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# What motivates maternal and child nutrition peer educators? Experiences of fathers and grandmothers in western Kenya

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ABSTRACT

*Background:* Peer-led dialogue groups (i.e., support or self-help groups) are a widely used community-based strategy to improve maternal and child health and nutrition. However, the experiences and motivation of peer educators who facilitate these groups are not well documented.
*Objective:* We implemented eight father and ten grandmother peer dialogue groups in western Kenya to promote and support recommended maternal dietary and infant and young child feeding practices and sought to understand factors that influenced peer educator motivation.
*Methods:* After four months of implementation, we conducted 17 in-depth interviews with peer educators as part of a process evaluation to understand their experiences as group facilitators as well as their motivation. We analyzed the interview transcripts thematically and then organized them by level: individual, family, peer dialogue group, organization, and community.
*Results:* Father and grandmother peer educators reported being motivated by multiple factors at the individual, family, dialogue group, and community levels, including increased knowledge, improved communication with their wives or daughters-in-law, increased respect and appreciation from their families, group members' positive changes in behavior, and increased recognition within their communities. This analysis also identified several organization-level factors that contributed to peer educator motivation, including clearly articulated responsibilities for peer educators; strong and consistent supportive supervision; opportunities for social support among peer educators; and working within the existing health system structure.
*Conclusion:* Peer educator motivation affects performance and retention, which makes understanding and responding to their motivation essential for the successful implementation, sustainability, and scalability of community-based, peer-led nutrition interventions.


## 1. Introduction

Suboptimal maternal dietary and infant and young child care and feeding practices continue to contribute to high rates of stunting, morbidity, and mortality in many low-income countries (Black et al., 2013), including Kenya (Infant & Young Child Nutrition Project, 2011a; Kenya National Bureau of Statistics and ICF Macro, 2010). Interventions to improve nutritional status have been well documented and, depending on the intervention, can be delivered through health facilities or communities (Bhutta et al., 2013, 2008; Haines et al., 2007). Peers are potentially powerful agents in promoting improved health (Simoni et al., 2011), and peer-led support groups are a recommended community-based strategy to promote and support recommended maternal and child health and nutrition practices (Bhutta et al., 2008).

Simoni et al. (2011) use four “essential elements” to define peers: (1) they share specific characteristics, experiences, or circumstances and are selected because they are from the same

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community or belong to a specified subgroup (e.g., fathers or grandmothers); (2) their shared qualities increase the effectiveness of the services they provide; (3) they lack professional training or status in the scope of their work, but are trained to deliver a specific intervention; and (4) they function intentionally based on standardized protocols, and therefore their interactions extend beyond their existing social network.

Peers have varied roles and responsibilities. Although community, or lay, health workers are typically peers, they often have different, more expansive roles than peer educators. Depending on the context, community health workers (CHWs) can be responsible for health promotion and preventive care, community mobilization, provision of curative health care services, and assisting women during labor and childbirth (Lehmann and Sanders, 2007; Lewin et al., 2010; Perry and Crigler, 2014). In this article, we differentiate the work of dialogue group peer educators from CHWs, because in Kenya (as in many countries) their roles are quite distinct (Table 1).

Peer-led dialogue groups (i.e., support or self-help groups) have the potential to increase families' and communities' uptake of recommended maternal and child health and nutrition practices (Bhutta et al., 2013, 2008; Fabrizio et al., 2014). Facilitated discussions allow group members to actively participate in the learning process and share their experiences and knowledge with other group members (AbuSabha et al., 1999), as well as engage in group problem-solving (Affleck and Pelto, 2012). Hearing what group members know, think, and do can lead other members to positively change their attitudes and behaviors (Cordero Coma, 2014).

Peer-led women's and mothers' groups, with a trained lay facilitator, are often used to promote improved nutrition and health. A meta-analysis found that participatory women's groups, facilitated by trained lay women (or peer educators), substantially reduced neonatal and maternal mortality in rural, low-resource settings in South Asia and Malawi (Prost et al., 2013). Similar groups in Mozambique, facilitated by volunteer “mother leaders,” were also associated with improved nutrition practices and outcomes (Davis et al., 2013). Finally, women's participation in peer-led support groups is strongly associated with improved infant and young child feeding and nutrition practices (Dearden et al., 2002; Pérez-Escamilla et al., 2008).

The majority of community-based infant and young child feeding behavior change interventions, including peer-led dialogue groups, typically target pregnant and postpartum women (Aubel, 2012; Infant & Young Child Nutrition Project, 2011b), even though fathers and grandmothers are well recognized for their influence on infant and young child care and feeding practices (Aboud and Singla, 2012; Aubel, 2012; Bezner Kerr et al., 2008; Mitchell-Box and Braun, 2013; Tomlinson et al., 2014). The results from several studies emphasize the importance of expanding nutrition interventions to target influential family members, such as fathers and grandmothers (Affleck and Pelto, 2012; Israel-Ballard et al., 2014; Matovu et al., 2008; Moestue and Huttly, 2008; Ochola et al., 2013; Tomlinson et al., 2014), as they can influence mothers' behavior and provide support for the adoption of recommended practices (Affleck and Pelto, 2012). New and emerging evidence suggests that engaging fathers and grandmothers can help improve nutrition practices and health outcomes (Alive and Thrive, 2012; Aubel, 2012; Bezner Kerr et al., 2011; Mitchell-Box and Braun, 2013; Sloand and Gebrian, 2006).

Despite the widespread use of peer-led behavior change interventions for maternal and child health and nutrition, as well as other health topics (e.g., human immunodeficiency virus [HIV], tuberculosis, and malaria), there is limited information in the literature on the experiences of peer educators themselves (McCreary et al., 2013). Although peer educators' roles (Dhand, 2006; Tobias et al., 2010), knowledge (Tobias et al., 2010), and personal changes (Hilfinger Messias et al., 2009; McCreary et al., 2013; Nankunda et al., 2010) have been investigated, most studies typically focused on the peer group members' behavior. It is important, however, to also examine the motivation, training, and performance of the frontline workers who are delivering an intervention to understand intervention utilization and impact (Pelto et al., 2015; Mbuya et al., 2013; Rawat et al., 2013). The success of community-based peer-led nutrition interventions depends on peer educator performance, effectiveness, and motivation, defined by Franco et al. (2002) as “an individual's degree of willingness to exert and maintain an effort towards organizational goals.” Therefore, this research sought to study the experiences and motivation of peer educators facilitating maternal and child nutrition peer dialogue groups.

## 2. Methods

The qualitative research presented here is part of a larger quasi-experimental study investigating the impact of father and grandmother peer-led dialogue groups on maternal dietary and infant and young child feeding practices in western Kenya. This study was conducted as part of a process evaluation within the primary study design (Fig. 1).

### 2.1. Overview of the primary study

The primary study evaluated the impact of a behavior change intervention, based on the socio-ecological model (McLeroy et al., 1988), which sought to engage fathers and grandmothers of

**Table 1**
Roles and responsibilities of various community-based workers.

| Community health extension worker[a] | Community health worker[a] | Dialogue group peer educator |
|---|---|---|
| • Trained health worker (public health office or enrolled community nurse) employed by health system and attached to a health facility<br>• Supervises a cadre of 25 CHWs in the facility's catchment area<br>• Trains CHWs<br>• Facilitates trainings in the community<br>• Serves as link between CHWs and health facility<br>• Establishes the information system and writes report<br>• Treats and refers common conditions<br>• Conducts home visits and growth monitoring | • Trained for nine months within a 3-year period<br>• Elected during village meetings<br>• Supervised by community health extension workers Provides services to 20 households within a specific catchment area<br>• Provides community entry, organization, and sensitization<br>• Registers, collects, and reports on household data<br>• Stimulates community dialogue for change<br>• Conducts health promotion activities<br>• Provides referrals for services<br>• Establishes support groups<br>• Conducts home visits<br>• Trains and supports caregivers | • Trained over five days on maternal and child nutrition, family communication, interpersonal relationships, and group facilitation<br>• Elected by peer group members<br>• Supported by CHW<br>• Facilitates dialogue group meetings once every two weeks with 12 or fewer members<br>• Attends monthly mentor meetings |

CHW, community health worker.
[a] Source: Ministry of Health (2006).