

MotherCare™



Applying Social Marketing to Maternal Health Projects

The MotherCare Experience



The Manoff Group

Bolivia

Cochabamba Reproductive Health Project

Background

Bolivia has the highest maternal mortality ratio in Latin America, an estimated 480/100,000 live births. Paradoxically, nationally there is one doctor for every 2000 people (similar to Costa Rica) and in urban areas, up to one doctor for every 410 people (similar to Sweden). Cochabamba is the third largest city in Bolivia. In this project covering Cochabamba poor urban and periurban areas, service delivery assessments have revealed that even though maternal health services are widely available, they are grossly underutilized because of poor quality of care (lack of equipment, ineffective use of referral system, poor client counseling) and the lack of information available to communities about why to use routine and emergency prenatal, delivery and postnatal health care services.

The Program

Working with the local public health authority and several local non-governmental organizations (NGOs) offering health services in Cochabamba, MotherCare's program seeks to increase the public's demand for reproductive health services, improve the quality of those services, and, subsequently, contribute to an eventual decline in maternal and neonatal mortality. The project has four principal components: research, health communications, training, and service enhancement.

The health communication component was designed to address some general maternal health care needs:

- increasing awareness of policy makers and service providers about the prevalence of maternal mortality and morbidity and the client and provider behaviors that contribute to or prevent those conditions;
- increasing the recognition of danger signs and complications during pregnancy, delivery and the neonatal period by women and their families, as well as improving their response to such problems, i.e., seeking medical attention;
- increasing the utilization of routine prenatal, delivery and postnatal care; and
- increasing the number of home deliveries attended by a trained health care provider equipped with a "Safe/Clean Birth Kit" and techniques.

Formative Research

A qualitative study of women's reproductive health knowledge, attitudes and practices was designed by expatriate consultants and a local private research agency, Center for Health Research, Consultation and Education (CIAES). CIAES carried out the study, receiving assistance in analysis from an expatriate anthropologist.

The objectives of the study were to describe and better understand the population's perceptions and behaviors in relation to the formal health care system. Over 230 women participated in focus group discussions, in-depth interviews and clinic exit interviews. Traditional birth attendants were also interviewed, and clinic-based observations of client-provider interaction were made.

The study focused on five stages in the reproductive cycle and three related topics:

- pregnancy
- labor and delivery of the infant
- delivery of the placenta
- the immediate postpartum period
- the newborn period
- breastfeeding
- family planning
- abortion

Findings were analyzed by reproductive stage and topic and as a whole to generate an ethnophysiological model, or an explanation of the way in which the women interviewed understand the physiology of the human body and reproduction. This analysis enabled the investigators to compare the women's (Quechua-Aymara) view of physiology with the biomedical model maintained by health workers in the formal health system. Following are some examples of key issues and the disparate perspectives of pregnant women and their formal health care providers:

Issue	Quechua-Aymara System	Biomedical System
danger signs	edema is a "positive" sign for a healthy delivery	edema of the face and hands needs to be addressed urgently
room temperature	warm environment	cold environment
ventilation	no air currents	ventilated rooms
attendants	husband, mother-in-law, TBA	doctors, nurses, interns
clothing	heavily clothed and wrapped	light, loose gown
preparation	none	enema, wash and shave vaginal area
labor position	vertical	horizontal
delivery position	kneeling	supine gynecological position
care of placenta	bury or burn in home area	throw in trash
primary concerns	modesty, privacy, well-being of women; adherence to protective customs	proper biomedical techniques; asepsis; well-being of infant; other patient needs.

Highlighting areas in which the two systems are in harmony, in ignorance of one another, and in conflict, findings then were used to develop intervention strategies to improve home practices, increase the appropriate use of formal health services, and to train health care providers to offer better quality services, i.e., more in keeping with women's needs and desires.

An important finding of this study is that "non-users" of Cochabamba's reproductive health services are not necessarily unaware of the existence of these services. In fact, they often have well-formed opinions about them and some level of appreciation for the expertise of health professionals. The factors that act as barriers to service utilization include the perceived mistreatment of women, institutional norms that conflict with women's modesty and ethnophysiology, the lack of information and orientation given to women during clinic visits, and the cost of services in both time and money.

Strategy Formulation and Development

A three-day strategy development workshop was conducted to define specific health communication, training and service delivery activities based on the research findings. Working groups identified practices harmful to the health and survival of women and their newborns as well as factors which women said kept them from using available health services. Practices were prioritized from most to least harmful and from difficult to most easily changed. Activities were prioritized accordingly. Feasible behavioral objectives, basic messages, and motivational and inhibiting factors that would shape the acceptance or rejection of the new behaviors were developed. Over 30 participants from the various NGO and government agencies were involved in the exercise.

The resulting health communication plan proposed five implementation phases. Each phase would last three months. The first phase, "sensitization," was aimed at creating awareness among policy makers, health providers and others of the problems of maternal and neonatal health and the differences in perspectives on health care between the Quechua-Aymara peoples and the formal health system employing the biomedical model.

The subsequent four phases were defined by maternal health themes and sub-topics for women of reproductive age, their family members (especially husbands) and community leaders. The themes were on the importance and utilization of:

prenatal care: what it is, the importance of routine and timely emergency care; recognizing the signs of edema as a danger. This particular phase included six questions which a woman should ask her prenatal care service provider about her own health and that of her baby.

safer/cleaner home delivery: the use of sterile materials to cut and tie the umbilical cord; recognizing complications during and after delivery and what should be done; avoiding labor augmenters; safe delivery of the placenta.

neonatal care: immediate attention to the neonate before the placenta is delivered; immediate and exclusive breastfeeding, including the giving of colostrum; recognition of maternal and neonatal danger signs and what should be done.

family planning: advantages, methods.

These topics were to be staggered every four to five months in order to avoid overloading project team staff time and resources and to incorporate lessons learned into subsequent phases from previous phases. Each phase would employ similar media and materials:

- educational video and radio programs covering the general theme, with an accompanying TV and radio spot for each major sub-theme; and
- one flipchart per theme (with instructional guides) for health care workers and one educational leaflet for the family per sub-topic.

Implementation and Monitoring

An inter-agency information, education and communication (IEC) committee with representatives of each participating agency was established in Cochabamba and health communication skills workshops were provided to all represented agencies to ensure an institutionalized capability to develop and implement the various phases. Expatriate technical assistance was provided, and two local health communication specialists were hired to implement and monitor the health communication strategy.

Training of service providers was given to upgrade clinical skills, as well as to adapt case management procedures to the needs of clients based on the formative research. Training in interpersonal communication skills and counseling and the use of the health communication materials developed by the project was also conducted as appropriate.

Due to the diversity of materials for each phase, the complexity of the messages and the health communication training process that was undertaken, only the sensitization, prenatal care and safer/cleaner delivery phases were implemented. Each phase took about six months to prepare, allowing for the participatory process of designing messages and media and intensive pretesting. However, the result was an IEC committee and staff that was able to mature in its technical acuity and its relationship with the project communities.

Monitoring was conducted by two local research agencies—CIAES and the University of Valle's Faculty of Communication. The monitoring exercise looked at coverage and the pervasiveness of the mass media and the messages being communicated.

Findings and Future Directions

Comparative data from baseline and final surveys yield the following results:

- Although no significant changes in total utilization of prenatal care services occurred in Cochabamba, increases in attendance from 17 percent to over 100 percent were seen at the clinics of four participating NGOs when compared to a similar six-month time period two years earlier.
- The percent of women who saw or heard a message about prenatal care rose from 42 percent to 71 percent; those who saw or heard a message about danger signs during pregnancy rose from 24 percent to 57 percent; women who knew any danger sign during pregnancy increased from 26 percent to 43 percent; and those who remembered edema as a danger sign rose from two percent to 64 percent (traditionally edema was thought to be a positive sign indicating an easy birth).

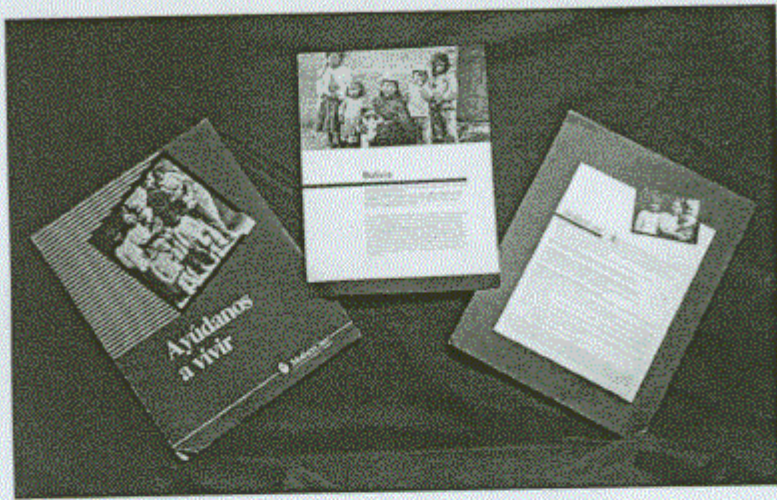
Key recommendations for future programming include the following lessons:

- The involvement of health workers in developing the philosophy and objectives of the project is essential. However, the challenge is to promote commitment on behalf of the health workers to change their attitudes and behavior towards the clients.

- NGOs were convinced to join the project because of the strategies that involved the utilization of formative research in the design of materials, the involvement of the community in the development of the materials, and a broader definition of reproductive health (prenatal, birthing and postpartum care, including the care of the neonate, and family planning).
- Certain "everyday" language used to promote awareness among clients was considered inappropriate by doctors for delivering medical and health information, demonstrating the need to further orient the health care staff to the needs of clients.
- Due to the implementation of the program in phases, health communication materials had an opportunity to improve in quality, messages could improve in accuracy and appropriateness, health workers became familiarized with materials at an acceptable pace and clients became used to and expectant of more information.

Because the existing Cochabamba project is an urban-based project promoting utilization of both private and public health services, there is an effort being made to expand the strategies and processes into other urban areas nationwide.

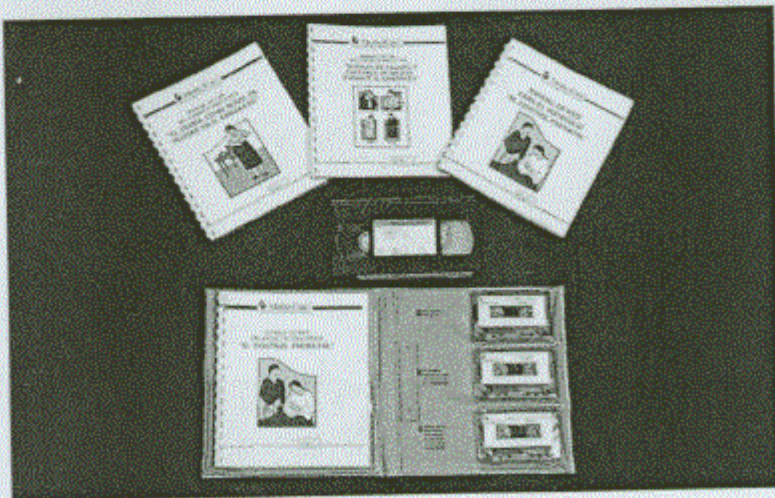
Cochabamba, Bolivia Health Communication Materials

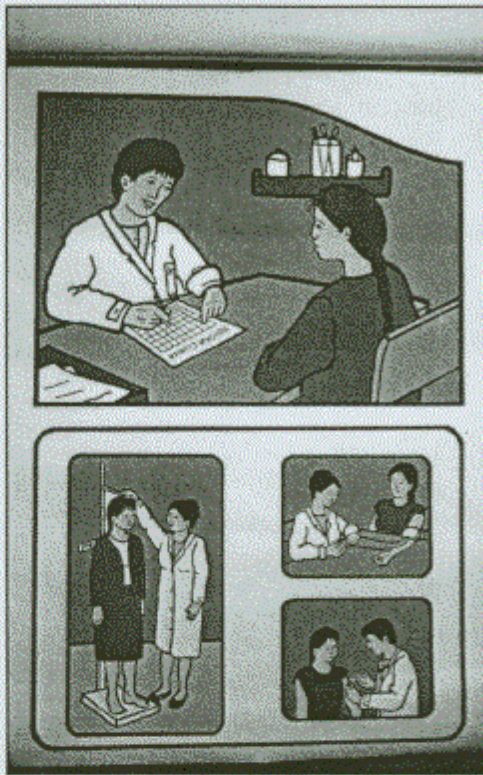


A. Sensitization Campaign
for Policy Makers



B. Prenatal Care
Campaign—
Health Educators'
audio/video and print
guides for using motiva-
tional print material





C. Prenatal Flip Chart Messages

C1. What happens during a prenatal care visit



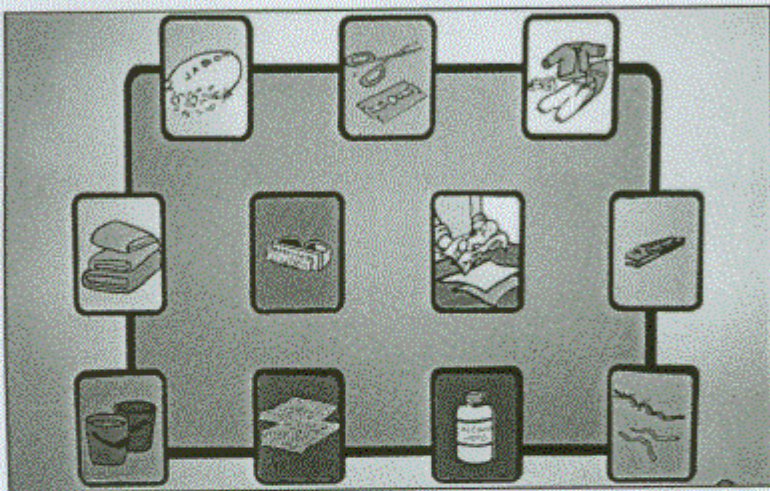
C2. Danger signs



C3. Key messages to remember

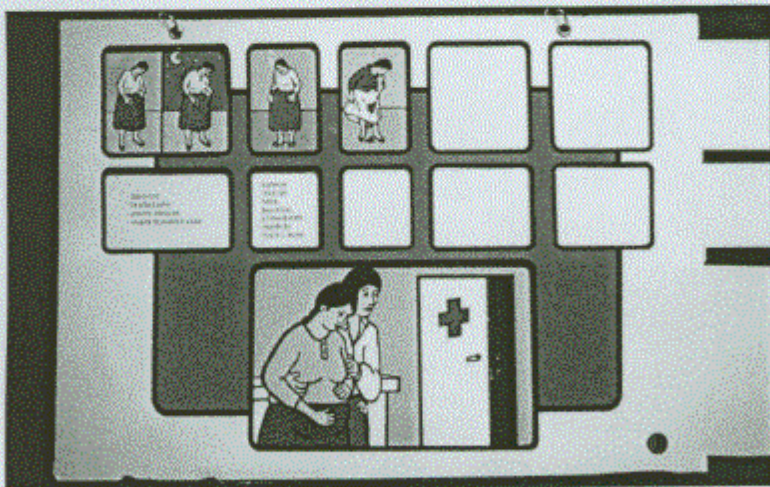


D. Safer and Cleaner Delivery Campaign—Health Educators' audio/video and print guides for using motivational print material

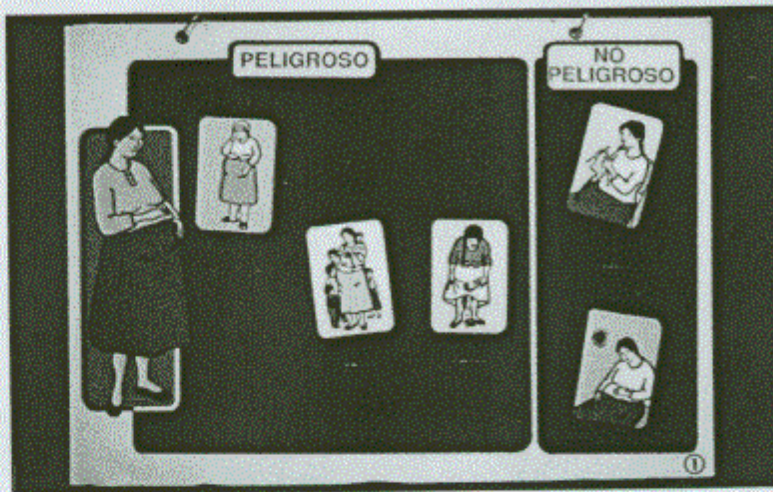


E. Safer and Cleaner Delivery: Participatory Flipchart Messages

E1. Safer, cleaner delivery methods



E2. Signs of complications



E3. Key messages to remember

Bibliography: Bolivia (Cochabamba)

1. For copies of the following reports, please address inquiries to:

John Snow, Inc.
1616 N. Fort Myer Dr.
Arlington, Virginia, 22209 USA
Attn: *MotherCare Publications*

(Please request the general MotherCare bibliography for a complete listing of all special reports, working papers and trip reports)

2. For further information on social marketing and health communications, please contact:

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(Telephone: 202-265-7469; Fax: 202-745-1961)
Attn: *Marcia Griffiths, President*

Special Reports

MotherCare Final Report
Cochabamba Final Report

Working Papers

Behavioral Determinants of Maternal Health Care Choices in Developing Countries

Working Paper 2
November, 1990
Mona Moore

Interventions to Improve Maternal and Neonatal Health and Nutrition

Working Paper 4
December, 1990
Niki George

Qualitative Research on Knowledge, Attitudes, and Practices Related to Women's Reproductive Health: Cochabamba, Bolivia (available in English and Spanish)

Working Paper 9
July, 1991

The Center for Health, Research, Consultation and Education (CIAES)

Communicating Safe Motherhood: Using Communication to Improve Maternal Health in the Developing World

Working Paper 14
November, 1991
Marcia Griffiths
Mona Moore
Michael Favin

Trip Reports

Assessment Report and Proposal for MotherCare Project in Cochabamba, Bolivia

July 9 – 17, 1990
Lisa Howard-Grabman
Dr. Alfredo Guzman
Dr. Pedro Rosso
Patricia Taylor
Melody Trott

Cochabamba Bolivia Trip (health communication assessment)

March 17– 20, 1991
Mike Favin

A Qualitative Assessment of Maternal and Neonatal Health Problems and Resources

May 29 – June 15, 1991
Susan Brems

Strategy Development Workshops and Proposed Communication Plan

August 26 – September 6, 1991
Sonia Restrepo Estrada

Transition From Qualitative Research to Program Development

August 26 – September 5, 1991
Susan Brems

Design of the Baseline Study for Cochabamba, Bolivia Project

September 14 – 27, 1991
Nancy Sloan

Strategy Design of IEC Component (in Spanish)

November 18 – December 6, 1991
Sonia Restrepo-Estrada

MotherCare Reproductive Health Project (health communication monitoring, in Spanish)

March 26 – April 16, 1992
Sonia Restrepo-Estrada

MotherCare Reproductive Health Project (health communication monitoring, in Spanish)

October 26 – November 7, 1992
Sonia Restrepo-Estrada

MotherCare Reproductive Health Project (health communication monitoring, in Spanish)

March 18 – 29, 1993
Sonia Restrepo-Estrada