Breakthrough ACTION

SBC Flow Chart: Democratic Republic of the Congo Spotlight

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Breakthrough ACTION
FOR SOCIAL & BEHAVIOR CHANGE

RESEARCH QUESTIONS

*How might we improve **essential household health practices and treatment seeking** for fever, cough, diarrhea for children under five, and prenatal care for pregnant women?*

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BACKGROUND AND CHALLENGE

Catalyst

Prompting dialogue about health:
Dialogue with the head nurses at local health centers has opened opportunities for community members to better understand how to take full advantage of the health services. It also helps to differentiate between the “services” offered by religious leaders and traditional healers.

By improving the dialogue between community members and healthcare providers, care providers are differentiated, costs are negotiated, and comparisons with daily consumed products show how health care costs are not really prohibitive.

Couple communication helps households seek best treatment for family needs.

Challenge

Community members rely on alternative health services offered by traditional healers, church pastors who may not offer effective treatments to community members but who offer affordable care, particularly for pregnancy, fever, diarrhea and coughs. Health services are valued but considered prohibitively expensive. Given prevalent poverty, health care is perceived to be an expense that most families cannot afford. Many illnesses and conditions worsen as a result.

Clean water and money to buy water or firewood are rare. Handwashing is rarely practiced.

Traditional beliefs are popular and social and gender norms entrenched.

Objective

This activity encourages parents to practice essential household health practices such as handwashing, sleeping under treated mosquito nets, exclusive breastfeeding, vaccination, and to seek medical treatment for children under five years of age for cough, diarrhea, and fever. Pregnant women will also use health services throughout their pregnancy, childbirth, and well-baby services.

GEOGRAPHIC SCOPE

Two teams of researchers made up of local, national, and international researchers conducted interviews and testing processes in Kasaï Oriental and Haut-Katanga. In each province, the teams visited households, health centers and community influencers.

The Discovery Phase of the project was conducted in five health zones in each province:

A Kasaï Oriental (Mbuji-Mayi area)

- Bibanga (rural)
- Kasansa (rural)
- Mpokolo (peri-urban)
- Tshitenge (peri-urban)
- Dibindi (urban)

B Haut-Katanga (Lubumbashi area)

- Kafubu (rural)
- Kapolowe (rural)
- Kipushi (peri-urban)
- Kalebuka (peri-urban)
- Kenya (urban)

DEFINE PHASE: APPROACH AND METHODS

The application of the SBC Flow Chart process in the Democratic Republic of the Congo (DRC) used methods which favor the participation of the community members who are directly impacted by the activities identified in the design and testing of those activities. Representatives from the provincial ministries of health, the national health communication program representatives, local NGOs, and many representatives of the community health system were involved in the research, design, and testing of the dozens of ideas that were generated during the SBC Flow Chart process.

Literature review and project planning

A comprehensive literature review summarized knowledge, attitudes, practices, behavioral determinants, and the social and cultural context of healthcare seeking and Essential Family Practices (EFP) in DRC. The literature review established a strong knowledge base to guide the project.

Intent workshop

An intent workshop brought key stakeholders from the Ministry of Health (MOH), United States Agency for International Development (USAID), Breakthrough ACTION, and other partner organizations to determine the parameters of the project and align expectations.

Capacity strengthening

We facilitated a two-day capacity strengthening workshop in each research locations to build knowledge, skills, and confidence in qualitative research approaches and techniques. Topics covered all methods and techniques required throughout the Define phase, including research ethics, elements of a good interview, how to conduct observations, and empathetic listening.

Discovery fieldwork

Two research teams, including Breakthrough ACTION staff, MOH National Program for Communication for Health (PNCPS) staff, MOH National Program for Reproductive Health (PNSR) staff, and Save The Children staff conducted research activities in Haut-Katanga and Kasaï Oriental.

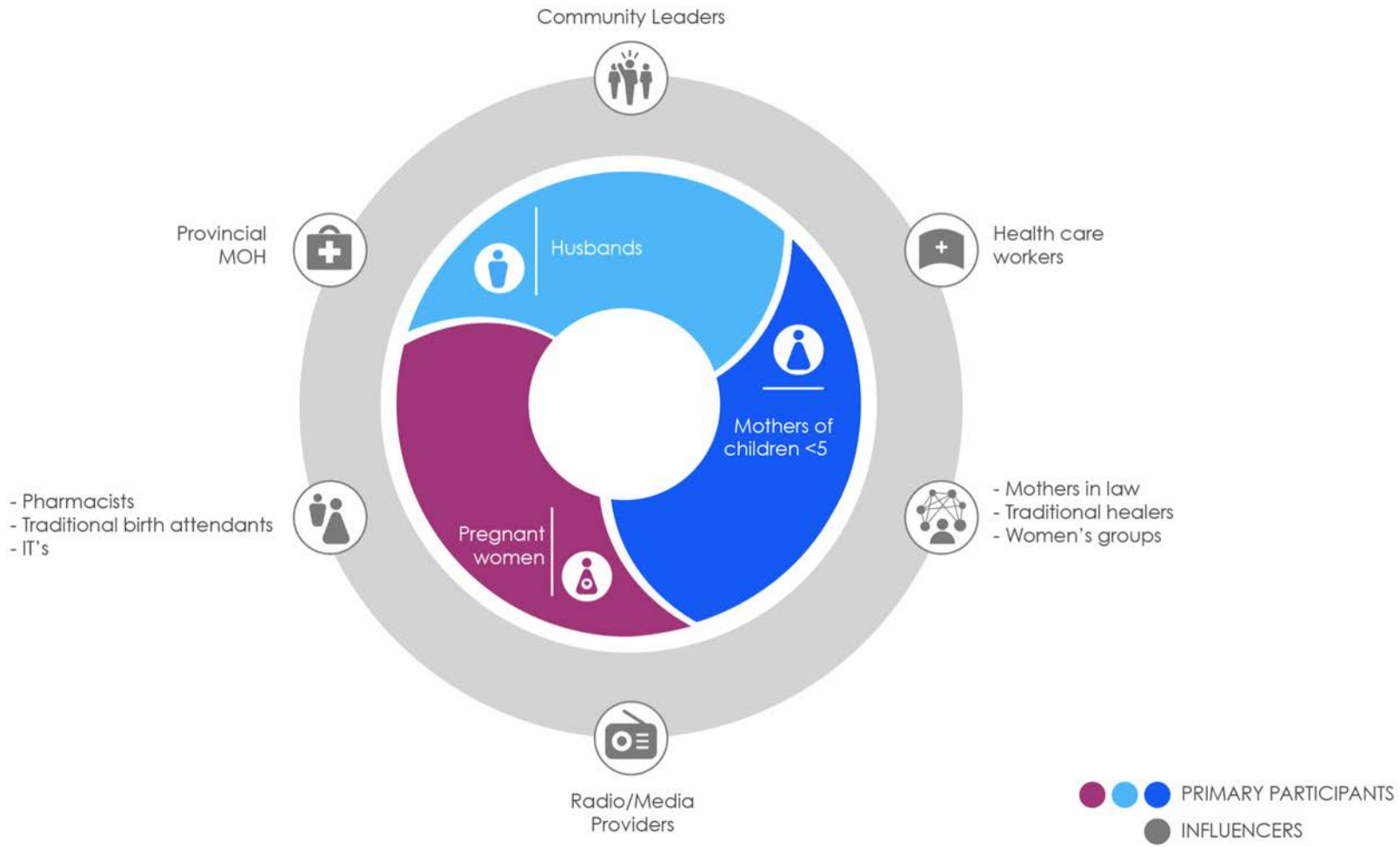
Insight harvesting and sharing

Insight harvesting occurred in Kinshasa. However, the two teams generated their own insights and then came together to combine and refine the themes emerging from the research. Next, an insight sharing workshop was held to share the insights with key project stakeholders and obtain their feedback.

Insights report

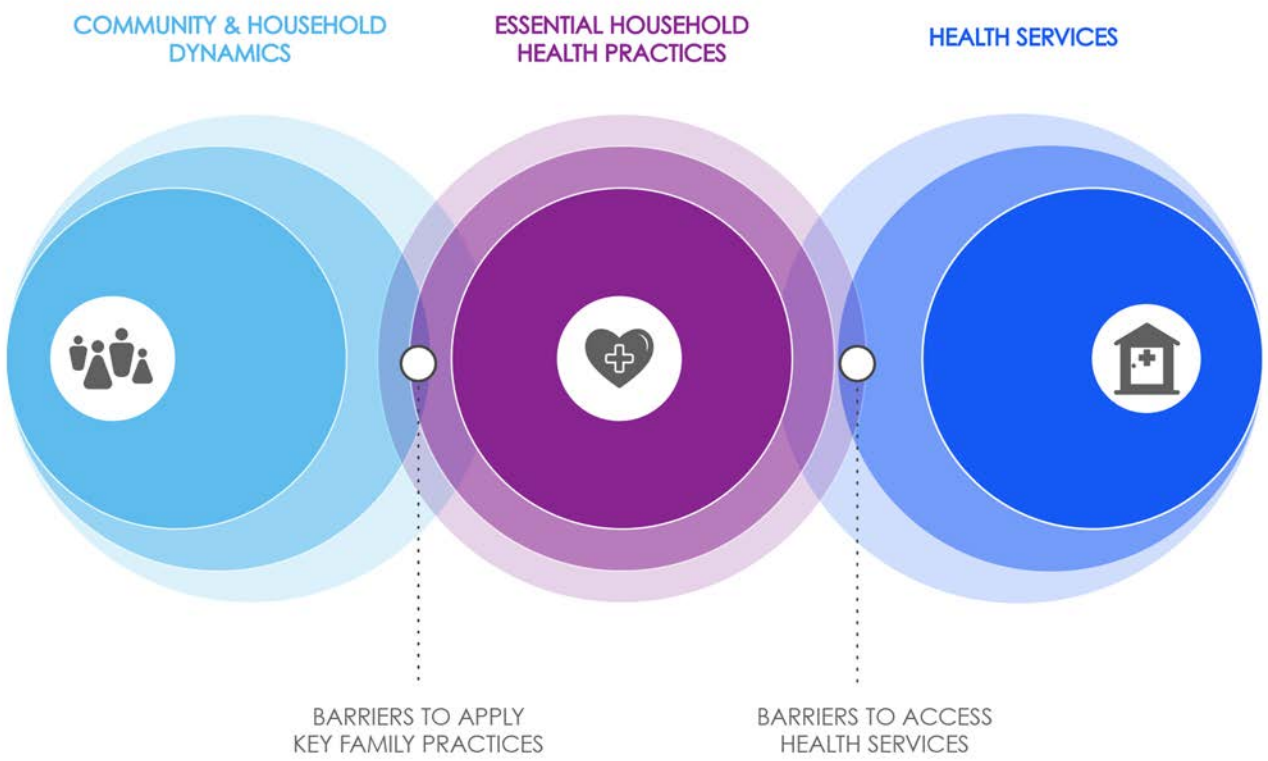
Persona and journey maps were developed to summarize who and what was heard during the fieldwork. The insights report provides an overview of all activities completed during the Define phase. Key findings are consolidated and presented alongside opportunities for the Design & Test phase.

PARTICIPANTS: KEY AUDIENCES



INSIGHTS WITHIN THE SYSTEM

Part of the potential of human-centered design (HCD) is that it uncovers people-level insights that have systems-level impact. During the Define Phase, the discovery (formative) research uncovered certain perceptions, aspirations, fears, and mindsets, which were mapped to show their influence on the key family practices and health seeking behaviors. The team unpacked the influence of some community members on current practices that put children and pregnant mothers at risk. The lack of health knowledge is sometimes filled by rumors that can lead to barriers to the adoption of essential household health practices and the search for health services.



INSIGHTS AND OPPORTUNITY AREA PRIORITIZATION

Insights and their corresponding “How might we” questions were prioritized through a matrix that was designed to give an objective look to the next steps of the process. The matrix took into account the opinion from different stakeholders that were part of the Insights sharing workshop in Kinshasa as well as different members of Breakthrough ACTION who were highly involved in the HCD process.

Each “How might we” question was rated on a scale of “0–10” according to freshness, impact on the design challenge, and relevance for the project.

INSIGHT	OPPORTUNITY AREA	FRESHNESS (0–10)	IMPACT ON THE DESIGN CHALLENGE (0–10)	RELEVANCE FOR BREAKTHROUGH ACTION DRC (0–10)	PRIORITY FOR DESIGN & TEST PHASE (0–10)
		“I did not think of this issue or idea this way before. I would be excited if a solution was developed to address this issue.”	*If a solution was developed to address this challenge, it would drastically improve the essential family practices and health care seeking behaviors*	*Breakthrough ACTION and USAID have interest and platforms to develop/implement interventions that target this challenge*	***Average results (F+I+R)***

PRIORITIZED OPPORTUNITY AREAS

INSIGHT #	INSIGHT	OPPORTUNITY AREA	PRIORITY FOR DESIGN & TEST PHASE (0–10) *Average results (F+I+R)*
2	Household goals are short-term. The future seems distant and is a concept difficult to imagine since present needs are so pressing. Prevention is hard to conceive if tangible associations are not seen in the present. Healthcare expenses are secondary or tertiary behind food and education.	***How might we make prevention behaviors tangible to assure that they become a priority in the household?***	8.08
3	Men are rarely involved in health practices within the household and assume that this is a responsibility of women. Nevertheless, when a child or a pregnant woman is sick, the husband is the principal decision-maker for seeking treatment or care. He is not well equipped to decide between therapies—traditional, religious or modern—and acts as a barrier to any care.	***How might we motivate men to be more involved in health practices within the household to make this a shared responsibility with women?***	8.08
6	Ignorance of the importance of exclusive breastfeeding for the first six months and the indifference to the risk of not breastfeeding exclusively, allows the proliferation of false beliefs about infant nutrition within the community. Where mystery and lack of knowledge exist, myths find their way in. Women look and receive personal support from a select few women in their intimate social circle.	***How might we normalize exclusive breastfeeding (for the first six months) while acknowledging the existence of false beliefs about infant nutrition within the community?***	8.17

PRIORITIZED OPPORTUNITY AREAS

INSIGHT #	INSIGHT	OPPORTUNITY AREA	PRIORITY FOR DESIGN & TEST PHASE (0-10) *Average results (F+I+R)*
8	Often, caretakers are not capable of recognizing when symptoms become severe enough to seek treatment at a health facility. This causes delay in treatment-seeking, increased costs as multiple solutions are tried and higher pressure for health facilities to treat very sick children and adults.	***How might we ensure people understand and are able to recognize when cough, diarrhea, and fever symptoms become severe enough to seek treatment at a health facility?***	8.00
9	Although all religious leaders and traditional healers are not trained in health, people trust and rely on them for guidance in care. Even though they could be bridge for safe healthcare, they are, in most cases, an obstacle. If the religious leader decides to treat an illness, the person will no longer go to a health facility.	***How might we transform the role of traditional healers and religious leaders to become bridges for safe healthcare and adequate pregnancy care?***	9.00
10	Price uncertainty is a source of anxiety and ultimately a barrier to formal health service use. In many cases, people approach health facilities without knowing the exact price of the services that will be provided to them. This creates a feeling of unease and a preference towards sticking to what is known to them, or the option of paying in kind.	***How might we reduce the anxiety of not knowing the total price people have to pay for services before approaching the health facility?***	8.92
		How might we uncover the risk and consequences of using traditional medicine or automedicating and make them relevant to different households?	8.42
		How might we ensure common understanding of needs and expectations between health centers, village chiefs, and the community are frequently shared?	8.50

PRIORITIZED OPPORTUNITY AREAS

INSIGHT #	INSIGHT	OPPORTUNITY AREA	PRIORITY FOR DESIGN & TEST PHASE (0—10) *Average results (F+I+R)*
11	The lack of financial means causes couples to minimize the risk of not being treated well and not delivering their babies in a health center. Families are making health care decisions based on cost, access, cultural considerations, and close proximity, rather than on quality of health outcomes.	***How might we inspire people to make healthcare decisions based on quality of health outcomes rather than on cost, access, cultural considerations, and proximity to health centers?***	8.25
		How might we build relevant cost comparisons to help households consider the longer term costs and risks associated with the adoption of other culturally accepted practices for healthcare?	9.08
12	People would consider paying for services as long as the services are not disappointing. Information about a bad experience with health providers/health facilities spreads as fast as viruses. Trust between the community and the health zones is often missing.	***How might we make positive experiences at health facilities more relevant than bad ones?***	8.08

DESIGN & TEST PHASE I & II: APPROACH AND METHODS

Review results from Phase I

The team reviewed testing results from Phase I and selected those that were the most desirable from the user perspective to be re-tested during Phase II.

The project tested a total of 19 prototypes during Phase I and for Phase II, prioritizing 11 prototypes to be refined due to the positive feedback received from users.

Select new testing sites and mobilize users

The project built a work plan together with the teams in Kasai Oriental and Haut Katanga to select the best testing sites for each prototype and understand the mobilization criteria for participants.

Select testing variables

Ethe project revised each of the 11 prototypes from their behavior change objectives and the hypothesis perspectives, to make sure that during the Phase II the prototyping methodology used for each of them was appropriate to understand the level of feasibility of each intervention.

Refine prototypes and feedback questionnaires

The team then refined prototypes and built them for a second time. Some elements that were not successful during the first phase were modified and some other variables were kept.

The team rebuilt qualitative and quantitative feedback questionnaires to match the modifications done to the interventions.

Deploy and test prototypes

Once the prototypes were refined, the project tested them in different health zones in both provinces of DRC. For a period of four weeks, users interacted with the concepts.

Gather feedback from users

After the testing time, the team went back to the locations in which prototypes were deployed and applied different feedback questionnaires to them.

Each prototype had its own qualitative and quantitative feedback questionnaire to make sure results of testing were as objective as possible.

PRIORITIZED SOLUTIONS

Parties for Couples

Public event targeting married couples led by an animator and information technicians (ITs) or community liaisons/*relais communautaires* (RECOs). The party is a moment in which couples are invited to share time together while participating in knowledge contests against other couples. Questions during the contest are related to health issues but also with topics in which both of them can contribute with their answers. The event is open to other couples who want to participate as observers and also learn from the contest.

Cost Comparisons: Is Healthcare Really Unaffordable?

This solution uses a comparison between the costs of non-essential items purchased in everyday life and the cost of key health services delivered by health centers. The objective is to raise awareness in the community of the accessibility of healthcare services that, compared to some expenses, are not at all expensive. With the new understanding of the affordability of health services, households will be able to benefit by getting proper healthcare for fever, cough, and diarrhea and making it easier them to seek preventive care for pregnant women and infants. Families will use also health centers for childbirth, rather than churches.

Health Savings Club

A structural solution to allows couples to learn to set savings goals and to distinguish between emergency expenses and planned ones. The strategy tackles the resistance of healthcare-seeking due to financial constraints by providing microfinance briefings, individual savings commitments and two saving boxes, one specifically for health services and another one for other household objectives.

Health Games for Home Visits and Health Centers

A series of games to convey key health messages among the community. Men and women are encouraged to share playful moments while learning about the importance of malaria prevention through the systematic use of impregnated bed nets, exclusive breastfeeding practices, handwashing practices and health-care seeking. The games are designed for RECOs to be used in their outreach strategies, and at health centers during waiting times.

Health Quizzes in Public Markets

A series of short quizzes that take place in markets. Since many women have stalls and sell their products in the markets, for many of them it is difficult to obtain information about essential household health practices. These quizzes facilitate the diffusion of information in a didactic way, allowing both women who sell things in the market and those who go shopping, to participate and learn without having to travel anywhere they would not have to. Quizzes are oral, which avoids barriers of illiteracy. The announcement of the winner is public, so that others can recognize winners, who will be awarded a free consultation coupon in the closest health center.

Portable Baby Basket

A basket designed with locally sourced materials equipped with an impregnated mosquito net to allow mothers of children under six months to take their babies along with them to place like fields or markets in order to be able to breastfeed them during the day while protecting them from bites, snakes, and the sun.

Health Center, Quality Center

A health center evaluation system that allows the community, with the help of RECOs, to give their appraisal of the health facilities on the basis of three criteria: Politeness, availability and cleanliness in an anonymous way. These three criteria are represented by three compartments of a small portable box, accompanied by green, orange, and red voting cards be used by the community to according to their most recent experience at the health center. RECOS handle and keep the box. They open the boxes at the end of each month, at the Health Zone's monthly meetings to lead to corrective measures in the health center.

Family Fidelity Cards for Use at the Health Center

A loyalty scheme for the community to be encouraged to visit the health centers more often when needed, without constraining themselves because of the foreseen cost. The program creates a compelling link between the community and the health center. Loyalty cards are distributed by RECOs to families entitling them to a free medical consultation or antenatal care (which is previously approved by the health center) after four visits to the same health center.

SBC FLOW CHART PHASE 3: PROGRESSIVLY APPLYING THE SOLUTIONS

1 campaign × 3 provinces × 3 health zones × 107 of 149 health areas × content on malaria; reproductive, maternal, newborn, and child health; nutrition; and family planning

1. The project teams trained over 1,000 people from the provincial Ministries of Health, the health zone teams, and health area leaders to conduct community entry and ensure the roll out of the activities. Today, the Community Agents and the Sanitary Development Committee (CODESA) conduct mapping to set priority health topics before starting implementation. The CODESA and local actors participate in the Cost Comparison activity as lead VIVA! activity.

2. The VIVA! Campaign: We developed a branding strategy to link all media and community activities with a single look and feel.

VIVA
Famille en bonne santé
Famille épanouie

3. Activities are rolled out according to health priorities in each Aire de Santé

Activity Bundle #1

- Parties for couples +
- Cost comparison +
- Health Savings Club (with savings boxes)

Activity bundle #2

Health quiz in markets + Health Savings Club + where possible, cost comparison

PHASE 3: CAMPAIGN IMPLEMENTATION

Campaign activities

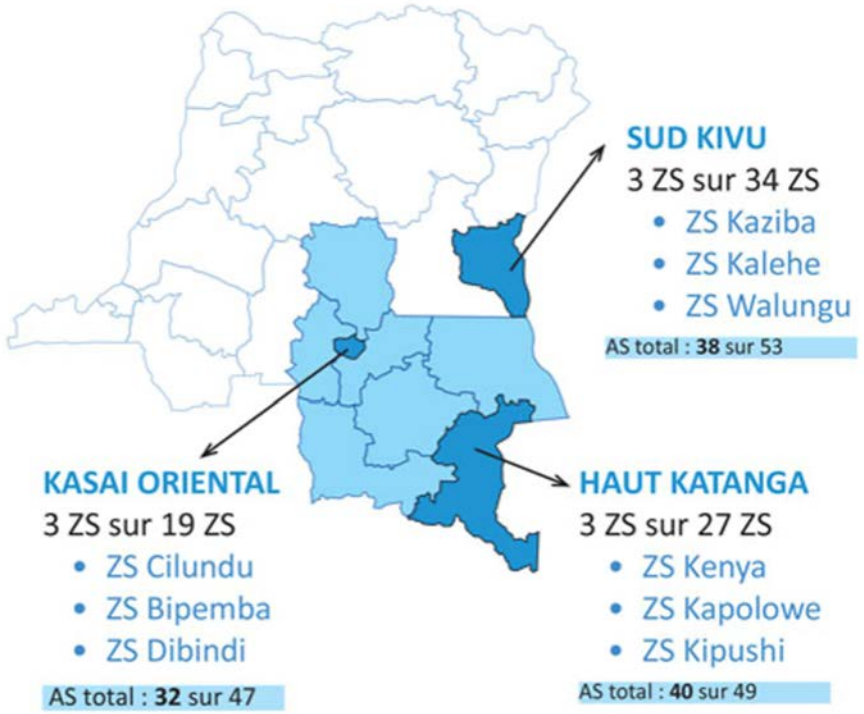
Content on malaria; reproductive, maternal, newborn, and child health; nutrition; and family planning

1. Health quizzes at markets
2. Parties for couples
3. Cost comparisons
4. Health Savings Club (with savings boxes)

1. Health center, quality center
2. Cost comparisons

Implementation locations

Map of intervention areas in three provinces, three health zones per province, and 110 health areas (Aires de Santé)



MONITORING THE CAMPAIGN: AT PRESENT

Using Real Time Monitoring to adjust the rollout of the campaign to ensure maximum reach: What “package” of campaign activities leads to recall?

CURRENT Monitoring and Evaluation Activities

Rotating quarterly surveys: Measure exposure and recall of content for VIVA! campaign activities

Questions to consider in future data analysis: Does bundling the activities increase recall of campaign activities? How will mass media complement recall of VIVA!?

Does participation vary by health topic or activity? What is the immediate effect of activity participation on intention to use services or recommend them to others?

Project logs: Monitoring and Evaluation (M&E) Teams in each of the project provinces record numbers of participants in each activity. To date (February 2021), over 85,000 men and women have participated in the VIVA! campaign community activities in roughly equal numbers.

	Kasai Oriental	Haut Katanga	Sud Kivu
People reached by campaign activities	33,215	23,590	24,579

MONITORING THE CAMPAIGN: IN TIME

Using Real Time Monitoring to adjust the rollout of the campaign to ensure maximum effectiveness: What “dose” of campaign activities leads to action?

FUTURE Monitoring and Evaluation Activities

Questions to consider in further data analysis: Does bundling the activities increase effectiveness of campaign activities? How does mass media complement the effectiveness of community activities?

Triangulation with routine data: Extracting data from SNIS from the health centers within VIVA! Implementation health areas

Which data will help us gauge the effectiveness of the community activities?

Development of a referral tracking system (referral tickets or a modified Family Fidelity Card): Tracking initial card redemption at sentinel health centers to generate data on service use attributable to the VIVA! campaign activities.

Is VIVA! contributing to service use? Did referral tickets increase uptake of services following VIVA! campaign activities, as compared to pre-cards and pre-VIVA!?

MOST SIGNIFICANT CHANGE STUDY: SELECTED RESULTS

Most Significant Change (MSC) is a complexity-aware technique that elicits participants' ideas about the most significant/salient effects the activity(ies) had on health-related behaviors, as well as the things that led to behavior change.

Using the MSC technique with VIVA!

- 236 semi-structured interviews conducted
  - Focus: Experience with health quizzes in public markets, parties for couples, and cost comparisons. Perceptions of changes in their community as a result of participation.
- November 23–27, 2020
- Three health zones in the Sud Kivu province
- Findings:
  - **Expected outcomes**: Encouraged household health practices like long-lasting insecticidal net use, handwashing, family planning, and exclusive breastfeeding, as well as the use of health services.
  - **Unexpected outcomes:** Increased couples communication, male involvement in family planning and child health decisions, more couples saving for health services within their household.

QUOTES FROM MOST SIGNIFICANT CHANGE RESPONDENTS

"In my family we have started a policy of saving, with an account for the family's health needs, so we have access to healthcare… We started the savings strategy to respond to our different needs, including those linked to illness."

Woman in Walungu, Sud Kivu

"I have taken a contraceptive method and I am very grateful to the VIVA! campaign for getting my husband to accept so that there would be a consensus for planning."

Woman in Kalehe, Sud Kivu

"Before, the situation was catastrophic, some pregnant women did not understand why they should start [prenatal care] at four months, others believed that [family planning] is a sin, there was a difficulty in accessing medical care when people do not have the cash... Now we find that in some households there is a climate of dialogue between husband and wife about how to handle family planning, prenatal care, and childhood vaccination."

Man in Kaziba, Sud Kivu

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