USAID COMMUNITY CAPACITY FOR HEALTH PROGRAM

Model and Mentor Families: Agents of Change for Maternal, Newborn, and Child Health

PROGRAM SUMMARY

The USAID Community Capacity for Health Program—known in Madagascar as Mahefa Miaraka—is a five-year (2016–2021) community-based integrated health program funded by the United States Agency for International Development (USAID). The Program is a collaborative effort among the Ministry of Public Health (MOPH), USAID, and JSI Research & Training Institute, Inc. (JSI). Mahefa Miaraka provides tools and capacity-building training to approximately 10,000 community health volunteers (CHVs) who provide basic maternal health, child health, and family planning services to their local communities. The Program also works with national and local government stakeholders to strengthen the health sector and health policies.

MAHEFA MIARAKA

- OPERATES IN **7** REGIONS OF MADAGASCAR
- COVERING A TOTAL OF **4,708** VILLAGES
- WITH A TOTAL POPULATION OF **6.6** MILLION PEOPLE
- OR **28** PERCENT OF THE COUNTRY'S TOTAL POPULATION

JSI

OVERVIEW

Families that adopt new health behaviors effectively and confidently can play a critical role in promoting community health. As the family successfully adopts each new action, they see that they can be the primary agents of improved household health and well-being. Fostering the emergence and growth of such families is an important element of many social and behavior change (SBC) programs. With technical input from Program partner FHI 360, Mahefa Miaraka identified the Model and Mentor Families (MMF) approach as an important component of its SBC strategy.

MMF is streamlined, easy-to-use, and encourages a shift from focusing on overcoming obstacles and barriers toward emphasizing and building on existing strengths and achievements. The approach has previously been implemented with success by communities in Ethiopia, Burundi, and Kenya. Over the course of the USAID Community Capacity for Health Program, more than 352,000 households earned Model Family status, and close to 181,000 subsequently became Mentor Families. During its final year, the Program conducted a qualitative study to better understand how MMF supported larger Program objectives and to identify which elements were most important in contributing to desired SBC.

APPROACH

MMF Guiding Principles

Principle 1: Clarify the behavior change "ask." Behavioral science tells us that having too many choices that are overly complex often leads to inaction. The MMF approach sought to avoid this common pitfall by prioritizing seven essential behaviors to be promoted at each of four life stages: pregnancy, infants <12 months, children 12–23 months, and children 24–59 months. Selecting these essential behaviors reframed the question from "What should women and families do?" to "Which critical behaviors can a family effectively manage?"

Principle 2: Establish reasonable targets and recognize achievement. Targets motivate, provide a goal, and help sustain activity following setbacks. Achieving a target boosts confidence and prepares families for new challenges. MMF encouraged families to achieve one well-defined goal: Carry out seven health actions during an 8–12 month life stage to become a Model Family. Once this goal was achieved, the Program applied a key principle of behavior change psychology: positive reinforcement. The MMF approach boosted the confidence of early adopters and successful families by spotlighting their accomplishments through community-level recognition, regular public ceremonies, and the presentation of Certificates of Merit. A mother from a Model Family explained, "I graduated. It's valuable. A lot of people would like to have them (certificates). Those who have found the way should lead the way for others."

Principle 3: Grow community assets. Each new Model Family is a nascent community asset with potential to catalyze further change through mentorship and peer support. To seize this opportunity, as their achievement is acknowledged, Model Families are encouraged to mentor a friend or neighbor who is working to become a Model Family. One mentor described her experience, "I informed and showed other households about the different essential family practices. After that, I also tracked their progress and verified if they carried out the essential family practices. For example, a woman, a friend of mine, was able to complete the seven practices, so I went to see our CHV and informed her that a friend of mine had adopted and completed the seven family practices exactly as I did." Another mentor stated simply, "I support friends. I raise awareness so that they become like me."

Principle 4: Support grassroots sustainability. Sustaining and broadening community engagement is a perennial challenge for most health programs. Community models frequently place sustainability in the hands of a small local health committee, and even the most enthusiastic of these committees can rarely carry on the array of activities needed to meet broad, integrated health needs. Rather than placing an untenable burden on local leaders, MMF suggests an alternate pathway: empower families as grassroots agents of change. The growing cohort of families earning Certificates of Merit or serving as Mentor Families represents an important way in which the Program created a sustainable enabling environment for SBC.

KEY ACTIVITIES

Streamlined tools, focused on action. Following a participatory process during which Program staff and MOPH officials identified seven essential actions for each of the four life stages, Mahefa Miaraka then developed a series of illustrated family checklists to specify the behavior change "ask." Each checklist (fiche ménage) incorporates health, nutrition and water, sanitation and hygiene-related home-based actions, and health-seeking behaviors. Men's participation crosscuts the four life stages with at least one action targeting fathers and another one directed to couples. The checklists included only the seven actions and illustrations, a reference to the corresponding page in the MOPH Health Cards (used by families and health providers to record services), and boxes to tick as each action is carried out. CHVs introduce the checklists during counseling sessions with families. The Program minimized the amount of information about each action to nudge CHVs towards a focus on behavior change rather than knowledge transfer. A CHV noted the value of this, "Now we've seen an evolution in our activities because there are seven SDAs (small, doable actions) that are clear, and so it becomes easy for us to raise awareness."

Short, skill-based workshops. CHVs were familiar with all 28 actions promoted across the four life stages. Therefore, rather than reviewing technical information about these actions, the MMF orientation workshops focused on building skills that would enable CHVs to be effective agents of behavior change: supportive counseling, behavioral negotiation, and use of the MMF tools. The goal of the workshops was to ensure CHVs understood the MMF approach and how the checklists could facilitate effective counseling.

Action-oriented home visits that shift the counseling dynamic. As CHVs gave the appropriate checklist to a family, they asked parents to post it prominently in their home. This simple gesture conveyed a powerful concept: You are in charge and can take steps to improve your family's health. One mother shared, "I hung my fiche ménage on the wall. I read it and consult it every day to see what I need to do." During home visits, the CHV would ask about any new actions the parents were practicing, check the appropriate box on the checklist, and consult with the mother on the best action to tackle next.

Peer exchange during community meetings. Community meetings, especially growth monitoring sessions and radio listening groups, served as opportunities for mothers to update each other on their progress and for CHVs to recognize achievements of new Model Families. Peer exchange and mutual support of community meetings complemented the one-to-one consultations of CHV home visits. Mothers had the opportunity to explain, for example, to their friends how they negotiated barriers or encouraged their husband's active participation in family health.

Verification and measurement. Forty percent of the 28 actions across the four life stages link the family to the health facility (e.g., antenatal care visits, danger signs, family planning, vaccination). Tracking home-based actions relied on self-report and trust between the CHV and the families. MMF approach emphasized self-reporting about the adoption of health practices, i.e., accepting reports from parents, for two main reasons: first, to develop self-reliance; second, recognizing that the benefits of bringing families inside the circle of those who adopt healthy behaviors far outweighed perceived advantages of critical questioning around reported new practices. During monthly CHV meetings at the health facility, these issues were discussed. Monitoring new MMF during these meetings became an unofficial indicator of expanded community commitment.

RESULTS

Incentives. Study results demonstrated that parents were highly motivated to be recognized as a Model Family. One mother explained, "It's really good because people who are not yet Model Families want to be. They saw that the life of a Model Family is good."

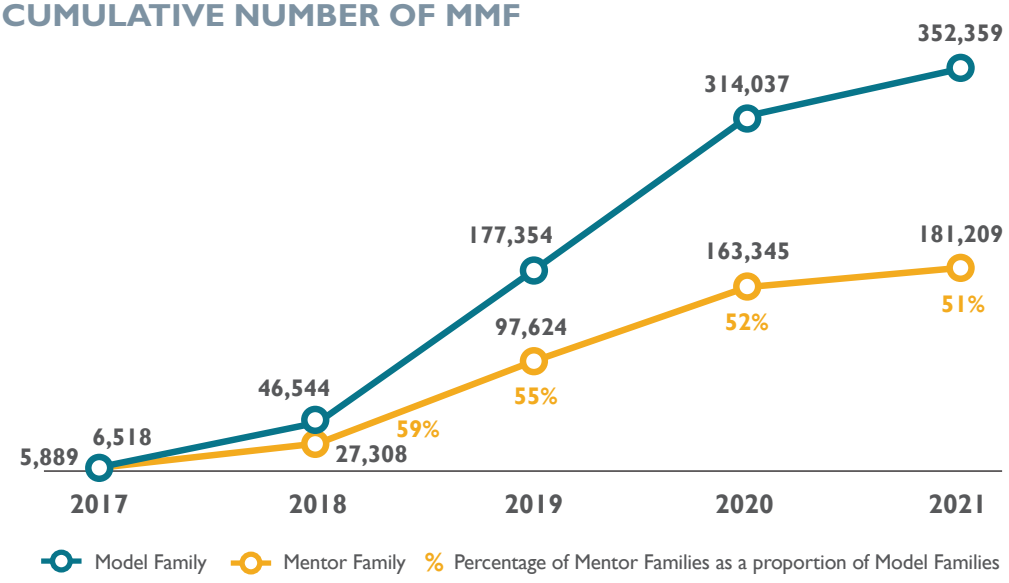
In addition, families reported that Certificates of Merit incentivized them toward greater success and triggered friend-to-friend health promotion. One mother said, "It is better if the distribution of certificates is done publicly since many people can see us, which can motivate them more to do as we do."

Figure 1 presents the cumulative totals of MMF across Program implementation regions.

Link to improved health indicators. The Program conducted a retrospective analysis of achievements in five key health indicators stratified by the level of adoption of the MMF approach in the commune or collection of villages. Communes with higher participation in the MMF approach also had higher rates of achievement in these indicators, as seen in Table 1. More research is needed to determine if this effect is due to the MMF approach itself or if villages and communes that have higher rates of adopting such an approach are places that demonstrate higher capacity to manage community health challenges in general.

Smooth transition. The MMF approach has the potential to catalyze behavior change during the first 1,000 days of life and beyond, with families moving directly from one stage to the subsequent package of essential actions. Once a pregnant woman "enrolls" in the Model Family program, she and her family can

FIGURE 1. CUMULATIVE NUMBER OF MMF



USAID COMMUNITY CAPACITY FOR HEALTH FY 2020 HEALTH CENTER AND CHV DATA

Regions	Communes with no Model Families	Communes where less than 50% of all households certified as Model Families	Communes where 50% or more of all households certified as Model Families
Attendance at four antenatal care visits	29%	33%	39%
Delivery at a health facility	28%	29%	35%
Infants 0–11 months receiving Penta3	74%	76%	86%
Regular growth monitoring of children 12–24 months	16%	22%	30%
Regular growth monitoring of children 24–59 months	23%	28%	37%

Maheta Miaraka

potentially be engaged in regular behavior change for 3–4 years. Study participants reported that, by promoting key actions for each sequential life stage, the MMF approach eliminated "down time" and helped families feel confident that they were focusing on the most critical, age-appropriate actions for themselves and their child. A CHV explained, "When they finish the first category, I make them aware of the next category until they have finished them as well. They were motivated, but I didn't let my guard down; I always continued my outreach. Then I counsel them continually, and after they continue with the other categories, they have not given up."

Broadened responsibility for community health. The significant contributions that Madagascar's CHVs make to their community cannot be overestimated, and their responsibilities are extensive. By cultivating new community assets in MMF, the MMF approach helps to expand the responsibility for improving health and well-being to a larger proportion of the community. By early 2021, each Program commune had 763 Model Families and 392 Mentor Families on average, or approximately 15 new "assistants" for each CHV. Over the course of the Program, the percentage of Model Families matriculating into Mentor Families remained steady at about 50 percent. CHVs universally appreciated the additional support. One mother explained her role as a mentor, "I became a Model Family, I was able to see benefits. Among other things, after being vaccinated, my child is healthy. The benefits I have experienced have led me to raise awareness among other households so that they can also benefit. Thus, I became a Mentor Family, which means I practice behaviors and make others aware of them at the same time."

Shifting health norms. Public recognition, Certificates of Merit, and testimonies by MMF all raise the visibility of early adopters and create a growing sense of action and progress. Parents explained their decision to become a Model Family with expressions like "My sister's baby is so healthy" or "My neighbor showed me his health certificate," demonstrating the influence of new practices being made visible by friends and peers and suggesting initial shifts in social norms. As one mother said, "I had a friend who encouraged me to do this. She said, 'Come on, I've already gotten benefits with this.' I was among those who really wanted to be like her. After that, I followed her. And I've seen the benefits it has brought us because my children are healthy; they're not sick."

CHALLENGES

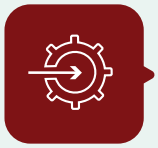
Competing activities. As a new approach, it took time for communities to integrate MMF into their health work plans, resulting in limited resources for implementation. In the initial years of the Program, regional staff made black and white photocopies of the checklists, and MOPH health center agents did not monitor MMF

activities during monthly CHV meetings. In 2019, the Program was able to distribute full-color checklists in sufficient quantities, and health center staff included a review of MMF progress in monthly meetings as well as Community Health Development Committee meetings each quarter. The limited initial reach of the approach was reflected in low numbers of MMF in the first two years of the Program. However, the rapid expansion in numbers of families engaged since 2019 reinforces the significant potential of the approach.

Lack of timely recognition. Before a final push at the end of 2020, only a small percentage of Model Families had received Certificates of Merit. This initial approach included the recognition of Model Families by the local health center. Unfortunately, this led to delays in the awarding of certificates, leading to a change whereby CHVs and village leaders would award the Certificate of Merits directly. Despite this, many CHVs found other ways to positively reinforce successful households, as expressed by one CHV, "Even if certificates and checklists were not available, after the training we received in 2018, our way of recognizing them is to congratulate them after completing the seven essential family practices."

Some village leaders, mayors, and health facility staff would wait until annual community celebrations before publicly acknowledging the achievements of Model Families. However, many CHVs did acknowledge new Model Families in front of their peers. Mahefa Miaraka made sustained efforts to encourage frequent, no-cost celebrations organized by CHVs, Mentor Families, and local leaders within the community with the understanding that these would accelerate the reach and impact of the MMF approach.

RECOMMENDATIONS



Fully integrate the MMF approach into national community programing. The adoption of the MMF approach by communities complements long-established national SBC approaches, such as use of the Women's and Children's Health Cards. The use of low-cost family checklists streamlines and focuses action on already established priority essential health actions promoted by national communication strategies, boosting the adoption of optimal health practices while growing community assets.

Apply concepts of positive reinforcement, recognition, and modeling. SBC approaches should seek to regularly recognize and highlight successes and achievements as a core feature of their programming. Effective, low-cost ways to do so can include public recognition and testimonies that allow community members to share their experiences with their peers. For example, during public events and on local radio programs, Model Families may be asked to share the ways in which they overcame obstacles and demonstrated resilience following setbacks.

Develop agile, low-resource methods to collect and interpret data. Traditional programmatic approaches have a tendency to apply exacting data collection requirements in order to verify and measure results. In order to maintain the momentum generated in communities, tools to measure progress should be streamlined, being judicious in determining what data is truly necessary for CHVs to identify and follow-up with families on their progress, recognize accomplishments in a timely fashion, and encourage families to take the next step. In this way, the focus remains on behavior change taking place at the community level, with the goal of engaging an increasing number of families to adopt health behaviors appropriate to their life stage.

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