USAID TULONGE AFYA

Maternal, Newborn & Child Health (MNCH) Audience Insights | Summary Report

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Maternal, Newborn and Child Health (MNCH) Insights Activity Overview

Social and behavior change (SBC) campaigns often start with listening to the hearts and minds of their target audiences. Without knowing what audiences feel, think, and believe, it is a challenge to create impactful SBC messages, activities, or strategies. However, asking straightforward questions often leads to straightforward lies. The "lies" audiences may tell in traditional focus group settings may be a deliberate attempt to role play for the moderator or group, with the intent to look better or smarter, or may be to protect their most intimate fears. Research suggests that 95% of decisions are based on subconscious or unconscious motivators and not logic and facts, so respondents may also simply be unaware of how they really feel about an issue.

Projective techniques

For years, researchers have relied on straightforward questions to gather data. Creating messages and activities on data that didn't represent respondents' truth rarely led to desired social and behavior changes or effective campaigns.

Projective techniques are questions that have no obvious answer. No one knows the correct answer to questions like "if behavior change were a car, what kind would it be." Because respondents don't know the "correct" answer, they project from their truth. This results in rare insights into the deepest desire of the heart, rather than superficial and often untrue data. This also provides program and message developers fresh and unique insights to inform message and campaign strategies.

Audience Insights Objectives

The goal of the MNCH audience insight gathering was to determine the emotional drivers of audiences related to priority MNCH behaviors along with barriers and facilitators to uptake of priority behaviors. Broad desired behaviors (to be later prioritized and phased within the project's adult strategy) for each target group are listed below.

Pregnant Women

- Attend antenatal care and attend facilities for delivery
- Early initiation (within one hour) and exclusive breastfeeding for six months after delivery
- Active demand at household level for identification and treatment of all HIV-infected pregnant women
- Take steps to provide essential newborn care for your baby immediately after birth

Mothers with at least one child under the age of two

- Exclusive breastfeeding for six months after delivery
- Seek full course of timely vaccinations for infants
- Seek prompt and appropriate care for signs and symptoms of newborn illness
- Bring your child to the health facility for a newborn check at 4-6 weeks
- Feed your children a wide range of different foods from age 6 months on

Fathers with at least one child under the age of two

- Attend ANC visits with partner
- Make financial and transportation plan for facility-based delivery

- Accompany partner for birth
- Provide partner with adequate, nutritious food during pregnancy and lactation period
- Support and participate in discussion of when to take a child to the health facility for care
- Support mother in exclusive breastfeeding for the first six months

Facility-based Health Workers who provide MNCH services

- Assess and talk to patients without judgment
- Use loving and kind words instead of harsh, heavy words
- Provide advice in a respectful way, not dictates or commands
- Strive to be likeable, as it's the first step to being more influential
- Show personal interest in the patient; don't treat them as people to be processed through the clinic
- Be considerate of the patients' time, energy and barriers
- Stay up to date and carefully follow the latest science-based processes so clients have a better chance of success
- Smile and be human, treat people as you would like to be treated
- Listen before speaking. Ask questions to be sure you know what the client feels and needs before providing advice
- Keep everything confidential, without exception, so you can earn your patients' trust
- Act in a way that will cause clients to talk about you positively in the community, lifting you up to others as a powerful and wonderful person of change

Approach

Design and Planning

USAID Tulonge Afya developed discussion guides for each target audience segment based on MNCH audience insights objectives, background on the MNCH context in Tanzania, and priority behaviors the project aims to address. The discussion guides were then reviewed and revised before being submitted to FHI 360's Office of International Research Ethics (OIRE) for review and non-research determination, which was approved.

Participants

Participants were selected from primary and secondary target audiences: currently pregnant women, mothers and fathers of children under 2 years of age, and health workers who provide MNCH services.

Recruitment

Prior to recruitment of participants, the USAID Tulonge Afya team introduced the insight gathering activities to Government of Tanzania partners, and secured an approval letter that was used with Regional, District, and community leaders. Recruitment of participants took place in coordination with the Regional Health Management Team (RHMT) and Community Health Management Team (CHMT), USAID Tulonge Afya zonal staff, and community health workers. Recruiters asked potential participants

for verbal agreement to participate in the activity but collected no demographic information in order to maintain confidentiality.

Insight Gathering Process

Small group discussions were conducted (4-6 participants) with pregnant women and parents of young children, while individual interviews were utilized for health workers. Seventeen audience consultations were held with a total of 59 respondents in Shinyanga Municipal Council (MC) and Ushetu District Council (DC) in Shinyanga Region, and Maswa MC and Busega DC in Simiyu Region. Sites were selected in collaboration with the Reproductive and Child Health (RCH) Section of the Ministry of Health. In all cases, conversations were directed by a trained facilitator in Kiswahili using audience-specific projective discussion guides. All interviews and discussions were audio recorded for later reference. After the interviews, moderators participated in an in-depth de-brief with experienced team leaders to tease out key information and insights. Moderators also completed a written de-brief form to document their impressions of the session, and key findings that arose during the activities.

Analysis

The traditional approach to analysis is logic based. Social and behavior change analysis is emotion based. To start the analysis in an emotion-based arena, the following springboard questions were used to gather information from the facilitators about each interview or discussion:

- What surprised you about this group conversation?
- What was upsetting to you about the group conversation?
- What about this group conversation made you happy or gave you hope?
- What did someone in the group say that you will never forget?
- Was there an emotional reaction to any of the conversation topics? Tears? Anger? Surprise? Disbelief? (Positive or negative)
- What are three key findings that were uncovered in this group?
- What was the most powerful emotional “heart buttons” for this group? Help me understand that choice.
- What other emotional “heart buttons” were important? Help me understand those choices.
- Please share other important thoughts or comments that would help me understand this group conversation.

While these questions helped to target emotional responses, the team leads followed up these questions with targeted probes and logic-based questions as needed. The team leads then compiled and summarized the information from the debriefs into an insight report that will be used to draft creative briefs for each target audience.

Findings

When presented with a behavior change opportunity, people ask themselves these three questions when considering the change:

- What’s in it for me to change?
- Why should I believe you?
- How will taking action solve a problem in my life?

This activity provided insights into these questions so SBC messages and strategies can provide answers to these questions in subtle yet effective ways.

What's in it for me to change?

Through the project's Pregnancy and Childbirth and Parenting and Caregiving lifecycle packages, a range of MNCH priority behaviors will be addressed. Although the specific behaviors are different, the emotional drivers of related behaviors within targeted groups are likely to be the same.

<u>Pregnant Women & Mothers of Young Children (18+)</u>

- Primary emotional driver: Family values
- Secondary drivers: Independence/control, status, nurturing

For mothers and pregnant women, their emotional drivers are deeply tied to how they identify as a mother and wife. Their hopes and dreams focus on proving to their family, friends, and community that they have the **perfect family and can provide their children with a wonderful environment** in which to grow up. They feel it is up to them to be the **peace keeper in the home and avoid conflicts** with their husband and keep him happy. They want to avoid violence and arguments for their sake, for the children, and for the family's image. Deep down, they **worry about the stability of the family** and **hope to have their own business activities** in case of abandonment, but say they **have to keep their husband from leaving at all costs**, in the meantime. Likewise, they spoke of the threat of being "sent home" for going against the will of their in-laws. While they say they personally want to seek preventive services and enact protective behaviors to prevent costly problems down the road and ensure their children have the opportunity to grow up healthy, they describe their ability to make decisions as limited by their **husband's control over decision-making and encouragement from in-laws, grandparents, and other community members to seek services from pharmacies or traditional providers**. However, they describe that some mothers want to be seen as "tough" and capable, rather than soft, so may not want to seek services from the facility because that is for first time mothers or "soft" mothers or those with complicated or difficult pregnancies, births, or children.

<u>Fathers of Young Children (18+)</u>

- Primary emotional driver: Status
- Secondary drivers: Power, achievement, recognition

Fathers are motivated by status and achievement. The describe the **importance of giving children the good life and maintaining a "family bond" by having "respect" between spouses** so others in society will see that you have the good life. They talk of the need for financial success to provide for children and give them a better life than what they had growing up. They see **children as the key to manhood**. Some say when you have your first child, it shows you are a "real" man. You are "total"; your family is "complete". Fathers see the value of things like ANC and delivery preparations to prevent costly emergencies down the line, but they also think traditional methods can solve some of the "normal" problems babies have, like colic. According to them, **going to the health facility comes down to the severity of the problem**, and one cannot just go for every little thing. While fathers say they will look to elders for advice, at the end of the day, he decides whether to try the pharmacy, the traditional healer, or go to the facility. While cost and time were the most frequent reasons men cautioned against

facilities, concern over being tested for HIV is also a barrier. Men fear the possibility of finding out they are HIV-positive. They see this as a death sentence and say they would rather not know. They focused less on non-facility behaviors, which may be due in part to their internalization of gender roles, whereby they are responsible for leadership and providing financially, but not necessarily for day-to-day caretaking, such as decisions around breastfeeding and nutrition.

Facility-based health workers

- Primary emotional driver: Recognition
- Secondary drivers: Status, nurturing, poverty of time

Overall, providers are seeking positive recognition from the health system—such as adequate pay, training opportunities—and the community, but also **want to belong to the community**. They want patients to listen to them and follow their directions. However, they say "other providers" are driven by status—they want to be the "big nurse" in town, and when they're at work, no one can tell them anything. However, when these providers are out in public, they try to fit in and act normal, but the community knows better. Some are driven by strong feelings of nurturing, especially toward women and children. They **worry about what happens to their patients once they leave** (will they face violence, will they follow directions); when they see providers treating patients badly, they think "can you imagine if that was your sister?" When discussing the constraints of providing caring care and following best practices, they continually **juxtapose their need for personal time with the demands of the clinic**.

Why should I believe you?

The audience consultations provided insights into the credibility of different audiences and SBCC channels.

Health Workers and Health Facilities

For adults with families, we **consistently heard that they believe that health workers have the most accurate information when it comes to MNCH**. This is the place to go when you have a "severe" problem, a "complicated" pregnancy or delivery, or when symptoms worsen or do not go away after trying home care, pharmacists, or traditional methods. Despite this conviction, we also **consistently heard that the health facility is not the first choice for care seeking or information** and people would rather try more convenient options where they will not face costs associated with getting to the facility and **poor treatment from providers** who are rude, distracted, or judgmental. **Health facilities are also associated with people with serious or chronic illnesses** and they wonder **what others will think of them** for going to the health facility or if they need to take their children there. Men in particular say they cannot visit facilities, but this puts the health knowledge in the hands of their wives, who do not have decision making power. Mothers and pregnant women described that going to the facility is for "soft" women, while "tough" mothers feel they have learned what they need to know after the first one or two babies and don't want to deal with the inconveniences after that point, especially when there is resistance from their partners and family elders. However, this norm was reported to create barriers for women and children down the road if they did not obtain an ANC card (also referred to as pregnancy card—see Box 1).

Box 1: The ANC card as gateway to MNCH services

In every group discussion with women, mothers and pregnant women described anxiety and concern over the challenges they may face in seeking facility-based services without an ANC card for their child. Based on discussion, the understanding is that a mother receives an ANC card when she visits the clinic for her first ANC appointment. However, some women described she may be denied a card if she does not bring her partner—or at the very least will face interrogation as to why she does not have her partner present—or if she comes for ANC later in pregnancy. Unfortunately, early and accompanied ANC visits are undermined by men's reluctance to visit facilities, local norms that sometimes encourage women to hide a pregnancy for some time to avoid judgement (for example if she is young/unmarried or if she has many children/unspaced children) and/or to avoid curses from ill-willed community members), and beliefs that ANC is not necessary for normal pregnancies—which is reinforced by parents, in-laws, and elders. Women related that if they did not have an ANC card, they would face barriers to later seeking services, including: later ANC visits (including if facing complications), facility birth, bringing newborn to facility after homebirth, routine newborn and infant check-ups (vaccines, growth monitoring), and for urgent care for infants (i.e. fever, coughing, diarrhea, or other signs of illness). They told stories of women being asked for bribes to obtain a card and of being embarrassed, interrogated, and mistreated by providers if they don't have an ANC card.

Family and Close Friends

While people said seeking health care for child illnesses is ultimately the father's decision, family elders are often consulted and usually suggest trying traditional healers before bothering with the health facility. Likewise, grandmothers and mothers also **advise against "complicating" things by going to the facility for every problem and for prioritizing "unnecessary" things like exclusive breastfeeding**. They say their children did not have these things and they grew up fine. Respondents described that elders are particularly unsupportive toward facility birth for women who have already had multiple children or if there was a traditional birth attendant (TBA) in the family. In some discussion, there was discussion of resistance to vaccination from elders and fathers due to fears of side effects. Young mothers and fathers also look to other young parents as examples of what is normal when it comes to childcare, and some mothers described that their friends encouraged them to wean when they notice weight loss for lactating women.

Pharmacies and Shops

Parents described seeking medicines from the pharmacy for themselves and their children when they first notice signs of illness, such as fever and coughing. If the symptoms worsen or persist, then you can consider going to the health facility. People said they believe some problems, like the flu or colic, are normal in children and don't need to be "complicated" by going to the health facility.

Traditional Healers

Participants described traditional healers as **widely available and convenient**. Although many of our participants were quick to clarify that they personally don't trust these providers, they say that others do—including their own family members. Similar to pharmacies, we heard that many people are willing to try traditional remedies as a first line of treatment when they notice problems like fever or coughing—for both themselves and for children.

How will taking action solve a problem in my life?

People only change when they feel the change will solve a problem in their lives. Based on the audience insight findings, these are potential ways in which adoption of priority MNCH behaviors can solve a problem in the lives of target audiences.

Pregnant women and mothers

Women who enact preventive behaviors and seek care for children showing signs of illness will:

- Be recognized by health workers, family, and community as caring and responsible
- Will have peace of mind because they know they are being proactive and preventing costlier problems down the road; you will get the right diagnosis and services are free
- Will be recognized by husbands and partners as smart and responsible (and a good wife and mother for those who are married)
- Know they are protecting their families' health and future

Fathers

Men who take steps to support preventive behaviors and care seeking for children showing signs of illness will:

- Have healthier children who will bring him respect in the community
- Gain status in the community as someone who is providing for a strong and healthy family

Facility-based health workers

When facility-based health workers take the desired actions, they will:

- Earn the respect and admiration of the people they serve
- Be seen as the "go-to" source for health advice and services, rather than a last-resort in case of serious illness
- They will feel recognized by community members for their caring actions
- Positive words and thanks will surround them as they walk through the community and people will seek them out for their attentive and gentle care, not just advice
- Other health workers will know they are esteemed when community members ask and accept them for appointment instead of refusing to see them

Barriers to change

There are always barriers to change. Knowing what barriers exist is important information for effective messages. This consultation identified many barriers for making MNCH-related behavior changes, which are detailed in the sections below.

Pregnant women and parents

- Male dominance of care-seeking decisions for child illness
- Limited social support for facility birth, early initiation of ANC, vaccines, or exclusive breastfeeding (EBF), especially from family elders
- Norms around pharmacies and traditional healers being a first-line of care, and health facilities only being for serious illness
- Belief that once you have had a few children, going to ANC and facility birth are less important

- Poor quality of services received at health facilities, including lack of confidentiality, rude and distracted providers, poor delivery services
- Perceived high opportunity costs of traveling to health facility (taking time off work, transportation, dressing well, arranging meals while at facility)
- Potential for exacerbating power imbalances within couples when women are reached with information during their ANC visits and child health visits, but this information does not resonate with or reach male partners

Providers

- The high number of patients is the primary barrier to following all standard operating procedures (SOP) and to respecting patients' feelings
    - Some providers acknowledged that there are times they can tell their patient is leaving demoralized or unsatisfied; they generally describe that they feel ill-equipped to address these sorts of problems because it is outside their work scope, they do not have time to spend more time with the patient, or because they do not know what they could do differently
- No formal consequences for providers who provide low quality services
    - Some providers described that in some cases patients make complaints to local community leaders, but generally other providers will "cover" for rude providers or the administrators disregard complaints
    - A few providers told stories of community-based consequences, such as violence toward providers or being "run out" of town
- Some clients expect fast services and do not want to sit through lengthy standard procedures
- Providers less likely to follow SOPs with patients with potentially "complicated" situations
- Lack of confidence in knowledge and procedures

Next Steps

Based on these audience insights, the project will develop creative briefs to inform development of maternal, newborn and child health messages, SBCC tools, and materials for stand-alone and integrated SBCC activities.