Technical Report

Behavior Change Communication

Maternal and Newborn Health
in Ethiopia Partnership
(MaNHEP)

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Technical Report: Behavior Change Communication interventions

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Acknowledgments

Acronyms

AAU	Addis Ababa University
ANC	Ante-natal Care
BCC	Behavior Change Communication
CHDA	Community Health Development Agent
CMNH	Community Based Maternal and Newborn Health
CQI	Collaborative Quality Improvement
EmONC	Emergency Obstetrics and Newborn Care
FLW	Frontline Workers
HC	Health Center
HEW	Health Extension Workers
HP	Health Post
HSDP	Health Sector Development Program
IEC	Information Education Communication
JSI	JSI Research and Training Institute, Inc.
L10K	Last Ten Kilometers
MaNHEP	Maternal and Newborn Health in Ethiopia Partnership
MNH	Maternal and Newborn Health
NGO	Non-governmental Organization
PSA	Public Advertisement Service
LCD	*liquid-crystal display*
OR	Odds Ratio
ORHB	Oromia Regional Health Bureau
PNC	Post-natal Care
QI	Quality Improvement
TBA	Traditional Birth Attendants
UN	United Nations
URC	University Research Co.

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Executive Summary

An estimated 2.6 million births occur each year in Ethiopia. The country is known for itshigh maternal mortality ratio and neonatal mortality rates (MMR = 676/100000 live births and NMR = 37/1000 live births). The causes of the deaths can be categorized as demand and supply side factors.On the supply side, factors include high levels of unskilled home delivery, little postnatal care follow-up, poor access to and utilization of emergency obstetric and newborn care (EmONC) services, very low critical life-saving services, shortage of skilled midwives, a weak referral system at the health center level, and under financing of services. On the other hand, cultural norms, distance to functioning health centers, and financial barriers were found to be the major demand side factors in Ethiopia.

The fourth Health Sector Development Strategic Plan (HSDP IV), identified demand side interventions as one of the three-pronged approaches to improve the quality of health services through active and inclusive participation of the community.To support this effort, the Maternal and Newborn Health in Ethiopia Partnership (MaNHEP), a collaboration among the Federal Ministry of Health, Emory University, JSI Research and Training Institute, Inc.(JSI),University Research Co., LLC, (URC) and Addis Ababa University and funded by the Bill and Melinda Gates Foundation- has implemented innovative behavior change communications interventions to shift community norms, to recognize the value of MNH care during birth and the early postnatal period.

Behavior change communications (BCC) is an interactive process to develop tailored messages and approaches using a variety of communication channels to bring behaviors that need to be addressed to the attention of a community, promote and sustain individual, community and societal behavior change and maintain appropriate behaviors. Effective BCC is vital to setting the tone for compassionate and responsible interventions. It can also produce insight in to the broader socioeconomic impacts of MNH and mobilize political, social, and economic responses needed to mount an effective program.

The formative research - which was done before developing the strategic document - had clear implications for behavioral change communication strategies implemented by MaNHEP. Following the research, the project identified pregnant women and their families, community members, decision makers/opinion leaders, and service providers as primary and secondary target groups, respectively. The aim of the program's behviour change efforts was also geared towards addressing key issues: involvement of husband, presence of HEWs during delivery, team work among FLWs, identified in the formative research.

For addressing the identified target groups, the project used a wide variety of media, including mass media, mobile video, and open market shows, to disseminate the messages.The great promise of mass media campaigns lies in their ability to disseminate well defined,focused messages to large audiences repeatedly, over time, in an incidental manner, and at a low cost.Mass media campaigns were used by MaNHEP to reach different audiences for different purposes. The most visible efforts focused on direct and indirectefforts to influence and produce positive change or prevent negative change in health-related behaviors across large sections of the population.

Based on assessment findings of community media preferences, MaNHEPused mass media to deliver key messages: Early pregnancy identification, notification of labor and birth, the importance of skilled care for mothers and newborns, and the critical need for post natal care within the first 48 hours.Initiativestargeted school-aged children who received messages through school TV programand radio public service announcements (PSAs),andthe general community and decision makers through community dialogue/panel discussion, and learning sessions which were aired through various radio programs. In addition, the key achievements of the projectwere documented and distributed to various stakeholders and target audiences through video and booklets.

The aforementioned interventions may not reach media dark areas where a significant proportion of the Ethiopian community resides. As per the EDHS 2011 report, 68% of women and 54% of men in Ethiopia have no exposure to radio, TV, or newsletters.Considering this fact, MaNHEP developed an alternative to reach this segment of the community. The two major activities included in this category are the mobile video show (MVS) and open market show. The former required professionally developed video, an LCD screen, and a van or screen with generator to reach remote villages. The team of project staff and local government representatives led the process of implementation. The second activity was implemented by a consultancy firm which developed a script and recruited talent for a live drama show performed at selected market places in the six interventiondistricts. More than 60,000 people were addressed by the two activities which were implemented in one round.

The MaNHEP end line survey tracked indicators related to demand creation. The percentage of women with four or more ANC visits increased from 16% to 52%, the percentage of women who delivered with skilled provider/HEWs increased from 17% to 30%, and post natal care (PNC) visits by a skilled provider/HEWs increased from43% to 75%. In such interventions, as written in multiple studies, community changes may not easily be attributed to a single intervention in a given point in time, however, compared to situations at the baseline - in selected sites –the improvements at endlinesignifies that MaNHEP contributed to enhanced demand for care.

Introduction

An estimated 2.6 million births occur each year in Ethiopia. On the other hand, the death of mothers and newborns is unacceptably high (MMR = 676/100000 live births and NMR = 37/1000 live births). Direct obstetric complications account for 85% of the deaths of mothers as well as many acute and chronic illnesses. The most important causes of death include obstructed labor (13%), ruptured uterus (12%), severe pre-eclampsia/ eclampsia (11%), severe complications of abortion (6%), post-partum hemorrhage /retained placenta (7%), postpartum sepsis (5%), ante-partum hemorrhage (5%), and direct complications from other causes (9%). Similarly, of the nearly four million neonatal deaths globally, 99% occur in developing countries. In Ethiopia, some 120,000 newborns die of preventable causes annually, making Ethiopia one of the ten countries with the highest number of neonatal deaths per year. The major causes of neonatal mortality are infections (46%),birth asphyxia (25%),and complications associated with low birth weight (17%).[i]

In general, the high maternal and neonatal mortality ratesin the country are attributable to various factors. On the supply side, factors include high levels of unskilled home delivery, little postnatal care follow-up, poor access and utilization of emergency obstetric and newborn care (EmONC) services, very low critical life-saving services, shortage of skilled

midwives, a weak referral system at the health centerlevel, and under financing of services. On the demand side, cultural norms, distance to functioning health centers, and financial barriers were found to be the major factors associated with maternal and neonatal mortality in Ethiopia. Some of the underlying causes of the high maternal death include early childbearing and the high fertility rate.[ii]

In Ethiopia, the period following birth is often marked by cultural practices that hinder the health and survival of the newborn. Delay in the initiation of breast feeding, giving newborns a bath immediately, discarding colostrums, providing food other than breast milk soon after birth, and applying butter or other substances such as cow dung to the umbilical stump,which increases risk of infection, are practices that lead to newborn morbidity and mortality. A survey conducted in four large regions by the JSI-led Last 10 Kilometers (L10K) Project in December 2010 revealed that only 53% of mothers initiate breastfeeding within an hour of delivery. Feeding of the colostrum was reported by only 43% of the mothers. Pre-lacteal feeds were given by 23% of the mothers to children age 0-11months. A quarter of the mothers also applied butter to the umbilical stump. 57%of the newborns were bathed within six hours of delivery.[iii]

Cognizant of all the aforementioned problems and issues, the Ethiopian health policy declared that information, education, and communication (IEC) for health would be a priority. It stated that,*"Information, education and communication (IEC) of health shall be given appropriate prominence to enhance health awareness and to propagate the important concepts and practices of self-responsibility in health."* In line with this, providing health education using mass media is indicated as a general strategy to enhance awareness of the population on health and health-related issues which will improve health service seeking behaviour. Moreover, the fourth Health Sector Development Strategic Plan (HSDP IV), identified demand side interventions as one of three approaches to improve the quality of health services through active and inclusive participation of the community. Under this intervention, community participation isthe main strategy to improve health service delivery by guaranteeing that patients' and clients' opinions are heard and their satisfaction with services is optimized.

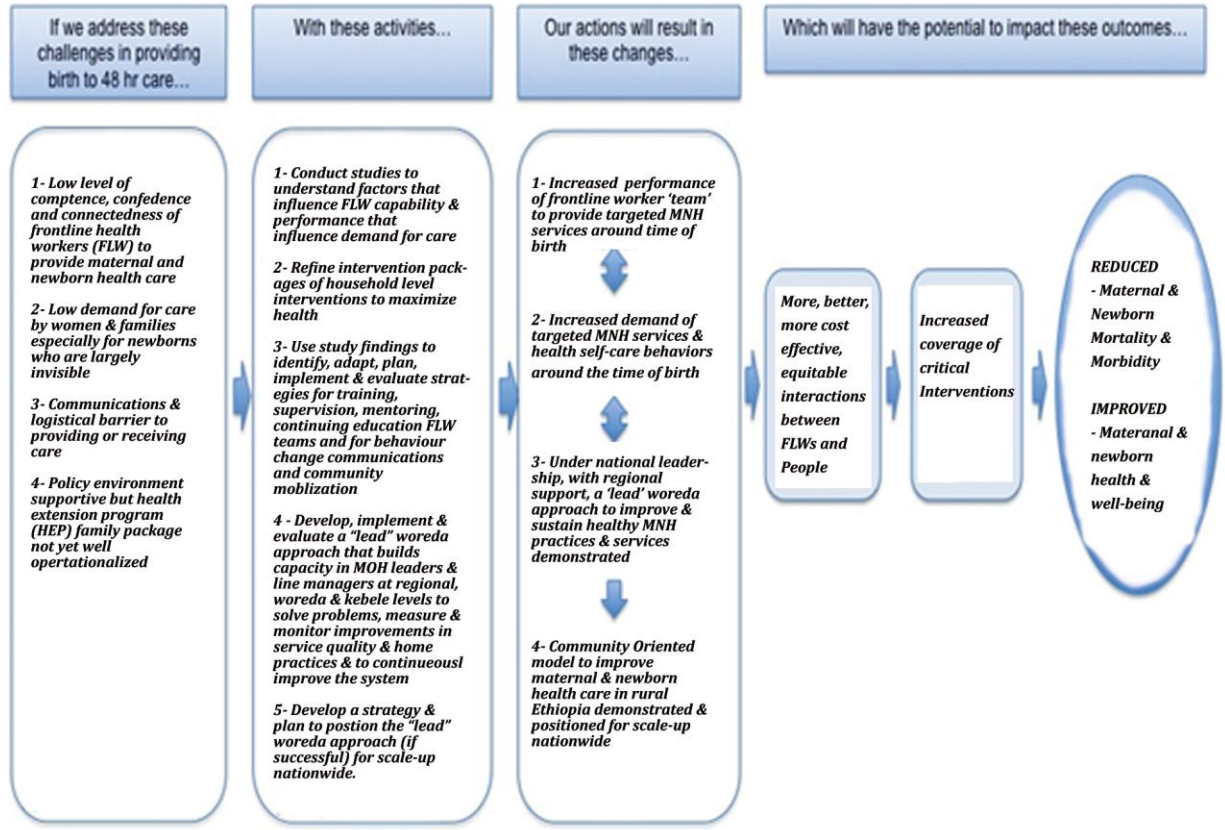
Maternal and Newborn Health in Ethiopia Partnership

Under the leadership of the Federal Ministry of Health, the Maternal and Newborn Health in Ethiopia Partnership (MaNHEP)is working to strengthen implementation of the Health Extension Programby building skills and teamwork among frontline health workers such as health extension workers (HEWs), volunteer community health workers, and traditional birth attendants (TBAs), and by developing the district-wide administrative and health systems needed to reliably deliver quality maternal and newborn health care around the time of birth when women and newborns are most likely to die. Funded by the Bill and Melinda Gates Foundation, MaNHEP works in six rural districts in Amhara and Oromia Regionsandis led by Emory University in collaboration with JSI Research and Training Inc., URC, and AAU. It is a "learning" project with the aim to demonstrate a community model of maternal and newborn care in rural Ethiopia and position best practices for scale-up.

Figure 1illustrates the project's action theory, incorporating the goal and objectives and known challenges described above. Assumptions in the model are: (1) The HEW is not likely to be present

around the time of birth and therefore family members, TBAs, or women themselves providedelivery care, (2) Awindow of opportunity exists for entry of the HEW into the home for delivery care through the early postnatal period-- a window that coincides with the period of greatest vulnerability for women and newborns, (3) Although little progress has been made to-date, it is possible shift towards having the HEW present in the home during delivery, (4) This shift will be made more easily if approached in stages, focusing first on existing frontline workers-- a 'team' comprised of HEWs, community health workers including TBAs-- and on getting a package of evidence-based interventions* into the home through enhanced appreciation for and relationship with this team, and (5) The approach can build a platform for adding other evidence-based interventions at the most local level, involving frontline health workers, communities and families.

Figure 1. Theory of action for improving MNH outcomes through community-oriented interventions focusing birth-to-48 hour period.



* *The evidence-based maternal health interventions include care at delivery (clean delivery, misoprostol, uterine massage), care after delivery (breast, bleeding, trauma and fever checks), and counseling (breast care, nutrition, hygiene, rest, uterine massage, illness recognition and care seeking).*

MaNHEP's core interventions include:

1. Training frontline workers, pregnant women, and family caregivers in *best MNH practices*;
2. Collaborative quality improvement working with district and community leaders and stakeholders to identify *best processes* to ensure that MNH care reliably reaches women and newborns in time, every time, and;
3. Behavior change communications to shift community norms around the value of MNH care during birth and the early postnatal period.

The MaNHEP monitoring, learning, and evaluation approach incorporates formative research, baseline and endline knowledge, practice and coverage survey, and monthly quality improvement tracking and charting of selected indicators to assess progress as well as local ideas tested and associated with progress.

Behavior Change Communication

Behavior change communication (BCC) is an interactive process with individuals or group of community members to develop tailored messages and approaches using variety of communication channels topromote and sustain individual, community, and societal behavior change and maintain appropriate behaviors.Effective BCC is vital to setting the tone for compassionate and responsible interventions. It can also produce insight in to the broader socio-economic impacts of MNH and mobilize political, social, and economic responses needed to mount an effective program. MaNHEP's BCC approach is based on sound practice and experience, focusing on building local, regional, and national capacity for positive behavioral change in relation to community-based maternal and newborn health (CMNH)care. BCC is both an essential component of each program area and the glue between the various components of the project. The project developed its BCC strategy in the context of service uptake, improved provider capacity at local and regional levels, creatingsustainable positive behavioral change in the community at large, and enhancingteamwork to take action on birth preparedness and complication readiness. It also advocated moving beyond individual communication products to an integrated use of many different interventions, products, and channels woven together into a comprehensive strategy.

FormativeResearch Findings

MaNHEPconducted a formative research study in Amhara and Oromia Regions to examine both supply-side and demand-side issues related to MNH care. The research also identified factors which facilitate or hinder interactions between mothers and trained frontline

health workers (FLWs) including health extension workers (HEWs), volunteer community health workers (vCHW), and traditional birth attendants (TBAs).

The formative research had clear implications for MaHNEP's BCC strategies.The research indicated that messages targeting families and FLWs, particularly TBAs, should highlight the importance of havingthe HEW present during labor, delivery, and the early postnatal period. Broader messaging should also be considered to strengthen systems of MNH care. These messages should focus on spurring teamwork among communities and FLWs, and encourage health managers at district and regional levels to adopt improved maternal and newborn care practices.

BCC messages for communities could then highlight the benefits of HEW's presence at the home during birth, which seem to be currently not well recognized by families. This could be done in reference to the specific problems; such as, low involvement of husbands that mothers mentioned in the interviews. There is also a broader need to work with communities and HEWs so each better understands the roles and responsibilities of HEWs.

These key messages should be incorporated into and reinforced through the CMNH and QI components of MaNHEP. However, there are other important channels and methods for getting the messages out to a broader audience. For example, MaNHEP should develop and implement a broader BCC strategy that targets not only these audiences but also health managers at district and regional levels. This work, which will draw upon the findings of this formative research and on the baseline survey, is currently being developed.

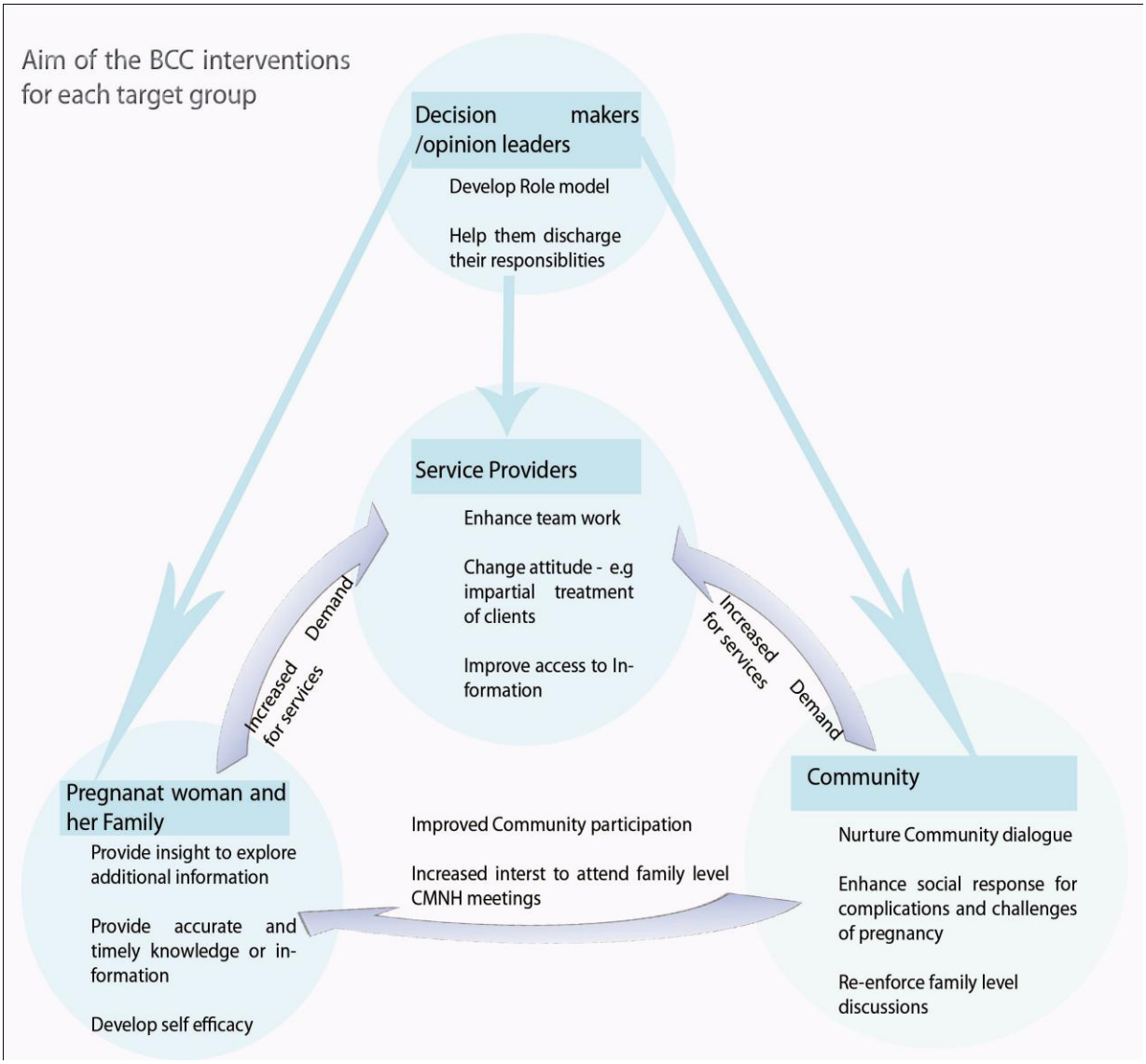
Process of BCC Strategic Document Development

To support MaNEHP'ssecond objective, creatingdemand for services provided at community and facility level, a BCC strategic document was developed. The process was led by a senior project advisor from JSI/Boston and the BCC advisor in Ethiopia. Literature, collaborative quality improvement tools, and CMNH family meeting facilitation materials were reviewed to develop a draft strategy. After developing a framework of the strategy, a series of consultation meetings with the project staff from thecentral and field offices were conducted. In the discussion, the scope of the BCC interventions, key messages, strategies, activities, and target audiences were identified. After implementing the document for 15 months, considering issues identified while implementing both family meetings and collaborative quality improvement,a revision of the BCC framework was made to refine key messages and activities.

Target Groups and Aim of the Messages

Following the formative research findings, a framework which relates the aim of each intervention under each target audience was developed (Figure 2). The framework identified pregnant women and their families, along withcommunity members, decision makers/opinion leaders, and service providers as primary and secondary target groups, respectively. The aim is also geared towards addressing key issues identified in the formative research.

Figure 2: Aim of the BCC interventions for each target audience, MaNHEP



Implemented Activities

Power of Media:

The great promise of mass media campaigns lies in their ability to disseminate well defined, behaviorally focused messages to large audiences repeatedly, over time, in an incidental manner, and at low cost. Typical campaigns have placed messages in media that reach large audiences, most frequently via television or radio, but also outdoor media, such as billboards and posters, and print media, such as magazines and newspapers.[iv] They may stand alone or be linked to other organized program components, such as clinical or institutional outreach and easy access to newly available or existing products or services, or may complement policy changes.[v]

Exposure to such messages is generally passive, resulting from an incidental effect of routine use of media. However, mass media campaigns can directly and indirectly produce positive changes or prevent negative changes in health-related behaviors across large populations.[vi]

4.1. Educational TV Plasma Show

Assumptions/Background

As documented in the literature,children's'development is influenced by multiple spheres/ factors, including schools, families, community groups, and peer groups. The goals, resources, and practices in these groups dictate the direction of in-school-children's development.[vii] One of the key evaluation criteria of the quality of education is its relevance to solve community problems and the role children can play at home. In relation to this, over 90% of parents of elementary and middle grades students, however, believe the school should tell children how to help at home. This remains high – over 80%- for parents of high school students.[viii]Notwithstanding this fact, children's participation in decision-making is complex: It is undertaken for different purposes and is reflected in different levels of involvement, different contexts and different activities.[ix] The role of media for this is also immense. It plays an important role in family decision making by influencing the child who, in turn, influences household decision making, one would expect the youth's exposure to advertising messages to be reflected in his/her greater participation and influence at various stages in the decision making process. [x] Genuine participation by children and young people in decisions and in processes that affect their lives depends on several conditions, one of which is access to relevant information. [xi]

Production of the TV Spot

The issue of producing the spot emerged from our learning in the collaborative quality improvement intervention. In this intervention,the MaNHEP team learned that some kebeles were using students to notify HEWs while on their way to their school in the morning. However, some of the students didn't consider their role seriously and act accordingly. Considering this reality, the project recruited Walta Information Center to do the production. The five minuteTV spot was aimed at instigating thoughts to help in-school children explore the role that they can play in maternal care.

Taking this objective into account, Walta Information Center submitted a script to the project and a team comprising of MNH specialists and a BCC advisor. The team reviewed the content of the script and further developed it to include some key messages based on the local context. Then, the production was completed in the rural settings which resembles the intervention areas. After pre-test and review made by experts, the final production was made.

Content and Flow of the Spot

A student living with her father lost her mother when she was born. Because of this coincidence, her father believes she was the reason for his wife's death. When anything happens, he shouts at her mentioning that she killed his wife. In one of the class lessons, she found out that her mother died not because of her, but she had had no consultation with health professionals and tried to give birth at home. The issue of frequent consultation with health professionals reminded her that her stepmother has also been doing the same as her mother did. Then, when she finished the lesson, she ran to home and nagged her stepmother to go to the health facility. While discussing, her stepmother felt pain. Suspecting a labor pain, she went to call for her father and HEWs to assist her. After arriving at home, the HEWs assessed and advised the father to take her to health center for the care she needs.

Implementation

The spot was broadcasted through the TV plasma educational program during students' day break time along with other entertainment programs twice a day for five days. Before the spot is broadcasted, school mini media and teachers, who are managing the plasma TV, communicate the schedule to the school community. From the agency managing the "Education by TV" program, the spot was released as per the schedule. The monitor who was assigned to follow the transmission in the selected schools reports to the staff assigned to coordinate the activity.

Results – Attendance

The data collected from three selected schools in intervention areas showed that of the high school students (grade 9-10) who were included in the cross-sectional study, 60% ofthem were exposed to the spot at least once. Of those students, 177 (61.7%) and 82 (28.6%) of them have watched the drama one and two times, respectively. Only 9.4% of them didn't finish the show once they started watching. The reasons - the time was not convenient and having other priorities contributed to 82.6% and 17.4%, respectively.The exposure to the spot, however,does also not depend on student's background characteristics: age, sex, school ranks, owning any media equipment, income of the family and education level of parents(*Table 1*).However, children's club participation, particularly, in gender clubs, mini-media and HIV/AIDS or health clubs, has contributed significantly to their exposure to the spot.

Table 1: Attendants of the TV Spot by BackgroundCharacteristicsin Amhara and Oromia Regions, October – November, 2012, MaNHEP

Characteristics	Watched the plasma TV		Sig.	Exp(B)
	Yes	No		
Gender				
Male (ref)	53.3	50.8		
Female	46.7	49.2	0.58	0.90
Rank				
1 –10	38	29.4	0.05	1.47
> 10 (ref)	62	70.6		
Birth Order				
First	19.2	16.2	0.41	1.22
Other than first (ref)	80.8	83.8		
Club participation				
Health/Gender/Mini-media	70.1	49	0.001	2.44
Other clubs (ref)	29.9	51		
Access to Media				
None (ref)	23.7	27.4		
At least one media	76.3	72.6	0.36	1.22
Have encountered pregnancy related complications or death				
No (ref)	66.9	69.5		
Yes	33.1	30.5	0.54	1.13
Heard message on MNH before				
No (ref)	34.5	40.1		
Yes	65.5	59.9	0.21	1.27

Challenges and Lessons

The first and most frequent challenge was the interruption of the transmission due to issues related to power and satellite receiver. In addition, because the spot was transmitted during break time, children may not stay long and finish the spot.

Given the fact that attraction to such program is related to a student's participation in the club, promotion of club membership would be of great importance. Furthermore, lobbying for having flexible education through TV programs is important to incorporate such messages whenever there is a need.

4.2 Use of Radio

Public Advertisement Services

Considering the importance of improving facility delivery, a minute-long PSA/message was tailored to improve awareness of the pregnant woman and her family on why and how they decide to seek care from professionals at health facilities. A rapid assessment to identify the radio stations which are preferred by the community and the reported strength of the wave was conducted. Based on the assessment, two radio stations each,foreitherAmharic orOromiffa languages, were selected. The stations aired the PSA for 15 days every other day during night time when most of the rural family members are at home.

Community Dialogue

In collaboration with Oromia Regional Health Bureau (ORHB) and Radio Fana, the project organized a community dialogue. The aim of the dialogue was to document and share experiences related tomaternal andnewborn care. During a panel discussion, different experiences in the region and project sites were presented by representatives of the ORHB and MaNHEP: 78 participants from intervention kebeles shared their experiences. The dialogues were documented and aired in three sessions. Radio Fana collected feedback from the community on the issues raised in the program.

Photo: Panel discussion podium at Kuyu woreda.

Radio Program for Disseminating the Change Package

Aiming at reaching and informing decision makers at higher level about what is happening at community level and efforts by community volunteers to improve the care provision, the last learning sessionwas attended by 128 people from 3 woredas in Oromia Regional State and key process owners from the Regional Health Bureau was documented. Change ideas/community based solutions to improve selected CMNH care steps includedCMNH family meetings, labor/birth notification, and post natal care visits. In addition, how the new spread sites have implemented the package prepared by MaNHEP.

At this event, where all intervention kebles were represented, the kebele level team was recognized for their contributions and awarded with solar torches and megaphones. The awards will thus assist them to properly engage in future endeavors aimed at improving the MNH care provision at the community level.

The documented practices were aired through Radio Fana national and 8 FM radio stations. The program was divided into three parts: Exploring the problems related to CMNH care provision, what MaNHEPhas tried to achieve, and implications for policy and program development.

4.3. Promotional Materials

Photo: volunteers with their promotional items, Amhara region

The key messages which were pre-tested at the community level were printed on any materials that the project produced. The selection of materials was made depending on theirimportance to the frontline health workers: HEWs, guide team, quality improvement team, and community members. In connection to this, a total of 153gowns, 1284 torches, 1650 umbrellas, 1900 t-shirts, and 1504 capes were produced and distributed to the frontline health workers.

Lessons

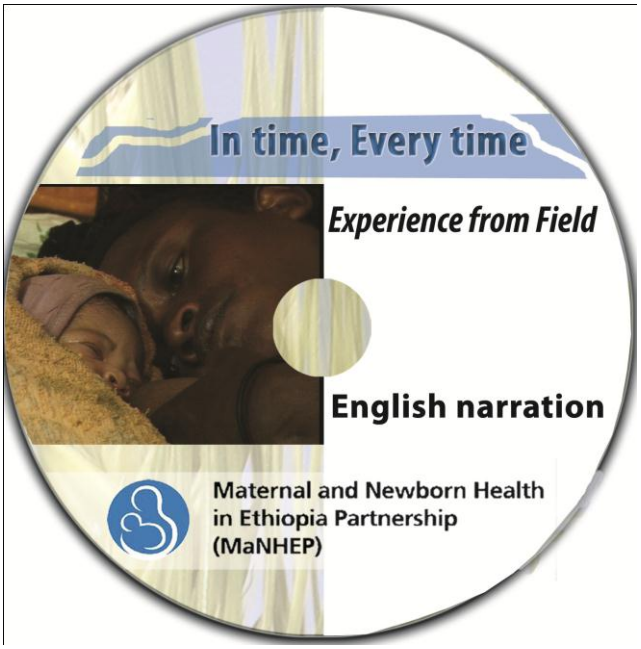
- Careful selection of materials can help to respond tosome requests of the health professionals. Materials can have a dual purpose: Assistingprofessionals to carry out their duties, and serving as a channel for message dissemination.
- Promotional materials can also be considered a motivation scheme for community volunteers.

4.4. Video Documentation

Aiming at sharing the experiences of the project and influencing partners and the MOH to replicate some of the learning the project has registered, four video documentaries were produced (500 copies each).

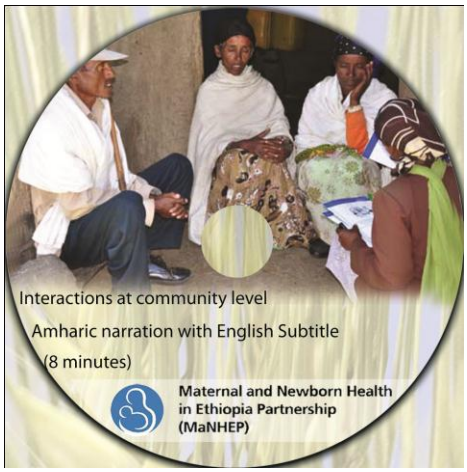
Experience from Field

This film documented experience from one village – TumanoAbdi - where health extension workers, guide team, and quality improvement team members, supported by health center and woreda health office staff have accomplished much in a short time period.The documentary included best practices to identify pregnant women, start ANC care early, how they motivate mothers and families to complete the CMNH meeting, conduct PNC timely, and most importantly, how they use the existing government structures and system – women development army, primary health care unit,and health management information system. The 28minutevideo is narrated in English.

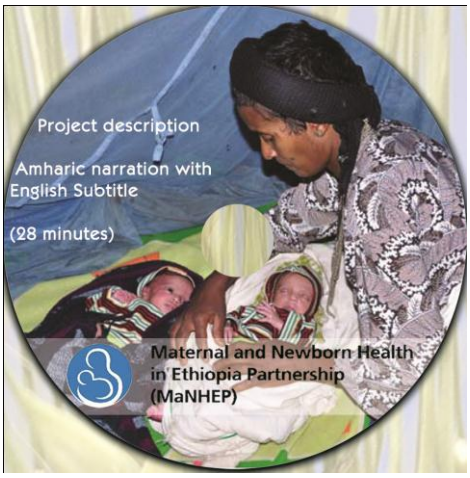


Interaction at Community Level

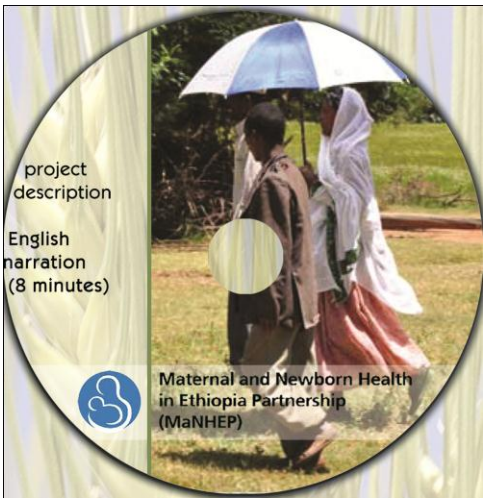
The community based maternal and newborn health service provision is about establishing and enhancing interaction between service providers and pregnant mothers and families.The efforts made by the project to improve this experience were significant. This documentaryshowcases different change ideas to improve the interactions among volunteers and service providers with pregnant mothersand families. The 8minutes video is narrated in Amharic, with English subtitles.



Project Description



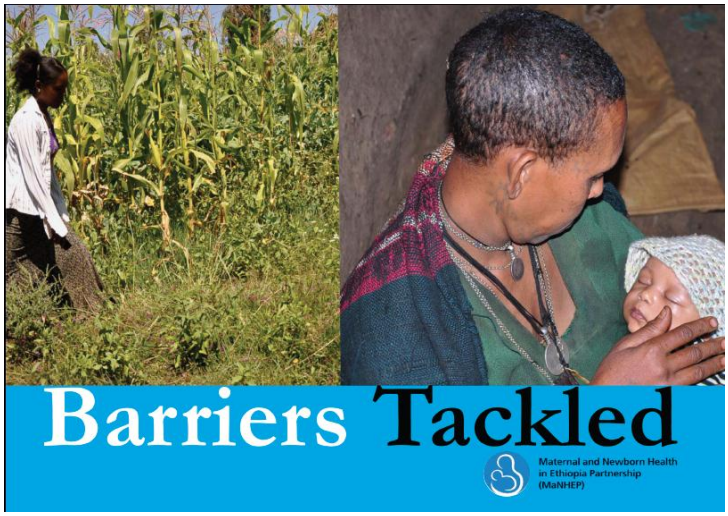
The three arms of the project were clearly documented in this video.The video illustratesthe path taken by the project since its inception by highlighting key milestones. It is presented through two versions. The first is a 28minutevideo narrated in Amharic with English subtitles. The second is a 10minute video with English narration.



4.5. Case Study Compilation

In order to capture the different perspectives of the project, four booklets with different themes were produced by collecting different cases from mothers, volunteers, government partners, and project staff

Barriers Tackled

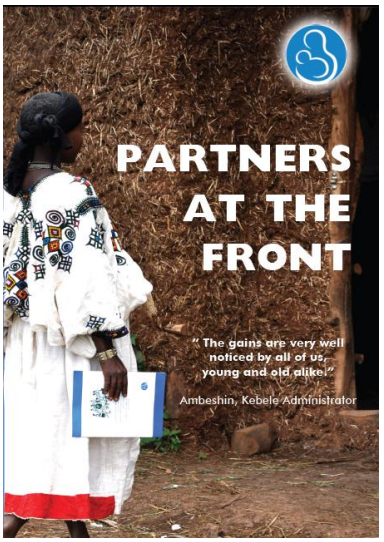


This booklet documents the experiences of guide teams, quality improvement teams,andhealth extension workers.

This booklet's target audiences includehealth professionals, government officials, NGOs, donors, and UN agencies, and responds to the following questions:

- How were volunteers selected, trained and deployed?
- How the daily activities of volunteers relate to CMNH?
- How do volunteersinteract each other and with the community/family?
- What was the perception of the community to the MaNHEP team?
- What were the key challenges, and how were they overcome?
- What results were achieved through the life of the project?

Partners at the Front



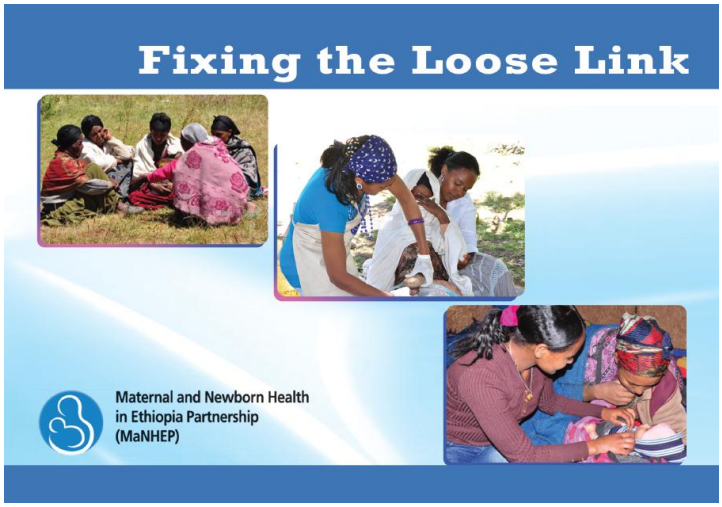
The primary focus of the project is to build the capacity of people working in various levels of institutions in the target woredas to increase demand for quality MNH services. Hence, the project understands capacity as "a means" and "an end". It is a means to provide the necessary MNH care to the target groups and an endto provide lens for the leadership and health professionals to assess the situation and collaboratively come up with different solutions for bottlenecks. Hence, this publication tries to present both situations.

The capacity building initiatives often require multipronged approaches and multiple levels of involvement for enhancing engagement, implementing and learning, fostering ownership, and sustaining capacity. Capacity canbe reflected in different strategic documents, procedures, manuals, day-to-day practices, and engagement with the community. The projectimplemented activities geared towards building the capacity of different levels of institutions with the ultimate aim of developing a laboratory woreda. Holding these assumptions, different case studies were collected from different individuals working at various levels of the system.

The production is aimed for the government officials, NGO partners, and UN agencies. Hence, for capturing their attention, the document was designed to beself-explanatory.

Fixing the Loose Link

Thiscase study included different cases collected across the intervention woredas. It aims to document community-level best practices for policy makers at the Federal Ministry of Health, RegionalHealth Bureaus, and other bilateral and multilateral donor agencies. The cases were selected based on their scalability and innovativeness. Cases were based on the following key questions:



- How do staff members at the health center level cover in the absence of HEWs?
- How did the woreda administration become involved in project implementation and what was its role in achieving project goals?
- How does the kebele administration runregular meetings in the absence of HEWs and other coaches?
- How is data managementconducted betweenvolunteers and woreda health offices?
- How do the HEWs provide group CMNH skill transfer?
- How was the WDA structure is re-engineered/made functional?

An Organization is all about its People

The success of the organization depends on the people who are working for its cause. We believe that MaNHEP has good people with different backgrounds, levels of expertise, and educational institutions. This mix, coupled with the extraordinary commitment of the field workers and their interaction with the community has contributed to the success of the project.This case study capturedthe memories of the staffand community and stakeholder perceptions. In addition, it is a mechanism of appreciating the contribution of staff members that have put unreserved energy, and left many personal interests behind.

Implemented Activities

Alternative for "Media Dark" Areas

Thereare challenges to implementing BCC in Ethiopia. There is poor access and exposure to mass media. According to the 2011 Ethiopian Demographic and Health Survey, only 41% and 10% of households have radio and television respectively; 25% have mobile telephones. Respondents were more likely to listen to the radio (22% of women and 38% of men) than to watch television (16% of women and 21% of men) or to read newspapers (5% of women and 11% of men) at least once a week. Surprisingly, 68% of women and 54% of men have no exposure to any of the three mass media.[xii]

Different efforts have been made to reach "media dark" areas in the country, such as home-to-home education. However, such interventions have taken resources – human and time – and may also be refused by some members of the community. Considering these situations, the project tried to develop strategies to reach target groups and influence community members to accept the home-to - home education.

4.6 Mobile Video Show

Preparation of the Video

MaNHEP outsourced the production of the video (script development, shooting and studio editing) in two languages: Amharic and Oromiffa. Referring to the technical training materials prepared by the project and series of consultations with the project team, a script for the video was developed. The company incorporated the comments provided by project team and then recruited talentand well-known artists from the intervention areas.While shooting, necessary adaptationswere made to ensure the best quality product. After initial shooting,a first draft was submitted to the project. It was reviewed by the project team and pre-tested at the selected intervention sites. The production team considered the comments gathered from the staff and community members, revised, and finalized the video.

Contents of the Video

Each film is approximately 1 hour and 40 minutes. The videos compare the experiences of two families. In the first story, a pregnant woman attends family-level meetings with her husband and other family members.As a result, she and her family know how to prepare and make sure the woman and her baby are healthy and alive. In addition, she receives additional support from her husband, health extension worker, and trained volunteersthrough the post-natal period. The second story is about a pregnant woman, who even thoughher friend and trained volunteer want to take her to the health extension worker, won't go because her husband is not willing to let her attend the prenatal care. He doesn't care for her; she was also forced to work hard in the family. Because of these circumstances, she and her baby lose their lives.The experiencechanges the husband'sattitude and he promises to teach the community by being an example.

Implementation of the Show

For facilitating and standardizing the procedure/implementation, a guide on how to organize the show was prepared by the MaNHEP central office and orientation was given to each MNH specialist. As per the guide, a local team was organized. The team shared responsibilities among themselves, including serving as master of ceremonies, mobilizing the community, taking attendance on a tally sheet, and preparing a stage. The leader of the team followed the checklist and made sure the assignments of each team member were performed completely before staging the show.

Photo: Mobile video van used to project the video.

Listening to the music, which has similar message to the video show, the community arrived at the site, which was school compound, farmer's training center, kebele administration, or open space convenient for the show. Then the facilitation of discussion followed a step called ORID (objective-reflection-interpretation-decision)[xiii]. After the show, the audience was encouraged to comment on the content, link to their knowledge/practices, and present their planned actions. The show was also accompanied by question and answer and poem contests.

Results – Attendance

Table 2: Attendants of the mobile video show in Amhara and Oromia Regions, December 2011 – February, 2012, MaNHEP

Site Name	Pregnant women	Elders		Youth (15-30 yrs)		Children	Guide and QI teams	Other Adults		Total
		Male	Female	Female	Male			Male	Female	
Kuyu	286	211	226	2842	2209	1482	117	659	506	8529
Degam	111	45	205	95	386	255	59	411	1939	3506
WereJarso	227	434	239	601	632	591	178	266	326	3514
Sub-Total (Oromia)	**624**	**690**	**670**	**3538**	**3227**	**2328**	**354**	**1336**	**2771**	**15549**
North Achefer	132	493	274	689	664	409	126	665	566	4008
South Achefer	32	150	124	778	490	802	104	829	449	3758
Mecha	86	532	327	1337	957	370	138	789	538	5074
Sub-total (Amhara)	**250**	**1175**	**725**	**2804**	**2111**	**1581**	**368**	**2283**	**1553**	**12840**
Grand Total	**874**	**1865**	**1395**	**6342**	**5338**	**3909**	**722**	**3619**	**4324**	**28389**

"In the past, nobody take cares of the laboring mother, culturally the husband has never been in the home when the women start laboring, but now we have learnt a lot about the care needed for laboring mothers, so I promise to be with my wife at this time and teach the same to other men."
-Attendee from from A/J/Gedam

Challenges of Implementation

- Accessibility of some of the villages posed a challenge to present the show by van. However, the backup plan of transporting the generator, LCD, screen and laptops for these areas helped to present the show.
- Competing activities in the project kebeles, such as natural resource conservation activities,frequently forced the project team to change schedules and waitfor the completion of the activities.
- When they were staged late in the evening, some of the activities like poem contests were left outfrom the package of the intervention.
- Many competing interest of the audiences diverted audience attention.

Lessons Learned

- Before presentation of the video, there should beintense community mobilization activities for some days before the event.
- Strong teamwork at both woreda and kebele levelsisrequired to organize the events successfully.
- An appropriate vehicle should be rented for the video show. Though the heavy track having all materials and equipment seems convenient, it can't reach all kebeles. Therefore small vehiclesand donkeys/mules are usefulto reachinaccessible kebeles.
- Materials and equipment that can help show the video in the daytime should be availed
- Harmonizing the show with on-going social events, such as safety-net activities, mass trainings, and resource conservations help to improve the attendance.
- Staging the show with multiple rounds at the same place may improve the reach and recollection of the key messages.

4.7 Marketplace Show

Preparation of the Drama for Marketplaces

The project found marketplaces to be appropriate place to reach a large number of community members. In many instances, two or three well-know market places exist in each woreda/district. As these places have different market days in a week, many people residing in the neighboring villages/kebeles visit these for many reasons, including selling, buying, and meeting people. Considering these facts, the project announced a call for expression of interest and proposals. Based on set criteria- technical feasibility, previous experience, team, and commencing early - a firm was selected to lead and implement the process in selected market places.

The selected firm received a creative briefing and agreed on the following key messages:

- A health facility is a better environment than home for giving birth.
- When the mother is in labor, inform to HEWs and escort mothers to the health post or health center.
- If the mother is not assisted by a skilled attendant, inform the HEWs as soon as possible.
- The post-partum period is as important as the prenatal period. Get counseling after birth and continue caring for yourself and your baby's health.

In addition to developing scripts in Amharic and Afan Oromo, the firm provided resources. The team commented and developed scripts to capture issues identified from the family meetings and collaborative quality improvement interventions. Then, before finalizing the script, the drama was staged in one of the market places and the project team accompanied the drama team/firm and assessed the community's reaction and steps of implementation. Then, based on this assessment, the final script was developed.

Contents of the Drama

A family with very limited knowledge about MNH care is the start of the scene. The mother is pregnant and her husband and mother-in-law need to seek care from TBA.The health extension worker arrives when the labor pain starts, as does the TBA. The show portrays the conversation between the health extension worker and the TBA. In the conversation, many community beliefs and the importance of facility care are discussed and the HEW tries to convince the family as well as the TBA. In between the conversations, the audience is asked about their reflections on the conversation and their responsesare included as part of the drama. Preferably mothers were encouraged to share their experiences with regard to MNH care. At last, the HEWs along with the audience convince the family and manage to take the laboring mother to the facility.

Implementation of the Drama

The show was implemented from June 16-July 1, 2012 in 13 selected market places (*Table 3*). It had multiple components, following carefully designed steps. The schedule was communicated to the woreda and district administration so that they assignedrelevant people to prepare sites and mobilized the community for the show. Then, on arrival at the place the team opens well-known local music which assisted them to gather the community in the podium.

Table 3:Selected marketplaces for the show

S.No	Woreda	Market places	Approx. Distance from Addis Ababa
1	Mecha	Merawi	535 km
		Berakat	560 km
2	North Achefer	Liben	610 km
		Yismala	605 km
3	South Achefer	Durbetie	510 km
		Lalibella	530 km
4	Dagam	Hambiso	120 km
		Alidoro	137 km
5	Kuyu	Gebreguracha	156 km
		Biriti	183 Km
6	Werejarso	Gohatsion	186 Km
		Tulu milky	171 Km
		Filiklik	208 Km
Total places		**13**	

The master of ceremony presented the schedule to the audience and informed the audience that there will be questions after the show based on the messages included in the drama and correct responses will be rewarded. Then, the drama was staged for 20 minutes and in the middle of every conversation, the audiences were requested to advice the family. Moreover, the master of ceremony communicated selected messages to the target audience at the conclusion of the

show and asks the audience some questions on key messages. Finally, the community is invited to join the team for traditional dances.

Results – Attendance

The show was approximately attended by a total of 31,200 people from the 13 market places (*Table 4*).In all marketplaces, the show was found to be appealing to and engaging the target audiences. During the reflection sessions after the show, most of the audiences said, "The shows were very informative and educative about heath facility delivery."

"We lost many lives of mothers and newborn in the delivery assisted by the TBAs. Even a mother and child survives in miracle, they may face complicated health problems. The drama teaches women and men about the importance of health facility delivery. It encourages the community to support facility delivery and about the importance of seeking such care."
-A mother from Felekelek

Table 4: Attendance of Marketplace Show, MaNHEP

Marketplace	Approximate Number of Attendees
Merawi	1,000
Berakat	3,300
Liben	3,000
Durbete	1,800
Lalibela	2,000
Hambisho	3,100
Alidoro	2,500
Gohatsion	2,500
Tulu miky	1,500
Filiklik	3,000
Gebreguracha	3,500
Briti	2,000
Yesmala	2,000
Total	**31,200**

Challenges and Lessons

Heterogeneous audiences at marketplaces created problemsfor customizing the messages disseminated to specific target groups. In addition, finding appropriate places for preparing the stage was also a challenge given the fact that most of the marketplaces are flat.

While implementing the show, the mixture of the audience members can provide an opportunity of facilitate experience sharing among attendants if it is well managed by the master of ceremony or a person leading the implementation.

Results and Discussion

Link to Other Components of the Project

The project had three mutually re-enforcing components. Two components, CMNH family meetings and collaborative quality improvement,created a basis for message identification and target audience analysis. Given the importance of repeating the same message across the spectrum of interventions, the BCC intervention emphasizedcreating links to other interventions.

Link to Family-level CMNH Meetings

The family level CMNH meeting included different topics; such as, women and baby problems, how to prevent problems before a baby is born, how to prevent problems when a baby is born, and how prevent problems after baby is born. In addition, it includedspecific actions in relation to first actions and referral actions for baby and mothers.The BCC mass communicationdrew the same message from the facilitation manual and strived to improve the participation of husbands and mother-in-laws in the meeting.On the other hand, the BCC interventions were trying to disseminate good practicesof the project to various target groups, family members, frontline health workers, policy makers, and partner projects/organizations. Moreover, the promotional materials produced for disseminating messages have served as a motivation for volunteers involved in facilitating the meetings at family level.

Link to Quality Improvement Activities

The collaborative quality improvement (QI) approach helps frontline workers and community members define improvement areas that may prevent all mothers and newborns from getting care in time, every time. The teamthen tests different change ideas using the plan-do-study-act cycle and measures the difference. The frontline workers and community members meet on a regular basis to share lessons and successful solutions. In their meetings,they usually propose change ideas for each of the care steps. For instance,

the mobile video show and the market show have helped them to identify pregnant women.

The BCC intervention also tried to substantiate CQI component of the project by focusing on disseminating messages on specific care steps – skilled delivery care and early post natal care - which do not show progress for a longer period. For example, the key messages of the BCC interventions, includes facility delivery, the role of children in labor and birth notifications, timely care for mothers and their newborns. In addition, the QI interventiondeveloped change packages and the BCC intervention has assisted in disseminating the change package and good practices to other similar projects and most importantly to government policy makers at regional and federal levels.

Changes

The concerted efforts of the interventions have contributed to improvedbehavior of community members towards maternal and newborn care. This change was reflected in the community's individual and communal commitments and improved services uptake. The project introduced robust data collection and analysis methods to follow the reflection and the contribution of the project's interventions. The data presented here were extracted from different papers prepared by staff members of the project along with project monitoring data. Both of the data sources have qualitative and quantitative data.

Two papers prepared by the project team, showed that exposure to the interventions of the mobile video show and educational TV show has improved certain knowledge and practice of individuals who attended the show. Key messages - ANC care, labor and birth notifications - portrayed in the mobile video show were more oftenrecollected by those community members who attended the video show compared to those who didn't attend the video show*(Table 5).*Apart from the message recollection, the commitments made by individuals or groups was commendable. The following two quotes signify the importance of individual commitment:

> *"…[we] men who have watched this film must come to our senses and make ready ourselves for change."*
>
> *" … We shouldn't leave this task to the government and health extension workers rather we should allparticipate to bring about any change … "*

The reflection also identified communal/social responsibilities:

" … We can only avert this problem if we . . . end all the harmful traditions we have in our society and listen to what health extension worker is telling and teaching us and put them into effect … "

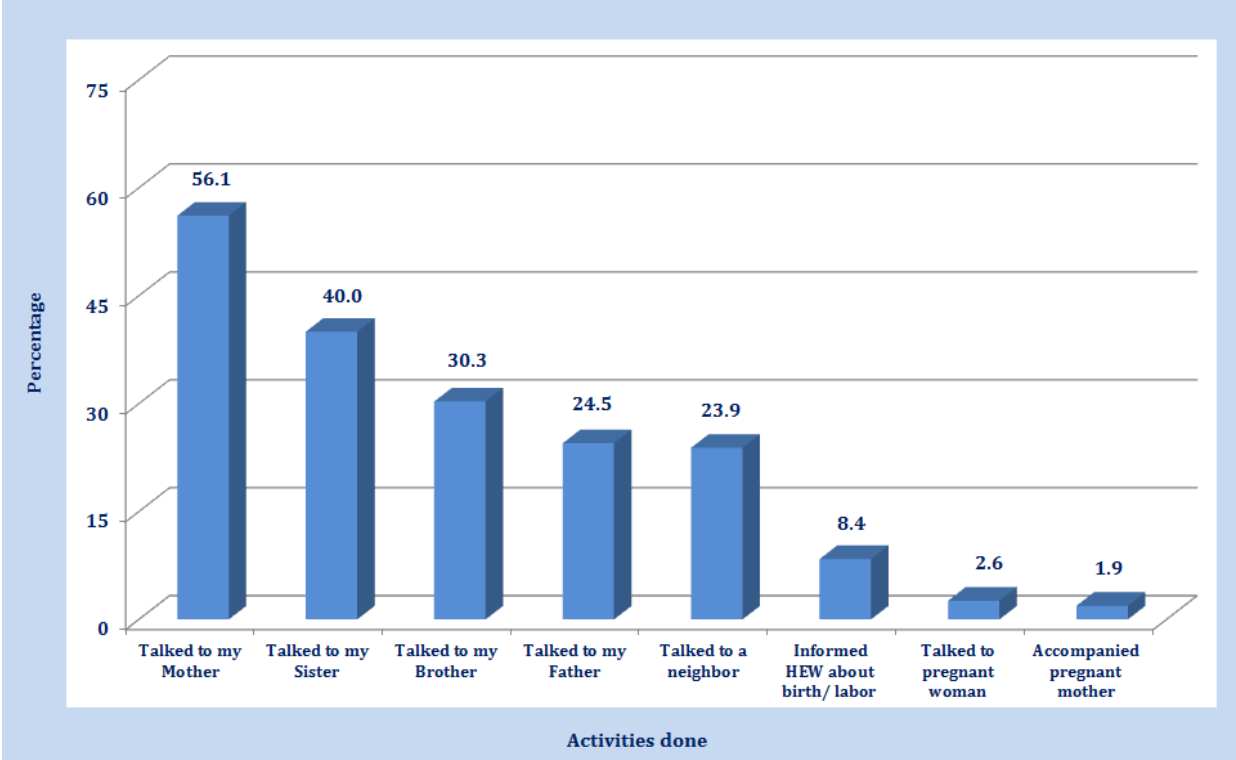
" … anyone who saw the MVS had an obligation to increase the awareness of the community at large about MNH problems and care…"

Another paper documented encouraging results forin-school children who were exposed to the educational TV program. The objective of the 5minute spot was to initiative interpersonal communication/discussion after the show. With this regard, a significant proportion of the students discussed the issue after the show. Exposure coupled with interpersonal discussion after the show exhibited key results. Children discuss the issue in the future (OR 3.8, P-Value 0.02), have adequate information (OR 2, P-value 0.02), and most importantly they had done anything differently (OR > 100, P-value <0.001). Discussing the issue with family members was the most significant change*(Figure 3).*

Table 5: Messages remembered by Adults who watched the TV spot and included in the EndlineSurveyin Amhara and Oromia Regions, May – July, 2012

Message	Attendee (n =172)	Non-Attendee (n =336)	P -value
Pregnancy Registration with HEWs	166(96.5)	283(84.2)	<.001
Labor notification to HEWs	170(98.8)	284(89.6)	<.001
Inform HEWs when baby is born	170(99.4)	274(84.3)	<.001

Figure 3: Behavior Changes among in-school children afterViewingEducational TV spot in Amhara and Oromia Regions, October– November 2012



Isolation of the independent effects of mass media campaigns is difficult. Substantial evidence has, however, been garnered from study designs that, in isolation, are less than classically excellent, but in aggregate yield a substantial body of support for the conclusion that mass media campaigns can change population health behaviours.[xiv]Taking this fact into consideration and the fact that we haven't used randomly controlled trials, we can only draw the conclusion that the project interventions havecontributed to improve the situation at baseline and registered remarkable achievements in-terms of assisting mothers receive complete care, and seek for ANC, delivery, and PNCservices*(Table6).*

Table 6: Comparison of Indicators underObjective two at Baseline and Endline in Amhara and Oromia Regions, May -July 2012

Indicator		Baseline (%)	End line (%)
Avg. % of 17 MNH care package elements women received from any FLW at last birth (completeness of care)	Element	32	83
% of women who knew FLW in their own *kebele*	HEW	70	91
	CHDA	21	72
	TBA	77	92
Avg. level of women's trust in FLWs to provide MNH care (1-5 scale)	HEW	3.4	4.2
	CHDA	2.8	3.9
	TBA	3.3	3.9
% of women who used ANC services	Any visit	48	86
	≥ 4 visits	16	52
	Skilled provider / HEW	91	98
% of women who used delivery services	Health facility	9	14
	Skilled provider / HEW	17	30
	CHDA / TBA	21	49
	(Family / other unskilled	62	21
% of women who used postnatal services	Any provider	20	69
	Skilled provider / HEW	43	75
	CHDA / TBA	17	16
	(Family / other unskilled	42	3

Conclusion and Recommendations

Despite the prevalence of maternal and newborn mortalityand the painit inflicts, communities continue to engage in practice and retain attitudes that put new mothers and babies at risk. Efforts have beenmade by many to improve the situation, butmaternal and newborn mortality rates have not improvedover the last decades in Ethiopia. Projects like MaNHEP contributed significantly to ameliorate the MNH problems and showed promisingresults. The results are partly brought by the focused intervention during abirth to 48 hours where majority of mother and newborn deaths occur. With its three interrelated components, MaNHEP strived to introduce interventions at multiple levels: Families, communities, and systems. As written in multiple studies, community changes may not be attributed to a single intervention in a given point in time, however, compared to situations at the baseline - in selected sites –the improvements at endlinesignifies that the interventions contributed to enhanceddemand for care. In addition, the trust level of the community infrontline workers (FLWs)changed positively. The interventions also initiated a process whereby people began to examinetheir actions at the family and society levels and assess their contribution for changing the situation in the community. The BCC as well as other components contributed for this success.

Many projects focusing on maternal and newborn health have different components and social and behavior change communication is usually part of them. The same holds true for MaNHEP. However, the development and implementation of the strategy is different. The development of the strategy called for participation of experts from the other two components:CMNHservice provision and quality improvement. The latter two components informed the contents of theBCC messages and BCC interventions were also geared towards strengthening and substantiating interventions from the other components. The implementation also included regular follow-up in all components of the project and entailed revision of messaging and approach to include issues emerging from the implementation of the project.

The strength of the messaging is partly measured by its ability to transport the audience into the world of the characters. The video productions of the project have achieved this aim. Teaming well know actors with the community representatives can help to establish the context similar to the local environment. In addition, pre-testing the productions and including comments from the community representatives also helped the show to resonate with community members.The process of staging the show is also another component that needs to be replicated. The objective-reflection-interpretation-decision (ORID) steps are important to consider while facilitating discussions after similar BCC interventions – the interpretation of the key scenes and decisionsmade based on the interpreted key practices or situations is quite strong in influencing the other attendants who have very little exposure to the key messages or resist otherwise.

Even though media has very strong influence in changing people's knowledge and attitudes, accessibility and ownership of electronic equipment do hinder the reach of campaigns. Hence, having a strategy, such as a mobile show or marketplace show can assist in disseminating the messages to people with poor access to media. Organizing frequent shows and including various target groups, such as young people, helps in influencing the family. Moreover, the fact that a significant proportion of rural youth are in schoolis an added advantage to consider them as a mechanism to disseminate messages to the family or their parents who in most of cases are illiterate.

As attributingchanges toa single intervention in a community setting is difficult, having robust system of tracking changes in the community is of paramount importance. To this effect, the project introduced documentation of the reflections and heldfocus group discussions after each intervention. Such practices can assistthe program managers to fine-tune interventions and learn from the implementation of such projects.In addition, using regular case studies helps in influencing practices of decision makers at various levels and health professionals.

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