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

<table>
<thead>
<tr>
<th>Programme Context</th>
<th>Country</th>
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<tbody>
<tr>
<td>Child Nutrition</td>
<td>Viet Nam, Mali, Haiti, Egypt</td>
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<td>Exclusive breastfeeding</td>
<td>Viet Nam</td>
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<td>Family planning</td>
<td>Guatemala</td>
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<td>HIV/AIDS</td>
<td>Indonesia, Viet Nam</td>
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<td>Maternal and newborn health</td>
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<td>Girl trafficking</td>
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<td>Antenatal care</td>
<td>Egypt</td>
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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 volunteer 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