

# Key results and lessons from the 3FM pneumonia programme

Cote d'Ivoire, Ethiopia, Mali, Sudan and Zambia

2017 – 2021

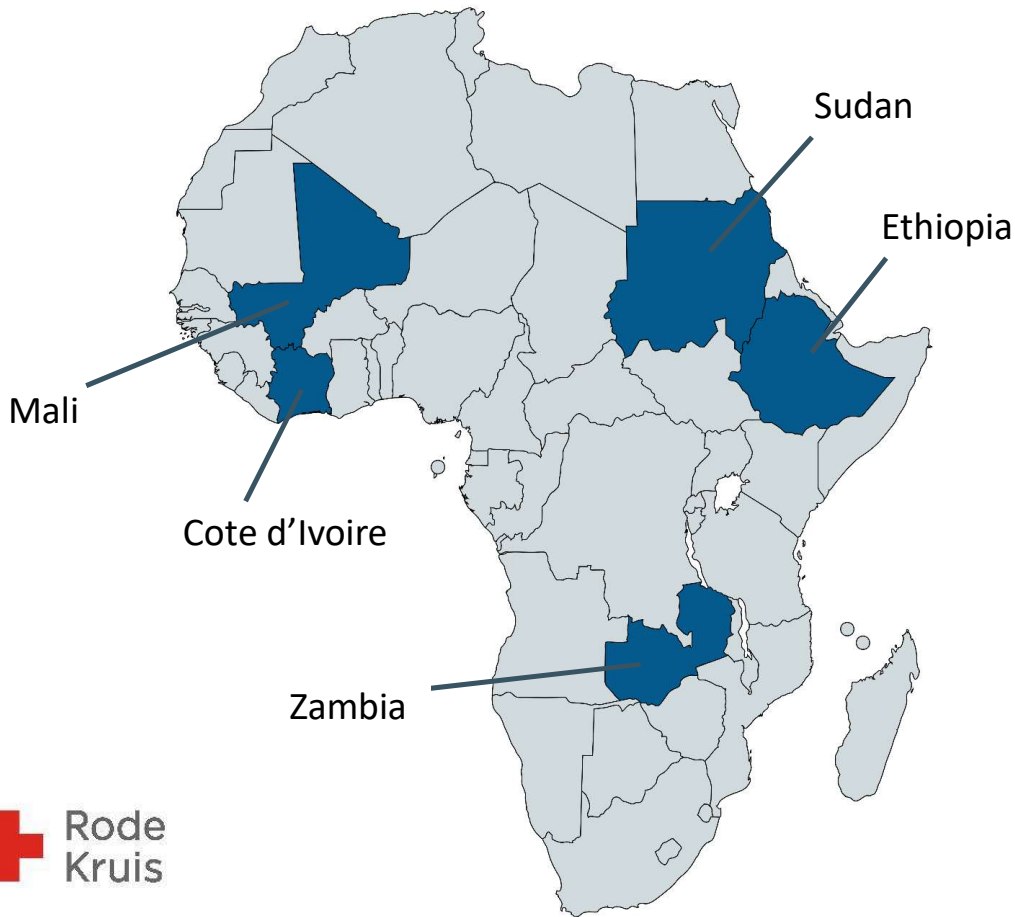


## Contents

- What was the 3FM programme?
- Selection of key results: health seeking behaviour and direct protective practices (breastfeeding, handwashing with soap, indoor air pollution and vaccination)
- Overview of the behaviour change communication (BCC) process
- Key lessons and recommendations for practice, using practical examples



# The 3FM pneumonia programme: A snapshot



Overall aim: Reduce child morbidity and mortality due to pneumonia

WHO and UNICEF Integrated Global Action Plan for Pneumonia and Diarrhoea

National Ministry of Health (MoH) guidelines

IFRC approaches and frameworks (e.g. CBHFA, BOCA, CEA)

Implemented over 3 to 4 years (2017 to 2021)

Funded by a public radio campaign (3FM)

## The 3FM pneumonia programme: 2 main components



### Pneumonia control

- Parent/caregiver knowledge and health seeking behaviour
- Health system strengthening
- Referral systems
- Case management
- Links with traditional medicine

Included in all 5 countries



### Pneumonia prevention

**Direct:** Vaccination, exclusive breastfeeding, handwashing and air ventilation/pollution

**Indirect:** Nutrition and safe feeding, water, sanitation and hygiene, prevention of co-morbidities, family planning

Direct preventative behaviours → all 5 countries  
Indirect → varied according to context

## What did we achieve?

**5**

Countries

**128,980**

People reached directly

**302,630**

People reached indirectly

Qualitative and quantitative evaluation data indicated significant:

- Improvements in key preventative practices
- Increases in knowledge of pneumonia danger signs and prevention among parents/caregivers of children under 5
- Changes in health seeking behaviour and attitudes related to traditional medicine/healers
- Strengthened referral systems (e.g. through CHWs) and health systems (e.g. capacity of local health workers)

## What did we achieve? Selected outcomes (protective behaviours) by country



63% increase in mothers reporting practicing **exclusive breastfeeding** (*Cote d'Ivoire*)

14% increase in mothers giving **"first milk"** (*Ethiopia*)



40% increase (observed) in the **separation of cooking and living/sleeping areas** (*Sudan*)

60% increase in **reported use of Mirt cooking stove** (reduces smoke pollution) (*Ethiopia*)



40% increase in children under the age of two who follow the national **vaccination** schedule (*Mali*)

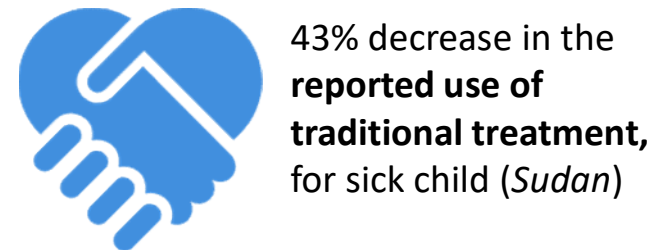
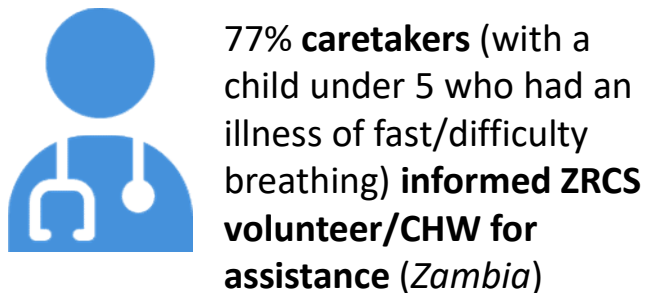
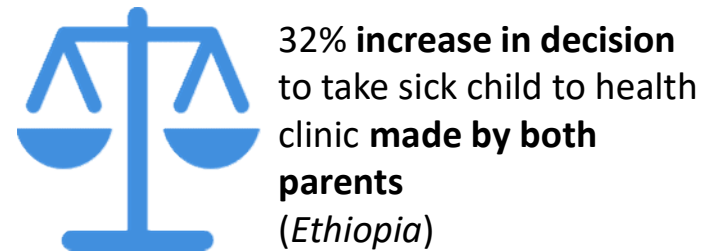
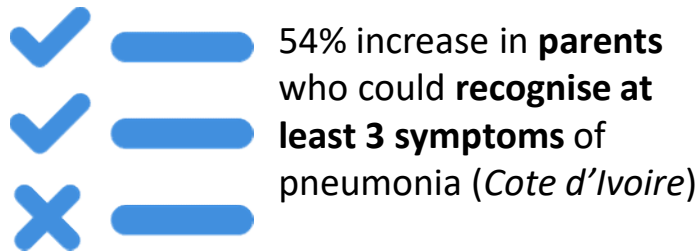
13% increase in **measles vaccination coverage** (*Ethiopia*)



28% increase in availability of fixed **handwashing** stations at household level\* (*Ethiopia*)

77% increase in **reported\*\* handwashing** at critical times (*Zambia*)

## What did we achieve? Selected outcomes (health seeking behaviour) by country



## What did we achieve? Selected qualitative outcomes by country

**“Availability of health services** (e.g. drugs for children under five) **and health promotion** activities **motivated the community** members to utilize health facilities, specifically for children. **They started to visit the health unit for treatment** and ask for drugs.” *Adult woman, Sudan*

**“Since this programme started** I can say very few people come to seek for help from us (traditional healers). **Most people are aware of pneumonia as a result they go straight to a clinic.** The ones who still come to us are those with little no awareness of pneumonia and what to do. But **we also refer them to the clinic.**” *Traditional healer, Cote d’Ivoire*

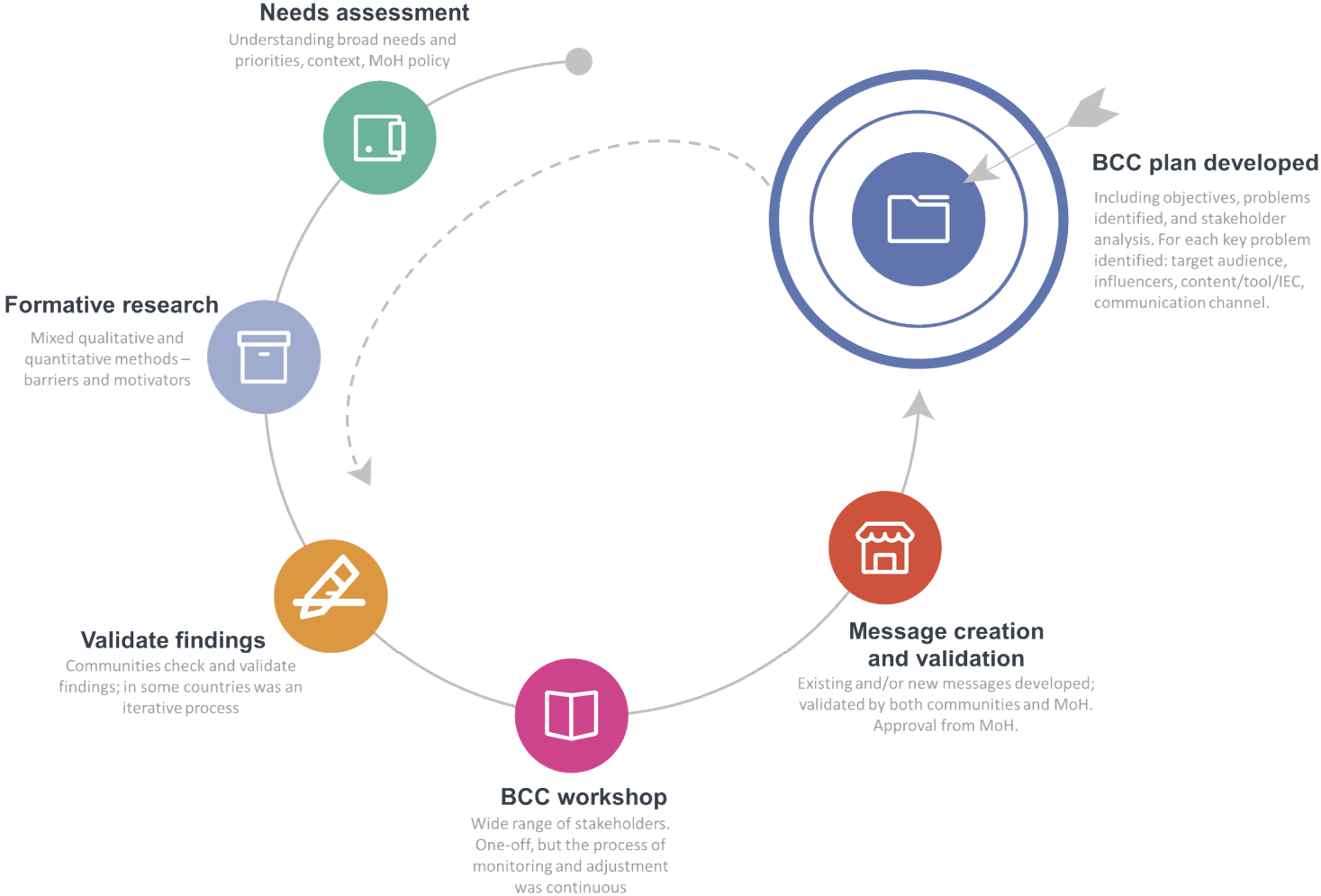
We used to take our children to the **local traditional healers, where they would burn the child's body** using a metal wire. This was very serious and so painful, I felt a lot of regret. We got **education from the Red Cross volunteers about signs of pneumonia** such as cough, fast breathing, and chest drawing in, and to bring children to the health facility for treatment. When **my 7 month old son fell sick with a cough, difficultly breathing,** and he was not breastfeeding and getting weak, **I went straight to the clinic and he was admitted** for 2 days. Finally, he got better and started breastfeeding. I thank Allah and the health care providers for saving my son’s life. **You see I wouldn’t have saved my son if I didn’t accept the health education by the Red Cross volunteers.** *Mother, Ethiopia*



## Key ingredients for success

- Working in partnership with local government, building upon existing structures and capacity
- Spending time and effort to deliberately involve the community (across the project, but specifically in validating and designing the BCC strategy)
- Buy-in from local community leaders and influencers, and their involvement in planning and conducting activities
- Existing relationship and trust with target communities, previous understanding of important social-cultural considerations
- Strong cross-learning and exchange between countries: joint inception, mid-term review workshops, regular online meetings etc. facilitated by NLRC

# The behaviour change communication (BCC) process



## Zooming in on the behaviour change communication (BCC) process



A video was developed which takes you through the steps used in the 3FM programme to facilitate behaviour change.



[Search on YouTube for: "behaviour change netherlands red cross"](https://youtu.be/tOB3mEyTCWk)  
<https://youtu.be/tOB3mEyTCWk>

## Tailored communication methods: guided by formative research

- Formative research to understand disease perceptions, barriers to protective practices, motivators, preferred ways to engage and communicate etc.
- Mixed communications channels guided by formative research and context: face-to-face, interactive media, participatory dialogues...

### Examples

- **“Husband schools” (Cote d’Ivoire)** – effective platform for men to discuss SRH and MNCH in a peer-setting
- **Community Conversations (Ethiopia)** – storytelling, testimonies, structured Q&A, participatory planning to facilitate discussions and address negative cultural norms
- **“Community caravans” edu-tainment events (Mali & Cote d’Ivoire)** – song, dance, skits, games, competitions, and basic medical consultations / referral for children under 5

## What did we find? Specific lessons on communications methods

Qualitative data and anecdotal evidence showed that:

- Highly accepted by communities, well aligned with cultural and social norms, high level of engagement and interest, significantly contributed to changing behaviour and health outcomes.
- Can be successfully facilitated by trained volunteers – trusted, same social-cultural background, helped to address sensitive issues such as gender relations and co-existence of traditional and modern medicine
- Giving community members the opportunity to ask questions strengthens trust, deepens understanding and can help to address misinformation
- Key factors for success are involvement of community in planning and conducting the activities, and endorsement by and leadership of local authorities
- Dialogue based methods provided great opportunity for collecting feedback, which was used to then adapt the intervention to improve acceptance and uptake of target behaviours



## Key lesson 1

**Understanding household decision making dynamics is important**

Primary caregivers (e.g. mothers) are often the target audience; but others may make decisions such as when to seek care

Husbands and key influencers (such as mothers-in-law and male relatives) must be involved in activities on disease prevention, home case management and referral, as they often make decisions relating to health seeking practices at household level

### Examples

**Ivory Coast:** “Husband schools” set up, together with MoH and UNFPA, to effectively involve men and provide a platform for them to discuss SRH and MCH issues in a peer-setting.

**Ethiopia:** Community Conversations (with diverse group of participants – men, women, religious leaders, young parents etc.) used participatory approaches such as storytelling, structured Q&A to address social-cultural norms.

## Key lesson 2

**Spend time and effort to deliberately involve the community in validating and designing the BCC strategy**

Validating formative research findings with communities improves transparency, trust, and quality of behaviour change activities.

*However* the process can take time and cause delays in implementation

### Example

**Zambia:** Validation and feedback process was iterative with several sessions held with the communities and local authorities.

This created a space for engagement which fostered transparency, trust and approval of community members in the design of the BCC strategy, helping to tailor the strategy to their life.

## Key lesson 3

**Focus on  
evidence-based  
direct risk  
factors for  
disease  
prevention**

Qualitative data and anecdotal evidence suggests a risk of “diluting” the quality of programming - resources, activities and messages are ‘spread too thinly’ and do not achieve the desired level of impact in behaviour change or health outcomes

### Examples

**Zambia/Ethiopia/Sudan:** Intervention was very focused on direct risk factors related to vaccination, exclusive breastfeeding, handwashing and avoiding indoor air pollution

BCC plans were very focussed and included behaviour change objectives that were directly connected to evidence-based pneumonia prevention and control interventions



## Key lesson 4

**Behaviour change cannot be achieved without securing access to basic services & commodities**

Improving health and hygiene behaviours requires a wide and long-running investment in water and hygiene infrastructure (O&M strategies, cost-recovery, willingness and ability to pay, government responsibility and capacity, technology choice etc. etc.), and access to commodities such as cooking stoves

Health promotion packages and standard messages from MoH are not always linked to infrastructure development, although it is critical to enable behaviour change

### **Example**

**Cote d'Ivoire:** Investment in water not planned initially; following mid-term review, top-up funding was secured to rehabilitate boreholes and reactivate community water committees

## Key lesson 5

**Innovative solutions are needed for physical & economic barriers to timely health seeking**

Key barriers across all countries were: distance to health facilities, cost of transportation and cost of consultation and/or medicines (all largely unchanged at the end of programme)

Potential innovations include vouchers for health services and related costs (e.g. transport cost and payment at the clinic, or medicine), conditional cash vouchers, and community-based health insurance

### Example

**Ethiopia:** Low-uptake of the Government-led “Community health insurance scheme” (CHIS) due to a lack of promotion, and lack of community organisation

Mid-term review found communities willing to participate in the CHIS; and subsequent support was provided to mothers groups to save and join (qualitative data indicated increase in use of health services)

## Key lesson 6

**Routinely  
measure  
indicators to  
check if the BCC  
strategy is  
working**

Indicators to measure the progress in implementation of the BCC plan were not integrated into routine monitoring

Difficult to know whether the strategy was working and difficult to adjust and revise messages and communication channels at regular intervals, ensuring maximum impact and results

Simple observation checklists which capture proxy indicators can give a good indication of progress for handwashing (presence/absence of facility, presence of soap, signs of use) or latrine use.

### Example

**Ethiopia:** Volunteers carried out home visits to informally assess progress and change in key behaviours, sometimes using an observation checklist (e.g. presence of immunisation cards, use of improved cooking stoves, and separate kitchen from the sleeping)

## Key lesson 7

**Explore and understand behavioural motivators, as well as barriers**

Barriers for the selected behavioural problems were documented extensively as part of the formative research in all countries

Social and peer pressure were analysed and incorporated into BCC plans (e.g. role of older women and grandmothers influencing behaviour, as well as the role of men in decision making about expenses)

Other motivators (such as nurture, pride, economic benefit) were not explicitly explored or included in BCC strategies

### Example

**Sudan:** Formative research included 'doer and non-doer analysis' was used in four communities where a local NGO had promoted the local construction of improved cooking stoves

Result – significant improvement observed in separation of cooking and living/sleeping areas (40% increase from baseline to endline)

## Key lesson 8

**Volunteers are uniquely placed to support behaviour change**

Identified in qualitative evaluation data as unique and successful in improving the connection between the community and health system

Key in enabling wider local participation and accountability

Are uniquely placed to support qualitative research: they are trusted, understand the language, beliefs and community perceptions, which communication channels are likely to be effective etc.

### Example

**Zambia/Ethiopia:** Red Cross volunteers had a significant role and were highly integrated into the existing MoH health system

Main activities were conducting household visits, providing advice to parents/caregivers, and providing basic identification/diagnostic and referral services

# Many other learnings: Pages 29 – 36 of the 3FM meta-evaluation report



## Sustainability

Include indicators for sustainability in monitoring framework; make co-developed sustainability plan a requirement; budget for “look-back” study



## Monitoring

Standardise descriptions of common terms; capacity building on data collection analysis (ensuring gender and diversity comes through); guidance on consistent counting of people reached (to enable comparison) etc.



## WASH

CLTS is a common approach but there are concerns with the poor-quality facilities – think about sanitation marketing, public-private partnerships; for water utilize existing tools such as UNICEFs’ “sustainability check”



## CBHFA

Valuable tool for training volunteers on basic disease prevention and control, as well as important ‘soft skills’ (e.g. listening and communication)

<https://watsanmissionassistant.org/?mdocs-file=19687>

**For more information, contact:**



**Libertad Gonzalez**

Hygiene Promotion Adviser

[lgonzalez@redcross.nl](mailto:lgonzalez@redcross.nl)

**Lotte Heuberger**

Planning Monitoring Evaluation  
Accountability & Learning Advisor

[LHeuberger@redcross.nl](mailto:LHeuberger@redcross.nl)

**Selam Seje**

Health Coordinator/Project Manager

[SSeje@redcross.nl](mailto:SSeje@redcross.nl)