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This project is part of the EDCTP2 programme supported by the European Union
EDCTP

Community-based home visits for families with preterm & low birthweight infants in South Africa: A Qualitative Evidence Synthesis

Sara Cooper, Idriss Kallon, Denny Mabetha, Amanda Brand, **Tamara Kredo**, Shakti Pillay, Gugu Kali, Willem Odendaal

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saMRC advancinglife
Stellenbosch University iYunivesithi Universiteit
University of Calabar Teaching Hospital
Høgskulen på Vestlandet
Kamuzu University of Health Sciences
NTNU Norwegian University of Science and Technology
Cochrane
MAGIC Evidence Ecosystem Foundation

The South African Medical Research Council

recognizes the catastrophic and persisting consequences of colonialism and apartheid, including land dispossession and the intentional imposition of educational and health inequities.

Acknowledging the SAMRC's historical role and silence during apartheid, we commit our capacities and resources to the continued promotion of justice and dignity in health research in South Africa.

transformation

WORKING TOGETHER FOR EXCELLENCE

The GELA project: Newborn child health guideline adaptation

- Poverty-related diseases is leading cause of death in children < 5 years in Africa
- Despite improvements in child and maternal health over past decade, SSA still faces ongoing struggle to reduce health inequalities and reach global sustainable development goal targets.

Global Evidence; Global Adaptation (GELA) project: Three-year project until July 2025

- Maximise the impact of evidence use for children and newborns by increasing researchers and decision makers' capacity to use research to develop locally relevant guidelines for newborn and child health.
- Implemented in 3 African countries: Malawi, South Africa, Nigeria




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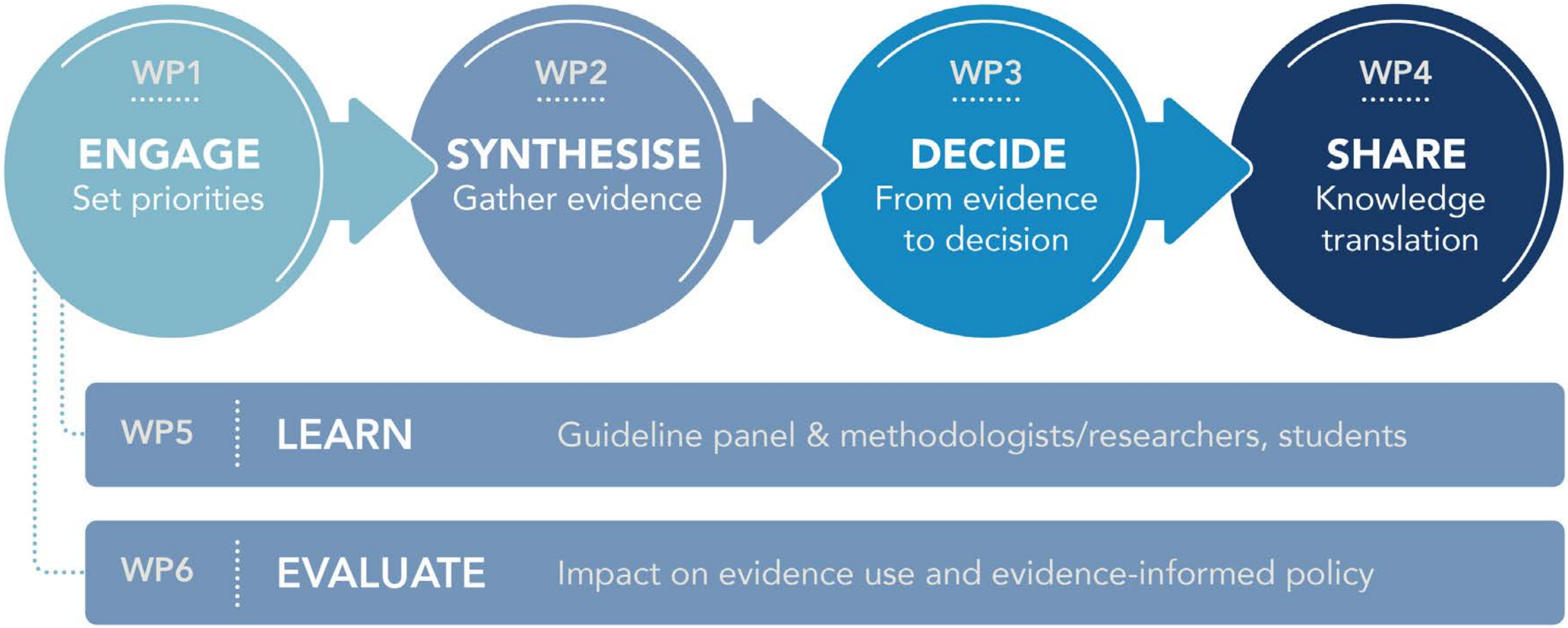
GELA project work



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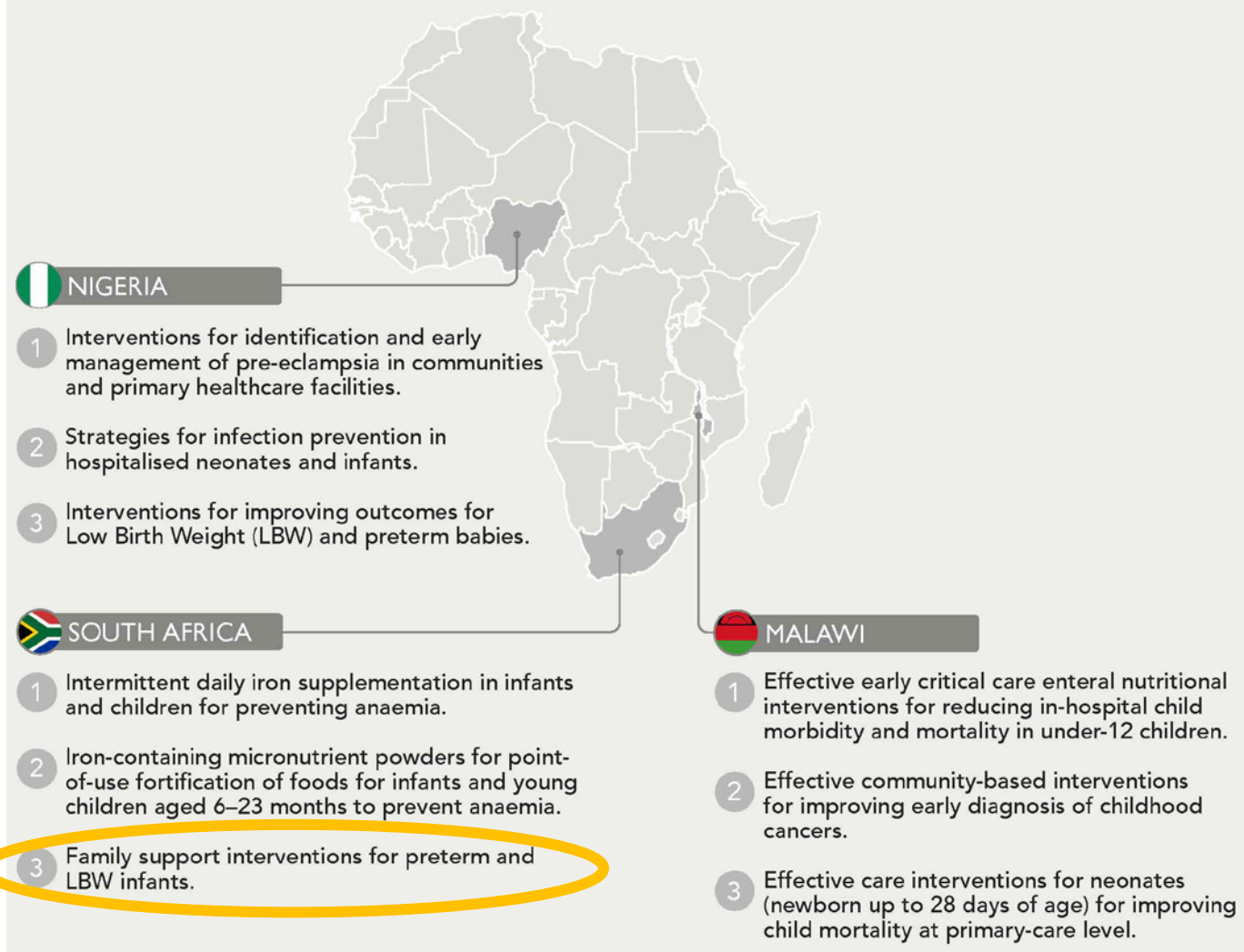
ENGAGE: Diverse priorities to match needs

Lilongwe, Malawi meeting
January 2023



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SYNTHESISE: Producing the evidence

Question: Should home visits be delivered for preterm and LBW infants following discharge from the hospital?

Systematic review of effectiveness: Assess the effectiveness of home visits compared to standard of care for families of preterm or LBW infants to reduce morbidity, mortality and enhance health and well-being

Review of costs and resources: Review available economic evidence on costs and resource requirements for community-based home visits for postnatal care and potential additional resource requirements for extending programmes for LBW/preterm infants in the SA

Systematic review of qualitative evidence: Explore stakeholders' views and experiences of home visiting programmes for families with preterm and LBW infants in South Africa, and identify the factors influencing the acceptability and feasibility of these programmes

Methodology: Systematic review of qualitative evidence

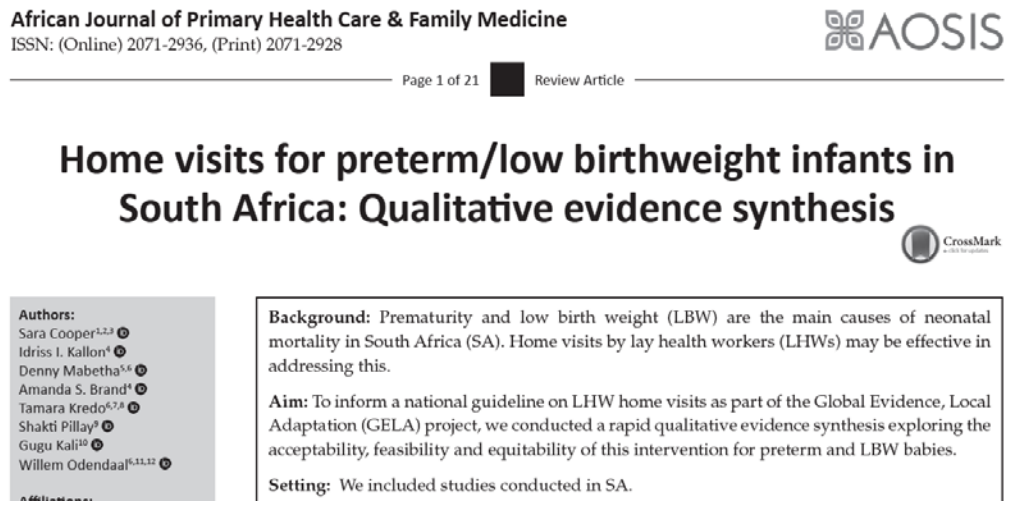
Identifying studies: Database searches (PubMed and EMBASE), Contacted experts; References list scanning

Inclusion criteria: Utilised qualitative methods for data collection and analysis; Focused on home visiting programmes/interventions to improve health outcomes for preterm and LBW infants in SA; Explored the views and experiences of any stakeholder involved in, or affected by, their design, receipt, delivery or implementation

Analysis method: Thematic analysis

Quality appraisal of included studies: Adaptation of the Critical Appraisal Skills Programme (CASP) tool

Confidence in the review findings: GRADE-CERQual.



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AOSIS
Page 1 of 21 Review Article

Home visits for preterm/low birthweight infants in South Africa: Qualitative evidence synthesis

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Background: Prematurity and low birth weight (LBW) are the main causes of neonatal mortality in South Africa (SA). Home visits by lay health workers (LHWs) may be effective in addressing this.

Aim: To inform a national guideline on LHW home visits as part of the Global Evidence, Local Adaptation (GELA) project, we conducted a rapid qualitative evidence synthesis exploring the acceptability, feasibility and equitability of this intervention for preterm and LBW babies.

Setting: We included studies conducted in SA.

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Results: Characteristics of the studies

Number of studies: 16 (from 18 full texts) included in analysis

Settings: 5 provinces (WC; Gauteng; KZN; Free State, EC); Rural and urban contexts

Participants: mothers, LHWs, supervisors, community members, key informants

Interventions:

- Based on Philani Mentor Mother model (n=9)
- Part of national/provincial DoH maternal and child health programmes (n=4)
- Part of PROMISE- Exclusive Breastfeeding (EBF) randomised controlled trial (n=2)
- Ububele Mother-Baby Home Visiting project (n=1)

Results: Recipient acceptability

A complex mix of facilitators and barriers to mother's acceptability

- **Facilitators of mothers' acceptance**

Knowledge, skills, and psychosocial support
(high confidence)

Time to learn/express needs
(high confidence)

Reduced clinic visits
(Very low confidence)

Better access to and relationships with healthcare facilities & staff
E.g. referral letters, logistical information, increased confidence
(moderate confidence)

LHWs coming from same community
E.g. more accessible, familiar, approachable, able to understand mothers' experiences and context
(moderate confidence)

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Results: Recipient acceptability

- **Barriers to mothers' acceptance**

Distrust of LHWs
(high confidence)

Privacy & confidentiality
E.g. disclose private information
(moderate confidence)

LHW gender
E.g. personal safety with male LHW
(very low confidence)

Perceived incompetencies
(moderate confidence)

Stigma associated with home visits E.g. believe home visits only for PLWHIV; fear of being judged as weak for needing support.
(moderate confidence)

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Results: Provider acceptability and feasibility

A complex mix of facilitators and barriers to LHW acceptability and feasibility

- **Facilitators of LHWs' acceptance**

Empowering, validating, employment and convenience
E.g. A sense dignity/purpose because of role, valued for making a difference, pride in earning a salary, appreciative of the convenience of their job.
(moderate confidence)

- **Barriers to LHWs' acceptance and feasibility of home visits**

Boundaries and emotional burdens, particularly when LHWs face similar burdens (e.g. HIV, poverty, hunger, community violence and crime) and when coming from same community as mothers (e.g. reachable at all hours)
(high confidence)

Practical and logistical challenges
E.g. inadequate transportation & tools, mobility of clients, personal safety
(high confidence)

Human resource-related issues
E.g. poor salaries, non-permanent contracts, increased workloads= high LHW turnover/attrition rates
(moderate confidence)

Lack of training, supervision, and support
(high confidence)

Conclusion

- A range of complex and interacting contextual factors that may impact on the acceptability and feasibility of community-based home visits for preterm and LBW babies in SA
- Many of the challenges identified not unique to maternal and child health but common to all community-based home visiting programmes in SA
- Importance of incorporating qualitative evidence within guideline development to explore questions beyond whether an intervention works or not, to questions about the meanings, processes, relationships and contexts that impact health and healthcare interventions
- Based on the findings of our review we developed a series of issues that we proposed should be considered when planning, implementing and managing community-based LHW home visit programmes for families with preterm and LBW infants in SA.

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Policy and practice considerations

Table 3: Policy and practice implementation consideration for lay health worker (LHW) home visiting programmes for families with preterm and low birthweight (LBW) infants in SA

Living and working in the same community	• When selecting LHWs, have you considered how they will be perceived by members of the community in which they will work, for instance in terms of their sociocultural or economic background or gender? For example, if male LHWs are included have you considered whether gender norms and safety issues may reduce mother's trust of them? • Do LHWs have ways of managing relationships with recipients and creating boundaries between work and personal lives when working and living in the same community?
Work activities	• Are LHWs providing services that they see as relevant to the challenges they meet during their working day and in their interactions with community members? • Have you provided LHWs with sufficient means of transportation, where necessary?
Working with other healthcare providers	• Have you considered how to ensure good working relationships between LHWs and other healthcare providers in primary care facilities (e.g. nurses or mid-level practitioners such as clinical officers, physician assistants, clinical associates)? For instance, are other healthcare providers encouraged to be respectful and responsive towards LHWs, to recognise their competencies and to accept their referrals?
Referral systems	• Where LHWs are trained to refer patients with complications, are there sufficient health professionals to care for these patients? Are these health professionals willing and able to cooperate with LHWs when they receive these referrals?
Payment, incentives, and out-of-pocket expenses	• Are you offering LHWs sufficient salaries for their time and effort? Have you considered whether, and if so how, more secure and full-time contractual arrangements could be put in place for LHWs? Might it be possible for LHWs to receive benefits, incentives and/or opportunities for career progression? What other factors could be incorporated that could make a positive impact on the retention of LHWs?
Training, supervision and support	• Have you clarified what essential competencies LWHs require to fulfil their roles and perform the tasks they are required to perform? • Are you offering LHWs sufficient training and supervision for them to fulfil these roles and tasks? This includes training in communication and health promotion. These tasks are often central to the LHW role but are often neglected during training. It also includes ongoing and refresher training as opposed to once-off training.
Community Oriented Primary Care (COPC	• What community-based care is already present in the target area(s)? • Which principles of Community Oriented Primary Care (COPC) are present in this community-based care? For example, do they include a defined community, and if so, in what terms? Do they incorporate a multidisciplinary team, comprehensive and/or equitable approach to service delivery? Are they informed by analysis and prioritisation of local health needs and resources? Do they foster community engagement and participation, and if so, which community members or structure do they collaborate with? What other values or principles might inform existing community-oriented care?
Governance & financing	• Have you ensured there is a clear directive from provincial governments? • Have you considered how ongoing political commitment by relevant stakeholders and collaboration between different levels of government can be strengthened and developed? How might a sense of ownership amongst managers at local levels and decentralised decision-making be strengthened and developed? • Have you considered how adequate resources will be allocated and ongoing financial commitment sustained?
Monitoring, evaluation, data and health information	• Have you ensured systems are in place to monitor implementation and identify and respond to (changing) needs and effects? What mechanisms are there for checking and verifying this information to ensure the quality of this data? • How might these monitoring and evaluation systems be integrated with existing primary healthcare information systems and data collection processes (e.g. from households, facilities, research and other sources)?

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Thank you!

More information about GELA and to contact us:

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