our Casas Maternas. In all, our Ministry, municipality and community partners cover 2/3 of the operation costs of the Casas Maternas. These commitments ensure that the project continues after the conclusion of the grant. In Kenya, a five-year memorandum of understanding (MOU) was drafted and signed between Curamericas Global and the Kisii County Ministry of Health. This MOU captures the commitment of both parties to continue the Kenya project through the MOH support of the CBCs, including the provision of nursing and administrative staff.

Our results, our partnerships, and our Center of Excellence position us well for the future. The partnerships will ensure that the health system strengthening we have achieved will endure. The results achieved, when disseminated, will help persuade our current partners to invest even further, as well as convince other practitioners to replicate our model. Our Center of Excellence will continue to provide a hands-on training, guidance, and inspiration to public health professionals around the world.

Our key learnings from the past three years have validated and reinforced our approach:

1) the need to invest time and resources in thorough formative research to really know the situation on the ground;
2) that ending preventable maternal and neonatal mortality requires teamwork, an “all hands on deck” commitment, and resource-sharing of civil society, the MOH, local government, and, especially, the communities themselves, who are the most important pillar of the system;
3) that this teamwork does not come easily, but requires persuasion, diplomacy, resolution of disagreements and misunderstandings, and a long-term perspective that cultivates the necessary patience to bring reluctant partners on board;
4) because this work is transformative and paradigm-changing, led bottom-up by communities rather than imposed top-down by MOHs, it requires long time horizons for full realization; and
5) that our model succeeds because it is “a bird with two wings”: one wing being empowered

communities practicing the behaviors that ensure maternal/newborn health and the other wing the Community Birthing Centers/Casa Maternas, offering accessible, affordable, high quality, respectful culturally-appropriate care. Without both wings, the bird cannot fly.

Two Photos with Captions:



COVID-19 struck Kenya, our KIKOP project communities mobilized to sew over 2,000 masks to provide to all project staff and community mothers, a testimony to the community initiative and empowerment our work cultivates.



Nohemí is 18 years old and lives in a community in the rolling hills of Tajulmulco, Guatemala. A first-time mom, Nohemí wanted to make sure that she was providing herself and her unborn child with the best chance at a healthy future. During her pregnancy, Nohemí attended 5 prenatal care checks at the Casa Materna, receiving health education as well as medical tests that enabled the Casa Materna staff to properly manage health issues to ensure a safe delivery. During her prenatal checks Nohemí also worked with staff to create a birth plan and schedule her upcoming visits. Nohemí gave birth at the Casa Materna to a healthy baby boy. She and her family expressed to the staff how fortunate they felt to be able to give birth according to their Maya customs and with people whom they know and trust. This is a selfie she took of herself at the Casa with her newborn.