



TECHNICAL BRIEF

March 2005

BEHAVIOUR CHANGE AND COMMUNITY MOBILISATION FOR SKILLED CARE

INTRODUCTION

For women in the developing world, basic health services during pregnancy, childbirth, and immediately afterwards are often out of reach; in many countries there are serious shortages of skilled providers and severe deficiencies exist in the availability of good-quality clinical and interpersonal maternal care.

In addition, a range of physical, cultural, and financial obstacles make it difficult for women and community members to use maternal health services, even if they are available and of reasonable quality. Women's low status, lack of education and employment opportunities, and limited rights and freedoms affect their ability to receive good-quality skilled care. Overcoming these barriers requires targeted behaviour change strategies that address deeply-held beliefs and prevailing behaviours and practises regarding care-seeking during pregnancy and childbirth.

In 2000, Family Care International (FCI), with funding from the Bill and Melinda Gates Foundation, launched a multi-faceted initiative to improve the quality of skilled care services and increase their utilisation among rural and disadvantaged populations in three countries in sub-Saharan Africa (Burkina Faso, Kenya, and Tanzania). The Skilled Care Initiative (SCI) aims to strengthen national policies, norms, and guidelines; improve the quality and availability of maternal care at health facilities; and promote behaviour change and community mobilisation to increase the utilisation of skilled care. In a step-wise approach, the initial phase of the project focussed on upgrading health facilities and improving knowledge and skills of different cadres of service providers. Once these improvements were implemented, FCI began partnering with communities in a behaviour change strategy to increase knowledge, motivation, and resources in support of skilled care.

This technical brief describes the process used to develop the SCI behaviour change communication strategy; illustrates the main barriers and constraints for increasing use of skilled care; and outlines the specific interventions that have been implemented to change attitudes and behaviours, and mobilise rural communities in support of skilled care.

WHAT IS BEHAVIOUR CHANGE COMMUNICATION (BCC)?

Behaviour change communication (BCC) is a research-driven approach for promoting and sustaining behaviour change in individuals and communities, and is implemented through the development and distribution of specific health messages via a variety of communication channels.¹

BCC serves as a mechanism for achieving *strategic* and *measurable* behaviour change. The following are key characteristics of BCC:

THE SCI EVALUATION STRATEGY

SCI includes a rigorous evaluation strategy to assess the project's effectiveness, with the overall goal of generating guidance on how to implement skilled care in rural, developing country contexts.

The pre-test/post-test evaluation design consists of the following elements:

- **a survey of health facilities** in the project districts on the quality, availability, and utilisation of maternal health services.
- **a household survey** to collect information on the use of skilled care at delivery, and knowledge, attitudes, and care-seeking behaviours during pregnancy and childbirth.

¹ Family Health International, www.fhi.org/en/Topics/Behavior+Change+Communication+topic+page.htm (accessed 16 March 2005).

- It is based on in-depth research of existing knowledge, attitudes, values, and practises of the key audiences or participant groups in the community;
- It identifies current behaviours among participant groups (e.g. women, community leaders, husbands, etc.), and promotes ideal or desired behaviours that are feasible, taking into account the factors that motivate and influence individuals to maintain current behaviours or adopt new behaviours;
- It identifies barriers and constraints facing participant groups, and addresses these issues through messages and mobilisation strategies;
- It addresses barriers outside the community, such as poor interpersonal skills of health workers, which deter people from seeking and utilising health services.

BEHAVIOUR CHANGE FOR SKILLED CARE: FORMATIVE RESEARCH



Singers in Burkina Faso develop skilled care songs.

As part of an effort to increase utilisation of skilled care in the SCI project districts, FCI is implementing a focused BCC strategy to educate and mobilise communities. The first step in the development of the behaviour change strategy was conducting formative qualitative research. Using an innovative set of tools developed in collaboration with The CHANGE Project and from a range of published materials, FCI conducted in-depth interviews and focus group discussions that gathered information about community members' knowledge, attitudes, and behaviours related to skilled care. The research revealed communities' understanding of birth preparedness; their use of and attitude toward

skilled care services; the causes of delays in seeking facility care; and other emotional, social, and practical barriers to care (from fatalism to gender inequities to cost considerations).

Key Findings Included:

- **Preparing for childbirth:** In all three project countries, few women and families make advanced preparations for childbirth. In Kenya and Tanzania, many community members do not believe it is possible to make advanced preparations for an event, such as delivery, which is unpredictable; many also saw such preparations as inviting misfortune or negative outcomes. In Burkina Faso, preparations for birth generally consist of purchasing articles for the baby (clothes, soap, ointment, etc.) and making antenatal visits; most families do not make any other preparations until the woman is in labour.

Within households, care-related decision-making varies widely. In Burkina Faso, there is little discussion about the place of birth within families; family members with influence (mothers- and fathers-in-law, as well as husbands) usually decide where the birth will occur and impose their decision on the woman. In Tanzania, most community members indicated that the husband was the primary decision-maker. In Kenya, respondents indicated that the woman herself plays a role in such decisions, but that they are often reached through consultation and consensus among many family members, leading to delays in seeking care when complications arise.

- **Knowledge of danger signs:** In Kenya and Tanzania, while most community members perceive pregnancy to be a time of risk, many have difficulty recognising signs of complications or knowing when medical care is needed. In Burkina Faso, very few danger signs are recognised by women and their families, and some of the normal signs and discomforts of pregnancy (e.g. vomiting, light-headedness, nausea) are perceived as complications.
- **Perceptions of and use of skilled care:** In all three countries, most community members believed that it was safest to deliver at a health facility, however, many women and their families also expressed concerns about the quality of available maternity care and how they would be received by providers at health facilities. They described health providers as rude, neglectful, and cruel, and cited numerous delays in receiving care at health facilities.

Women's use of early postpartum care is almost non-existent. Few women in all three of the project districts were aware of the importance of early postpartum check-ups for a new mother, and most did not see such check-ups as necessary if the woman was not experiencing any complications. In addition, some communities cited cultural taboos that restrict new mothers from leaving home during the period after delivery (ranging from 3 to 40 days). Moreover, even when they do visit the health facility during the postpartum period for newborn check-ups or immunisations, health providers generally do not examine the woman.

FROM RESEARCH TO INTERVENTIONS: IMPLEMENTING BCC

Using the rich data gained from the community research, FCI and local partners developed a **behaviour change matrix** that charts the process that individuals go through in modifying existing behaviours and adopting ideal/desired behaviours in five key areas: birth preparation, use of antenatal care, skilled care at delivery, recognising (and responding to) emergencies, and early postpartum care.

For each participant group (women, mothers-in-law, husbands, etc.), *current* behaviours were analysed in relation to the ideal behaviours being promoted through the project. Prevailing attitudes and beliefs—as well as external factors that impede or motivate individuals to seek skilled care—were also analysed. Using this information, FCI and district partners identified *feasible* behaviours that women, husbands, and other family members could realistically be encouraged to adopt. For each of these feasible behaviours, a range of appropriate behaviour change activities were developed and specific messages were formulated.



BCC drama troupe practising in Tanzania.

The behaviour change campaigns in each district include both traditional health education tools, such as printed pamphlets and posters, as well as a variety of other approaches, such as participatory drama and performing arts, community discussion and dialogue, mobilisation of local leaders, and improvement of provider skills and attitudes. Selected behaviour change communication activities implemented in the project countries are described below.

Participatory Theatre and Folk Media

In all three countries, performing arts and interactive drama are a centrepiece of the BCC campaigns. In Kenya, three different dramas were developed with local drama troupes, who have travelled to and performed in different communities within the project district. Performances have been timed in conjunction with other community events, such as market days, special “open days” at health facilities when clinic services are offered free-of-charge, and *barazas*, or community-level meetings, which provide a forum for discussing key issues affecting the community.

Drama, song, and dance have also been used to convey key behaviour change messages in Tanzania. A traditional singing and dancing performance called *mamanju* was held as part of a three-day festival on the theme of skilled care. In addition to the *mamanju* performance, FCI trained local dramatists and helped them develop skits and songs to communicate messages about the importance of delivering at a facility, of preparing for birth ahead of time, and of discussing plans with immediate family members.

In Burkina Faso, three local theatre troupes and two popular singers have drafted story lines and lyrics focussing on skilled care. Incorporating music, singing, and traditional dancing, the performances dramatised different scenarios to promote use of facility-based skilled care.

Mobilising Community Leaders

In Kenya, the project is targeting local and assistant chiefs, religious leaders, and women's groups with skilled care messages, encouraging these opinion leaders and groups to educate their constituencies about key messages. These meetings have also provided an opportunity for community and religious

leaders to discuss the barriers to using skilled care, and to identify mechanisms for addressing them (pooling community resources for an emergency fund for obstetric complications, for example). Similar approaches are being used in Tanzania and Burkina Faso.

Involving Communities

In Tanzania, village health workers have been trained to conduct participatory meetings at the village level, which have been used as a forum to discuss danger signs during pregnancy, the benefits of preparing for delivery, and the importance of delivering at a facility with a skilled attendant. These meetings have generated considerable discussion and dialogue about household and community-level factors that affect the use of skilled care, and how families and communities can overcome some of the barriers to reaching care.

Local outreach volunteers in the Burkina Faso project district have been recruited to serve as community educators on skilled care. One individual was selected from each of the 180 villages in the project district and trained in basic messages on skilled care. Through discussions with friends, neighbours, and other community members, these community relay agents are supporting awareness-raising efforts within their communities.

In Kenya, FCI has involved communities in addressing critical gaps at health facilities, from repairing roofs to constructing foundations for water tanks to installing solar equipment. These community mobilisation events have provided an important opportunity to communicate skilled care messages.

MONITORING AND EVALUATING BEHAVIOUR CHANGE

A comprehensive monitoring and evaluation plan has been designed to obtain continuous feedback on programme activities and to measure behaviour change as a result of the BCC interventions. In each of the BCC project districts, monitoring is composed of a variety of ongoing activities, including keeping track of the number of participants attending community-level activities, monitoring the number of materials distributed, and collecting data on maternity services at health facilities, among others.

The overall impact of the BCC interventions will be evaluated through household surveys carried out before and after programme implementation. Key behaviours of interest and appropriate indicators for measuring changes in knowledge, attitudes, and behaviours were identified through the development of the detailed behaviour change matrix (described above). Household survey questions were developed to obtain quantitative data on women's and men's current knowledge, attitudes, and behaviours that would enable FCI to identify where women and their families are in the process of changing behaviours related to skilled care. This in turn allows for the detection of relatively small shifts in attitudes and intentions related to skilled care—progress that is critical to measure given that use of skilled care during childbirth is a relatively rare behaviour (any given woman may become pregnant only a few times during her lifetime).

The surveys are conducted in comparable control districts in Burkina Faso and Tanzania to facilitate an understanding of whether demonstrated behaviour change is due to the project or other factors. In Kenya, there are two intervention districts—one in which the community-level behaviour change campaign is being conducted, and another in which interventions focus only on the facility level. Comparing the results from these two districts will enable FCI to assess the “added value” of the community-level behaviour change activities. In 2006, post-intervention surveys will be conducted to measure changes in women's use of skilled care during pregnancy, delivery, and the postpartum period.

