# Positive deviance: an innovative approach to improve malaria outcomes in Myanmar

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# Background

► **Collaboration with Myanmar Medical Association (MMA)**:
- The pilot project is being implemented in collaboration with MMA in a remote island, Kyun Su Township, Myanmar
- Funded by Department for International Development/Ukaid

► **Myanmar Artemisinin Containment Resistance (MARC):**
- Positive deviance (PD) is being implemented in the MARC project area
- At risk populations i.e. mobile and migrants, rubber tappers, forest workers etc. are key target audiences of the MARC project
- Lack of understanding about their context, knowledge and behaviours are main challenges to develop effective strategies
- Focus and innovative approaches are required to better reach out to these populations
- PD is an approach that can fill in this gap

# Positive deviance

► Positive deviance is an asset based behaviour change approach which highlights and appreciates the positive behaviours of the community

**Concept:**

► In every community there are certain individuals whose **uncommon positive behaviours** enable them to find better solutions to problems than their neighbours who have access to the same resources
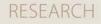
# PD programme experience

| Programme Context | Country |
|---|---|
| Child Nutrition | Viet Nam, Mali, Haiti, Egypt |
| Exclusive breastfeeding | Viet Nam |
| Family planning | Guatemala |
| HIV/AIDs | Indonesia, Viet Nam |
| Maternal and newborn health | Pakistan |
| Girl trafficking | Indonesia |
| Antenatal care | Egypt |

# Objectives

- To describe the practical application of positive deviance informed pilot project on high risk community members, rubber tappers and fishermen

- To orient the National Malaria Control Programme, Myanmar and key partners on the PD approach

- To conduct evaluation of positive deviance approach using both quantitative and qualitative methods

- To document the process and lessons learned to share with national malaria programmes and key stakeholders/partners

# PD pilot villages

PD is being piloted in 6 villages of
Kyun Su Island, Myanmar

► Population: 7000

► April 2013 – March 2014

► Selection criteria:

- High risk MARC area
- Presence of high risk population rubber tappers/fisher men
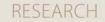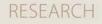- Presence of village volunteers

# Phase 1:  PD Process
# (8-10 Days)

# Postive deviance process

1. Community orientation

2. Situation analysis

3. Positive deviance inquiry

4. Participatory analysis of PD findings

5. Feedback session

# 1. Community orientation

- Invite 40-50 community members from each village

- Explain PD concept with games and stories

- Identify key community partners

- Plan for situation analysis i.e. focus group discussions, in-depth interviews

- Promise to assemble again in 10 days with solution

# 2. Situation analysis



- Conduct focus group discussions (FGDs) with:

    - Community members

    - Rubber tappers

    - Fishermen

- Establish normative behaviours of community around malaria prevention and control

- Identify potential positive deviants individual through FGDs or mapping

Conducted 18 FGDs in Kyunsu

# 3. Positive deviance inquiry

- Enables community to discover **uncommon successful behaviours and strategies** of the PD role models

- In-depth interviews with potential PD role models (male/female)

- Identify successful PD behaviours and strategies

# 4. Participatory analysis

- Write all the identified PD behaviours on flips charts

- Invite key stakeholders to vet the PD findings

- Select only those behaviours that are accessible to all

# Example of PD role model behaviours

A female rubber tapper who works in rubber farm for 15 years but never gets malaria:

- She always **wear long sleeved shirt, long trouser** and **rubber boots** when she works in rubber farm
- **Covers her head and face** with a cloth during rubber tapping to avoid mosquito bites
- When she is at home, she always **sleeps under the LLIN**
- Burns coil when cooking/TV
- Whenever gets sick, she always **contact the volunteer for blood test**

# 5. Feedback session

Conduct at the end of PD process (after 10 days as promised) to share the identified PD role model behaviours:

- Invite community members (70-80) from all villages

- Share PD findings through interactive role plays and actual role models
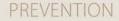
- Identify volunteers

- Prepare plan of action

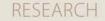# Phase 2:  PD implementation
# (6-10 months)

# Training of volunteers

Two-days training in:

- Community based

- Communication and health education skills

- Identified PD behaviours (build on the positive behaviours)

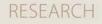- Plan of action for sharing these behaviours with other community members

# Positive deviance sessions

- PD volunteers conduct monthly/fortnightly sessions to share PD behaviours

- Conduct sessions on their convenience

- Social places i.e. schools, monasteries, village chief house, community events

# Monthly meetings

Monthly meetings are conducted to:

- Strengthen linkages
- Provide on-job training
- Share monthly progress report through maps
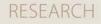- Plan for the next month activities

# Community seminar

A large community event conducted at the end of project to:

- Officially end intervention (handing over to the community)

- Acknowledge volunteers

- Provide platform for advocates

- Reinforce messages through innovative ways (i.e. role plays, poster competitions, games and success stories)
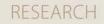
# Participatory monitoring

- Develop village maps

- Mark the houses with fever/malaria cases

- Mark the houses covered with PD sessions/health education activities

- Update these maps on monthly basis

# Evaluation methods

► Baseline and end line surveys

► Quantitative

- Household survey conducted in April 2013

- Number interviewed (n=504)

  ✓ Data entry is completed, analysis is in progress

  ✓ End line survey will be conducted in March 2014

► Qualitative

- Focus Group Discussions

- In-depth interviews

# Community mobilisation aspects

► **Emergence of new leadership**

- How successful was the project in developing and retaining all the volunteers

► **Degree and equity of participation**

- How community members were engaged in the project
  - Timing of sessions, accessibility of venues for sessions to maximise participation

► **Information Equity**

- How the outreach was ensured to each part of village (mapping)

► **Sense of ownership**

- How the community was engaged in the project?

# Lessons learned

- PD is an effective interpersonal communication (IPC) tool to better understand and reach out to at risk communities
- PD process helps understand context, normative behaviours which enables us to develop tailored communication strategy for target groups
- PD engages community at each step which develops ownership
- As PD behaviours and strategies are local hence easily accepted which expedite the process of behaviour change
- PD approach provides on-job training opportunities to volunteers which boost their confidence, increase motivation and ensure their retention(no volunnteer has left yet)
- PD can be replicated through volunteers and health staff
- PD is a human and time intensive approach, requires skilled facilitators

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www.malariaconsortium.org

**Thank you**

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