MAHEFA's Behavior Change Empowerment:

A new model for community-centered behavior change

Madagascar Community-Based Integrated Health Program (CBIHP), locally known as MAHEFA, was a five-year (2011-2016), USAID-funded community health program that took place across six remote regions in north and north-west Madagascar (Menabe, SAVA, DIANA, Sofia, Melaky, and Boeny). The program was implemented by JSI Research & Training Institute, Inc. (JSI), with sub-recipients Transaid and The Manoff Group, and was carried out in close collaboration with the Ministry of Public Health, the Ministry of Water, Sanitation and Hygiene, and the Ministry of Youth and Sport. Over the course of the program, a total of 6,052 community health volunteers (CHVs) were trained, equipped, and supervised to provide basic health services in the areas of maternal, newborn, and child health; family planning and reproductive health, including sexually transmitted infections; water, sanitation, and hygiene; nutrition; and malaria treatment and prevention at the community level. The CHVs were selected by their own communities, supervised by heads of basic health centers, and provided services based on their scope of work as outlined in the National Community Health Policy. Their work and the work of other community actors involved with the MAHEFA program was entirely on a voluntary basis.

This brief is included in a series of fifteen MAHEFA technical briefs that share and highlight selected strategic approaches, innovations, results, and lessons learned from the program. Technical brief topics include *Behavior Change Empowerment, Community Radio Listening Groups, Community Score Card Approach, Chlorhexidine 7.1% / Misoprostol, Champion Communes Approach, Community Health Volunteer Mobility, Emergency Transport Systems, Malaria, Community Health Volunteer Motivation, Family Planning & Youth, WASH, eBox, Community Health Financing Scheme, Information Systems for Community Health and NGO Capacity Building.*

Background

Health communication professionals have long struggled to find ways to help people adopt and sustain critical health and hygiene-related behaviors. Early on, Information, Education, and Communication (IEC) efforts often failed to motivate significant uptake of improved practices because they concentrated on informing people of why a new behavior would benefit them instead of addressing what determined their ability to practice the desired behavior. More recent Behavior Change Communications (BCC) approaches have taken into account the social environment in which behavior shifts occur and have more effectively used multiple communication channels to reach people. The success of these interventions has mostly been short-term because they haven't often built the capacity of those who are closest to the community (local health workers and leaders) to sustain the continuous process of improving the practice of healthier behaviors by families.

Madagascar Context

Over the past decades in Madagascar, the Ministry of Health and other Ministries have directed health communications such as behavior change activities through communications policies, strategies and plans. However these directives were not evenly or fully implemented across the country. As a way of saving time and resources, a number of previous multi-region programs conducted formative research in only one geographic area in order to inform their Behavior Change strategies. This common pitfall of assuming that different regions within a country are fairly similar runs the risk of overlooking important socio-cultural influences or behavioral nuances, particularly in a country like Madagascar, which has 18 distinct ethnic groups with differing traditions.

The MAHEFA Approach

Behavior Change was an integral part of the MAHEFA program's strategy to improve health, sanitation, and hygiene in the most under-served communities of Madagascar's north and northwest regions. The Behavior Change Empowerment (BCE) strategy mobilized community health volunteers (CHVs) to choose and conduct a range of communications activities, and extended the responsibility for behavior change to community leaders and groups to become key players in facilitating behavior change. In this way, many different people participate in and learn to manage the process of achieving healthy behaviors to enhance health outcomes within their communities.

To inform the content of it's BCE strategy, MAHEFA applied six interconnected formative research methodologies at program start-up to study twenty-two targeted behaviors in the areas of maternal, neonatal, and child health; family planning; and water, sanitation, and hygiene. These research methodologies included an annotated bibliography, inventory of existing IEC materials, a materials barrier analysis, ethnographic research, Trials of Improved Practices (TIPs), and a gender analysis. This research effectively confirmed that practical differences between regions were critical to ascertain and use to design behavior change activities.

Key Activities

1.Conducted regional BCE workshop. After implications from the formative research were identified, MAHEFA held *Designing for Behavior Change* workshops in each region with NGOs and local stakeholders to identify appropriate behavior change strategies and activities for each program region.

2. Developed BCE comprehensive guidebook and other BCE materials. Findings from the workshops enabled the development of MAHEFA's *Torolalana sy Vahaolana* (Guide and Solutions Book). The guide provides step-by-step instructions on how to organize and conduct 18 different types of community-led behavior change activities, ranging from tailored interventions for groups and individuals to high-profile community events to catalyze behavior change. Beyond the *Torolalana sy Vahaolana*, MAHEFA developed numerous materials such as regionally-based counseling cards to encourage reduction of gender inequalities; a booklet of theatrical skits; stickers to recognize household participation in care groups; updated family planning invitation cards; and a wide variety of radio spots including theatrical episodes to assist CHVs in conducting BCE activities. A guide was also developed that details how best to use these various materials.

3. Implementing BCE activities: With the *Torolalana sy Vahaolana* as a centerpiece, MAHEFA mobilized 6,052 CHVs in the six MAHEFA regions during the third year of the program through training and follow-up supervision. Afterwards, the program and NGO field staff provided supportive supervision to help CHVs carry out the BCE activities.

Results

The reach of BCE has been extensive and has shown rapid growth with more community actors trained and supported to be change agents in their own communities. At the end of the program, there were 146,295 community actors who were trained and equipped to conduct BCE activities on various health topics in their communities (Table 1).

Table 1. Community actors and their BCE responsibilities

BCE Community Actors	Number	BCE Responsibilities
Community Health Volunteers (CHVs)	6,052	Provide counselling and conduct education sessions as part of their health services delivery.
Youth Peer Educators	614	Conduct education sessions for youth in family planning and reproductive health.
Radio Listening Group Facilitators	763	Conduct weekly sessions to listen to and discuss specially-produced radio programs on health topics
Ménages parrains (Care Group Households)	130,251	Already have good health practices and responsible for convincing at least three other households to do the same.
Members of the Water Users, Sanitation and Hygiene Associations (WUSHA)	3,580	Promote good WASH practices, including water treatment.
Local masons	532	Produce latrine concrete slabs or dalle sanplat (DSP) for sale at the community level and promote latrine use.
Natural leaders	1,450	Mobilize the community to build and use latrines and promote village cleanliness.
CoSan (Local health committees)	3,053	Mobilize the community on all health issues.
Total	146,295	

The BCE activities conducted by the community actors presented in Table 1 resulted in a substantial increase in the number of people reached by the BCE activities in the program compared to the beginning of the BCE activities in 2013. As shown in Figure 1, the largest source that reached the highest number of people was the CHVs and other community actors. Table 2 shows the number of people that received key BCE messages from the 146,295 community actors involved in BCE activities.

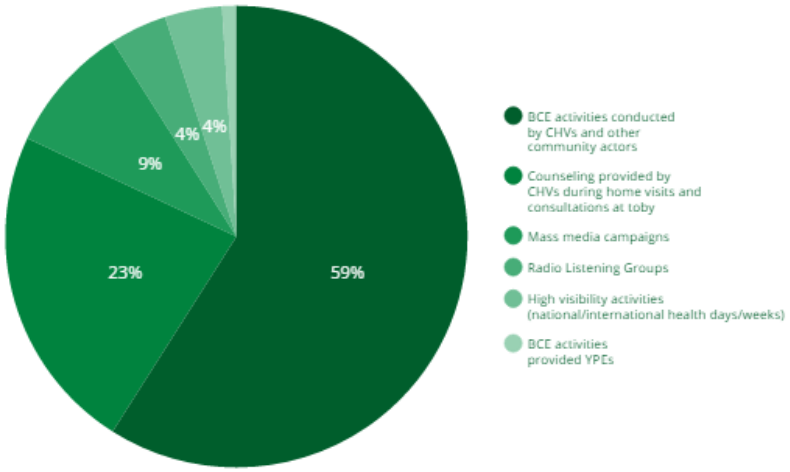
In addition to routine program reporting, an assessment of the BCE strategy was conducted in Menabe Region in December 2015. Interviews were conducted with nearly nine hundred women of reproductive age, and focus group discussions were held with CHVs, women, men, and community leaders.

The quantitative survey results showed the impact of different BCE techniques related to the adoption of ten behaviours. Overall, the results showed a positive impact of using different BCE approaches through multiple channels. Findings showed that an individual who was exposed to many BCE techniques was more likely to adopt those behaviours than an individual who was not exposed to any BCE or an individual who was only exposed to the messages from the mass media or the personnel of CSB. Specific results are presented below.

- For individuals exposed to multiple BCE messages on family planning, the chance of changing behavior was 12 percent greater, and for diarrheal treatment, it was 36 percent greater.

- The CHVs preferred to use home visits and education sessions most often as their BCE technique. 64-93 percent of the CHVs reported that they used the home visit technique and almost all CHVs (73-100 percent) reported using education sessions as their BCE technique. Less than 15 percent of the CHVs reported using other BCE techniques than these two. These choices were based on the CHVs' preference and not on the effectiveness of the BCE methods themselves.

Figure 1. Percentage of people reached through different BCE channels (February 29, 2016)



- The study also investigated the use of the 16 BCE techniques excluding home visits and education sessions. Results indicated that the other techniques had similar impact on behaviors as home visits and education sessions with the exception of family planning, antenatal, breastfeeding and the prevention of pneumonia.

Table 2. Number of People Reached by Key Messages (2013-2016)

Key messages	Participants in BCE activities in FY2013	Participants in BCE activities in FY2014	Participants in BCE activities in FY2015	Participants in BCE activities in FY2016
Drinking clean water	167,175	285,524	782,519	868,477
Handwashing with soap	167,175	287,841	876,149	930,962
Use of latrines	167,175	294,530	819,180	873,926
Family Planning	137,005	256,865	559,539	507,276
Child health (messages include malaria prevention)	99,312	308,995	925,528	1,019,922
Prenatal exams for pregnant women (messages include malaria prevention)	121,058	204,591	487,854	672,261
Nutrition for children under five	95,827	211,389	595,966	564,551
Sexually Transmitted Infections (STIs) and HIV	-	187,097	417,222	412,531
Nutrition for pregnant and lactating women and promotion of exclusive breastfeeding	83,538	258,312	403,116	416,036
Newborn healthcare (Chlorhexidine)	-	64,800	53,391	334,606

Challenges

The geographic and environmental limitations hindered NGOs' capacity to operate effectively in some of the fokontanys in which they worked. Therefore, NGOs had trouble managing their program districts and were not able to make frequent site visits to communes.

Challenges experienced with the training of 6,052 CHVs attested to the complexity of building the capacity of large numbers of people across a wide intervention area in primarily remote regions. It was difficult to confirm the quality of training at the NGO supervisor level.

As behavioral change empowerment, particularly its focus on empowering community actors, is a new concept in Madagascar, most MAHEFA and NGO staff were not used to the concept. When the MAHEFA and NGO field staff did not master the BCE concept, it was difficult for them to support the community actors in using the various BCE techniques and tools.

Several BCE techniques and tools were not used by the community actors. Additionally, few CHVs conducted activities that promoted aspects of gender sensitivity, often due to CHVs' perception of community resistance to changing ingrained traditions that dictate the roles of men and women.

BCE activities were not rolled out and reported to the program in an integrated manner with other core program activities. Because of the separate introduction, monitoring and reporting, the CHVs saw BCE activities as separate activities when in fact they used BCE techniques and tools on a daily basis as they provide counseling at their *toby*, when they make home visits, and when they conduct education sessions.

Lessons Learned and Recommendations

As a fundamental companion to efforts to improve access to services and service quality, MAHEFA's BCE strategy created opportunities to improve behaviors for underserved populations by not only introducing new communications activities that address community-specific determinants of behavior change, but also by engaging community actors. Beyond MAHEFA, as greater numbers of BCE activities are conducted and more change agents participate, the impact of the strategy will continue to increase.

Provide BCE training including how to use BCE tools to staff and all stakeholders early on in the program. This training will provide staff and implementing partners with necessary knowledge and skills to use the tools so they can pass on the knowledge and skills to the CHVs.

Prioritize variety among BCE solutions. Formal training workshops, informal training opportunities, supervision visits, exchange visits, and other post-training capacity reinforcement opportunities could ensure that CHVs master both large-scale and small-scale communications activities.

Identify best practices for use of BCE tools and themes especially around gender programming. CHVs' choice of themes appeared to be based on what they felt was most critical or least understood in the community at any given time. Strong socio-cultural determinants suggest that facilitating exchanges between CHVs of different villages to determine best practices may be an effective method to begin this process.

Accelerate and sustain community behavior change through supportive supervision. As discussed earlier, the study in December 2015 showed that more BCE techniques used through more channels have a greater impact on behavior change.

FOR MORE INFORMATION, PLEASE CONTACT:

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