

**DEVELOPMENT MEDIA INTERNATIONAL  
 QUARTERLY REPORT (April to June 2015)  
 Maternal and Child Health Project, DRC  
 Report to UNICEF, IMA and Save the Children**

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## 1) EXECUTIVE SUMMARY

UNICEF, IMA and Save the Children are funding Development Media International (“DMI”) to run a campaign to reduce child mortality in target districts of DRC. The campaign is a mass media campaign focusing on promoting healthy behaviours through radio adverts. The project will run from January 2015 – December 2015 and the broadcast period will be May 2015 – December 2015 (8 months). The project aims to reduce under-five mortality in target provinces of DRC by 11%, by promoting healthy behaviours through radio adverts. We expect to reduce maternal mortality in target provinces by approximately 2%.

The production of the radio spots for the campaign began in this quarter. Over the course of the campaign the DMI team will write and produce radio spots to cover 34 weeks of broadcasting. To do this, the creative team will write 30 radio scripts which will then be recorded in 4 languages (Lingala, Kiswahili, Tshiluba and Kikongo). By the end of October 2015 the DMI team aims to have produced 120 spots for the radio campaign. During April and May our local scriptwriters were given intensive training on the writing and production of spots by two experienced DMI scriptwriters. The scriptwriting team also began writing and producing spots and by the end of June 14 scripts had been written and 56 spots recorded ready for broadcast. Further details on the spot production process, as well as a selection of recorded spots, are included in Section 4.5, Spots Production.

Distribution and broadcast of the radio spots started in May 2015, and the campaign is now being broadcast across 8 provinces of DRC. All stations have received the spots to be broadcast. To monitor the broadcast outputs DMI has set up a tracking system in order to provide independent verification of broadcasts and to ensure that the campaigns broadcast requirements are met. Nearly all 35 stations are broadcasting DMI’s spots (there are a couple of stations with technical difficulties which will be replaced), although some stations require further reminders about broadcast frequency and following the broadcast schedule. Further details on this are included in Section 5.2, Broadcast Partners.

Over the last 3 months we have continued to develop and refine our message briefs (appendix 2). Our formative research has revealed some important barriers to the behaviours our messages are aiming to change. Most mothers in rural communities have limited knowledge about the causes of major childhood illnesses and lack awareness about how these diseases are transmitted and how best to treat a child suffering from an infection. Superstitious beliefs, myths and misconceptions about causes and cures for malaria and respiratory illnesses can prevent mothers from accessing modern health care services. While many people do understand that mosquitos transmit malaria, others believe it is associated with sorcery or sun exposure. In many remote villages, distance to a health facility can also be a significant barrier to accessing health services.

As an illustration, our formative research on handwashing behaviour indicated several barriers to behaviour change which DMI’s spots have to address. The availability of clean water for drinking and washing is a barrier to the prevention of childhood illnesses, as is the limited awareness people have about the importance of handwashing and safe disposal of stools in order to prevent the spread of many diseases. There is minimal awareness of the significance of germs; so many families are not motivated to wash hands to reduce the spread of infectious diseases. People may wash their hands with water before sitting down for a meal, but rarely use soap because the smell and taste can remain on their hands and in their nails and ruin the taste of meals such as fufu (manioc paste) which tend to be eaten with fingers. People often use soap after a meal because they are motivated to remove the smell of the foods they have eaten, but otherwise the use of soap when washing hands is not commonplace. These barriers are included in DMI’s message brief and the scriptwriters

will use them to create spots which challenge or resolve the barriers. Further details of DMI's formative research is included in Section 4.1.

The baseline survey for the quantitative evaluation of the project took place in quarter 2. Data collection was carried out by Kinshasa School of Public Health, led by Professor Patrick Kayembe. The raw data has now been sent to DMI for analysis by our Research Manager, Dr Joanna Murray. In total, 395 mothers of a child aged under five years were interviewed in Kenge (the intervention area) and 450 mothers were interviewed in Popokabaka (the control area). The survey captured basic demographic information (mother's age, ethnicity, education, religion, occupation) as well as data on radio ownership and penetration, listening habits, maternal and child health behaviours and knowledge (questionnaire, research protocol and ethical approval attached in appendix 6). Full analysis will be shared in the quarter 3 report.

## 2) BACKGROUND INFORMATION

### 2.1 Campaign Design

The campaign is designed to reduce child mortality in DRC. The target for MDG-4 is to reduce under-five deaths per 1,000 live births from its current level of 146 to 57 in 2015, however annual rates of reduction until 2012 were around 0.7%. The DRC Ministry of Public Health (via the National Health Development Plan, "PNDS") has named maternal and child health as a priority for the department.

We know that we can reduce child mortality by promoting the adoption of simple, proven family practices such as exclusive breastfeeding, handwashing and the use of insecticide-treated nets, and by encouraging caregivers to seek treatment when their children show symptoms of serious illnesses. The design and implementation of a mass media behaviour change campaign on family practices in DRC will significantly contribute to reducing under-five and maternal mortality. The campaign aims to promote healthy behaviours by improving knowledge, attitudes and practices among pregnant women and mothers, their partners and other members of the community

The UNICEF, IMA, Save the Children and DMI campaign is covering the following topics:

Vaccination for children	Diarrhoea treatment (ORS) and oral rehydration
Birth registration	Treatment-seeking for pneumonia
Family planning	Ante-natal care and giving birth in a health facility
Care for low birth weight infants	Hand washing
Early and exclusive breastfeeding	Purification and conservation of drinking water
Complementary Feeding	Malaria prevention and treatments

The project aims to reduce under-five mortality in target provinces of DRC by 11%, by promoting healthy behaviours through radio adverts. We expect to reduce maternal mortality in target provinces by approximately 2%.

Radio penetration is far stronger than TV penetration across all parts of DRC, with the exception of Kinshasa. Therefore DMI will deliver a radio campaign in target health zones of eight provinces (Bandundu, Bas Congo, Equateur, Kasai Occidental, Kasai Oriental, Maniema, Nord Kivu and Orientale).

Information on the radio partners and DMI's research partner is included in section 5 – Partnership and Coordination.

### 2.2 Key Team Members

There has been no change to the key team members during the last quarter. The key team members are:

Helen Vesperini – Country Director. Helen is the key contact in Kinshasa for this project and runs DMI's DRC office.

Jennifer Steel – Head of Operations and Finance. Jennifer is based in the London office and provides support to Helen in running the project. Jennifer also manages the finances and reporting for the project.

Dr Joanna Murray – Research Manager. Joanna is responsible for organising all the research activities of the project, including designing the quantitative evaluation. Joanna also ensures all DMI’s messages meet current WHO guidelines.

Nicole Cauverien – Creative Director. Nicole works with the creative team in DRC to ensure the radio spots produced are entertaining as well as containing all the key information and messages.

A full list of team members is included in appendix 1.

### **2.3 Approach**

Message selection:

The key topics for DMI to message on are included earlier in the report. DMI will play a different spot each week in order to keep listeners attention. The spots will be played up to 10 times per day as repetition is key to DMI’s ‘*Saturation +*’ methodology of behaviour change. Each topic will be covered for a minimum of 2 weeks during the campaign. DMI has weighted the number of weeks dedicated to each message according to their predicted impact on child mortality. To do this we used our model predictions (which were calculated using the Lives Saved Tool LiST), to weight our messages so that those behaviours which are predicted to save the most lives will be broadcast most intensively.

The table on the following page shows the weighting of topics during the campaign and also the sub-messages that will be broadcast on that topic. Within each topic the ratio of broadcasting for sub-messages is shown, weighted in favour of whichever sub-message is predicted to save the most lives. A broadcast schedule has been created based on the message weighting table (see section 3 – Calendar of Activities).

DMI

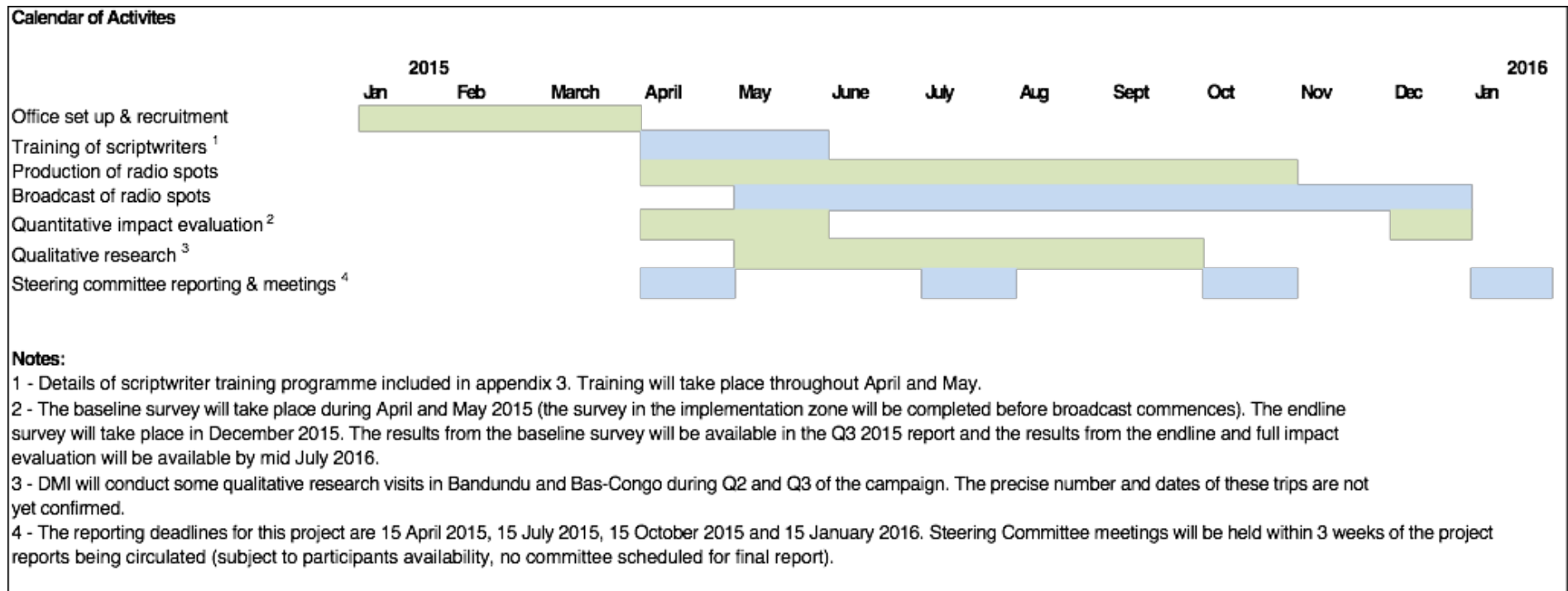
Topics for UNICEF/SCI/IMA spots		Number of lives saved	Number of weeks of spots	Sub-message 1	Sub-message 2	Sub-messages ratio
V	Vaccination for children	622*	3	Your child should receive a single dose of IPV in addition to OPV, to fully protect them against polio.	Ensure your child receives all their vaccinations to prevent serious infections (e.g. measles, polio, tetanus, pneumonia etc.)	1:2
HF	Giving birth in a health facility & attending ANC	413	2	Attend at least 4 antenatal care appointments during pregnancy	Give birth in a health facility/in the presence of a skilled birth attendant	1:1
LBW	Care for low birth weight infants	417	2	Skin-to-skin contact 24 hours a day and exclusive breastfeeding	-	-
BF	Early and exclusive breastfeeding	703	3	Early initiation of breastfeeding from birth	Exclusive breastfeeding until age 6 months	1:2
CF	Complementary feeding	13	2	Add varied and healthy foods to a baby's diet from age 6 months	-	-
BR	Birth registration	(Not in LIST projection)	2	Register your child's birth soon after they are born	-	-
D	Diarrhoea treatment (ORS) and rehydration	877	4	Increased liquids plus ORS (+zinc) to treat diarrhoea	-	-
PNE	Treatment-seeking for pneumonia	855	4	Seek treatment at a health facility for fast/difficult breathing	If given treatment (antibiotics), follow to the end of the course	3:1
MAL	Malaria prevention & treatments	1,542	5	Sleep under ITN for children under five & pregnant women	Seek treatment (anti-malarials) at a health facility for fever	2:3
HW	Hand washing with soap	710	3	Appropriate hand-washing with soap (e.g. before cooking etc.)	-	-

DMI

Topics for UNICEF/SCI/IMA spots		Number of lives saved	Number of weeks of spots	Sub-message 1	Sub-message 2	Sub-messages ratio
DW	Purification and conservation of drinking water	(Not in LIST projection)	2	Water purification and storage methods	-	-
FP	Family planning	(Not in LIST projection)	2	Use contraceptives to increase birth intervals (to 24 months)	Following birth, attend post-natal care and ask for contraceptives	1:1

\* Note: this does not include lives saved by the polio vaccination

3) CALENDAR OF ACTIVITIES AND BROADCAST CALENDAR



The broadcast calendar for the project is:

Month	June							July							August							
Week	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36					
Week commences date	11-May	18-May	25-May	01-Jun	08-Jun	15-Jun	22-Jun	29-Jun	06-Jul	13-Jul	20-Jul	27-Jul	03-Aug	10-Aug	17-Aug	24-Aug	31-Aug					
Subject of spot	PNE	HW	HF	DW	V	BF	BR	LBW	PNE	DW	D	MAL	CF	HW	D	MAL	BR					
Month	September							October							November					December		
Week	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53					
Week commences date	07-Sep	14-Sep	21-Sep	28-Sep	05-Oct	12-Oct	19-Oct	26-Oct	02-Nov	09-Nov	16-Nov	23-Nov	30-Nov	07-Dec	14-Dec	21-Dec	28-Dec					
Subject of spot	CF	V	FP	MAL	BF	HW	MAL	PNE	HF	D	V	BF	MAL	PNE	D	FP	LBW					



Topics for UNICEF/SCI/IMA spots		
V	Vaccination for children	3
HF	Antenatal care and giving birth in a health facility	2
LBW	Neonatal Care / Care for low birth weight infants	2
BF	Early and exclusive breastfeeding	3
CF	Complementary feeding	2
BR	Birth registration	2
D	Diarrhoea treatment oral rehydration	4
PNE	Treatment-seeking for pneumonia	4
MAL	Use of mosquito nets and seeking treatment for malaria	5
HW	Hand washing	3
DW	Purification and conservation of drinking water	2
FP	Family planning	2
		<b>3</b>
<b>Total</b>		<b>4</b>

NB – All calendars are operational calendars and are subject to change by DMI in order to meet operational challenges.

## 4) ACTIVITIES IN QUARTER AND RESULTS

### 4.1 Formative Research

Over the last 3 months we have continued to develop and refine our message briefs. We have reviewed the existing evidence base in published as well as grey literature (academic literature not formally published) and have received input from Dr Jean René Kwilu Mondo, an experienced Congolese public health consultant. The message briefs that have been developed are attached in appendix 2.

Our formative research has revealed some important barriers to the behaviours our messages are aiming to change. Most mothers in rural communities have limited knowledge about the causes of major childhood illnesses and lack awareness about how these diseases are transmitted and how best to treat a child suffering from an infection. Superstitious beliefs, myths and misconceptions about causes and cures for malaria and respiratory illnesses can prevent mothers from accessing modern health care services. While many people do understand that mosquitos transmit malaria, others believe it is associated with sorcery or sun exposure. In many remote villages, distance to a health facility can also be a significant barrier to accessing health services.

Poverty contributes to poor and unhygienic living conditions for many families. The availability of clean water for drinking and washing is therefore a barrier to the prevention of childhood illnesses, as is the limited awareness people have about the importance of handwashing and safe disposal of stools in order to prevent the spread of many diseases. The belief that “germs don’t kill black people” is widespread among rural, uneducated communities, so many families are not motivated to wash hands to remove germs and reduce the spread of infectious diseases. People may wash their hands with water before sitting down for a meal, but rarely use soap because the smell and taste can remain on their hands and in their nails and ruin the taste of meals such as fufu (manioc paste) which tend to be eaten with fingers. People often use soap after a meal because they are motivated to remove the smell of the foods they have eaten, but otherwise use of soap when washing hands is not common place.

A widespread barrier to exclusive breastfeeding is the belief among many mothers and mothers-in-law that babies need sugared water (mayi ya lobo in Lingala) in addition to breast milk, that breast milk alone is not enough. Many mothers feel they are depriving a baby and leaving him/her thirsty if they do not give them additional water, especially in the warmest seasons. There is a general lack of awareness that breastmilk contains all the water and nutrients a baby needs to grow and develop in the first six months. In some communities, particularly more urban settings, women view breastfeeding as in some way primitive and view bottle feeding as a more modern, progressive approach to feeding their baby.

A common barrier that prevents families sleeping under insecticide treated bednets is the complaint that it can get too hot or that it feels claustrophobic. Others simply view malaria as a very common and not dangerous disease, and do not understand the vulnerability of children and pregnant women. Some pentecostal churches in DRC have also discouraged bednet use, suggesting the insecticides they are treated with will make black people sterile. Another barrier to their use is the availability of bednets, which UNICEF and IMA World Health distribution programmes are aiming to address.

A summary of the barriers to behavior change and contributing factors to behavior change is below, further details are included in the message briefs (appendix 2).

Behaviour	Contributing Factors to Behaviour Change	Barriers to Behaviour Change
Vaccination for children	<ul style="list-style-type: none"> <li>• Health workers have received additional training on IPV polio vaccination</li> <li>• No wild polio cases in DRC since 2011</li> <li>• Vaccination card should be presented before every immunization</li> </ul>	<ul style="list-style-type: none"> <li>• Logistical and operational challenges can prevent vaccination teams reaching certain areas</li> <li>• A strong belief in divine intervention against polio can lead to parents refusing vaccination</li> <li>• Concerns about safety and side effects of vaccination</li> <li>• Children with minor illnesses not taken for vaccination</li> </ul>
Birth registration	<ul style="list-style-type: none"> <li>• The whole family benefits from the rights awarded to registered individuals</li> <li>• Mothers can sign a power of attorney to allow another registered individual to register their child</li> <li>• Births can be recorded as part of a vaccination campaign</li> </ul>	<ul style="list-style-type: none"> <li>• Widespread confusion that civil registration and issuing of a birth certificate are separate processes</li> <li>• Parents do not understand necessity of having a birth certificate</li> <li>• Registration facilities are few – there is approx. 1 per 1,952 sq km</li> <li>• There is a fee to register a child older than 3 months</li> <li>• Parents require their own identification documents to register their child</li> </ul>
Family planning	<p>To be finalized following research trip, but include:</p> <ul style="list-style-type: none"> <li>• Many people know about modern contraceptive methods and are in favour of family planning</li> <li>• Spousal discussion is strongly predictive of family planning use</li> <li>• Many women have access to some form of health care and any interaction with health agents presents an opportunity for women to ask about contraception</li> </ul>	<p>To be finalized following research trip, but include:</p> <ul style="list-style-type: none"> <li>• Advantages of family planning not understood</li> <li>• Awareness of contraception is lowest among adolescents</li> <li>• Fear of side effects and infertility</li> <li>• Social status associated with high fertility and desire to have at least one child of each sex</li> <li>• Women using contraception may be considered promiscuous, especially young unmarried women</li> <li>• Husband’s permission usually required for a woman to use contraception</li> <li>• Some religious groups oppose contraceptive use</li> </ul>

Behaviour	Contributing Factors to Behaviour Change	Barriers to Behaviour Change
Care for low birth weight infants ("LBW")	<ul style="list-style-type: none"> <li>• Skin to skin can be provided by fathers as well as mothers</li> <li>• 76% of births have their weight recorded</li> <li>• 80% of babies in DRC are born in a health facility or in the presence of a skilled attendant</li> </ul>	<ul style="list-style-type: none"> <li>• Identifying LBW; not all newborns are weighed at birth</li> <li>• Mothers who deliver their baby at home cannot know if their child is LBW. They must visit a health centre to get the baby weighed.</li> <li>• Few health workers trained in "kangaroo mother care"</li> </ul>
Early and exclusive breastfeeding	<ul style="list-style-type: none"> <li>• 98% of children in DRC are breastfed and women attach great importance to breastfeeding</li> <li>• Children under 6 months usually in close physical proximity to mother</li> <li>• Other programs / health agents recommending feeding of colostrum</li> </ul>	<ul style="list-style-type: none"> <li>• Frequent nursing associated with lack of breast milk</li> <li>• Feeding of other liquids to baby results in reduced milk supply</li> <li>• Belief that babies require other liquids in addition to breast milk</li> <li>• Belief that babies require solid food before 6 months to prevent stunting</li> <li>• Aesthetic concerns and belief that bottle feeding is more modern</li> <li>• Belief that colostrum is bad for the baby and mother</li> <li>• Entourage of new mothers reinforce false beliefs</li> </ul>
Complementary feeding	<ul style="list-style-type: none"> <li>• Most women breastfeed until child is 2 years</li> <li>• From 6 months almost all children are given a simple porridge</li> <li>• Women trust health workers advice on child nutrition</li> <li>• Local nutritious foods are available throughout DRC</li> </ul>	<ul style="list-style-type: none"> <li>• Women do not know when to introduce complementary foods</li> <li>• Nutritional value of foods not known</li> <li>• Availability of foods / equipment can be an obstacle, particularly for those affected by war</li> <li>• Certain foods may be associated with adverse outcomes or reserved only for adults</li> <li>• Enriched porridge seen as expensive or too slow to prepare</li> </ul>
Diarrhoea treatment & rehydration	<ul style="list-style-type: none"> <li>• Many women are aware of ORS products and know how to mix them</li> <li>• Many mothers continue to breastfeed during a diarrhea episode</li> </ul>	<ul style="list-style-type: none"> <li>• Many women reduce access to fluids / food for children suffering from diarrhea believing they will worsen the illness / go straight through the child</li> <li>• Children suffering from diarrhea can lose their appetite</li> <li>• Traditional treatments used, and medical attention only sought</li> </ul>

Behaviour	Contributing Factors to Behaviour Change	Barriers to Behaviour Change
		<p>when symptoms are serious</p> <ul style="list-style-type: none"> <li>• Fluids not given from the start of the episode and ORS not correctly mixed</li> <li>• ORS unknown or supplies can be far away</li> </ul>
Malaria prevention & treatment	<ul style="list-style-type: none"> <li>• 70% of households possess at least on insecticide-treated net (“ITN”)</li> <li>• Use of ITN’s for young children and pregnant women has greatly increased in last 7 years</li> <li>• Ministry of Health initiative to ensure malaria treatments available at a low cost</li> <li>• Widening knowledge that symptoms of malaria knowledge require medical attention, and that fever is associated with malaria.</li> <li>• Most people aware that mosquitos cause malaria</li> </ul>	<ul style="list-style-type: none"> <li>• A minority believe malaria associated with other sources such as the sun, witchcraft etc.</li> <li>• Household arrangements do not encourage bednet use, especially by those most at risk</li> <li>• Various financial reasons prevent use of ITN (e.g. net too expensive, free net sold or used for other purposes...) and costs of medical treatment perceived as high</li> <li>• Negative perceptions of using nets (e.g. risk of breathing difficulties, adults (i.e. not children) need net for a good night’s sleep...)</li> <li>• Medical treatment only sought when traditional methods have failed</li> <li>• Treatment is not always for full recommended course</li> <li>• Fathers usually control household finances and may prefer traditional treatments to save money</li> </ul>
Handwashing	<ul style="list-style-type: none"> <li>• Many women say washing hands is important and associated with preventing disease</li> <li>• People do wash hands before and after meals, and sometimes in other circumstances</li> <li>• Most households have access to water, and sometimes to soap</li> <li>• Other recent campaigns including UNICEF’s “clean villages”</li> </ul>	<ul style="list-style-type: none"> <li>• Soap not seen as necessary, water is believed to be enough</li> <li>• Negligence in using soap</li> <li>• Soap is saved for household tasks</li> <li>• Belief that “black men don’t die from microbes”</li> <li>• Lack of facilities in schools does not encourage handwashing among students</li> <li>• Invisibility of microbes (if not seen, must be clean)</li> <li>• Effect of soap on food taste</li> </ul>

Behaviour	Contributing Factors to Behaviour Change	Barriers to Behaviour Change
Purification & conservation of drinking water	<ul style="list-style-type: none"> <li>• Many families know and understand it is not safe to drink water directly from the river</li> <li>• Some suitable water storage containers are available</li> <li>• Boiling water can kill all pathogens</li> </ul>	<ul style="list-style-type: none"> <li>• Lack of access to clean drinking water</li> <li>• Belief that clear water (without suspension) is clean</li> <li>• High costs of water purifying tablets / firewood for boiling water prevent use even where people know water taken directly from rivers not safe to drink</li> <li>• Water storage containers do not always have lids</li> </ul>
Antenatal care	<ul style="list-style-type: none"> <li>• Women generally have a positive view of health centres and ANC</li> <li>• Many people realize that only qualified health agents can deal with complications following delivery</li> <li>• Family circle can encourage the woman, help ensure the last phase of pregnancy goes smoothly and that plans are made for the delivery.</li> <li>• The number of health zones has recently increased which brings health services closer to the population</li> </ul>	<ul style="list-style-type: none"> <li>• Pregnancy not recognized early on</li> <li>• Costs associated with ANC and giving birth in a health facility</li> <li>• Pregnancy outside of marriage is socially unacceptable and women do not want to invite ridicule</li> <li>• Husband may not be supportive of ANC due to cost or unwillingness to accept recommendations such as reduced workload</li> <li>• Early signs of delivery and/or complications not known</li> <li>• Geographical accessibility of health centre and transport costs</li> </ul>
Treatment seeking for pneumonia	<p>To be finalized following research trip, but include:</p> <ul style="list-style-type: none"> <li>• Some mothers have learnt to recognize symptoms from prior experience</li> <li>• TB is a shameful disease, mothers can misrecognize pneumonia symptoms as TB and bring the child for immediate treatment</li> </ul>	<p>To be finalized following research trip, but include:</p> <ul style="list-style-type: none"> <li>• Parents do not understand symptoms or serious nature of disease</li> <li>• People self-medicate</li> <li>• Medical attention only sought when symptoms become serious</li> </ul>

During our upcoming qualitative research trip in July, one of the key focuses will be on conducting formative research about pneumonia awareness, knowledge of symptoms and treatment-seeking behaviours in rural communities. The information collected will be used to refine our pneumonia and family planning message briefs before the next batch of scripts are written on this topic towards the end of August.

## **4.2 Pre-testing**

IMA World Health's recent field trip to Equateur and West Kasai, provided an opportunity for two scripts of spots on treatment seeking for fever (malaria symptoms) to be pre-tested. This field research was led by Crystal Stafford at IMA, with assistance from Marie-Chantal Lumba, Maura Lash and Fanny Mbokote. The scripts were acted out in front of focus groups and questions were then asked to gauge comprehension, acceptability and persuasiveness of the spots among our target audience. The question guide used as well as scripts for the two spots tested, can be found in appendix 4. Focus groups consisted of 8-10 people, one mixed group, one group of mothers only and one group of students and adolescents. In North Ubangi (Equateur) the pre-testing revealed both spots were well received by the target audience and appeared to reflect the realities of rural life in these communities. Both were deemed acceptable and were understood by the focus groups, with no clear pattern of preference for one spot over the other in a particular subgroup.

## **4.3 Qualitative Research**

We are planning to conduct four qualitative field research trips during the third and fourth quarters of 2015. These will allow us to conduct formative research as well as post-broadcasting feedback research in rural areas of Bandundu and Bas Congo provinces (since these are accessible by car from our Kinshasa office).

We have written a protocol outlining our research plans (see appendix 5), for submission to the KSPH ethics committee and we hope to have received approval for the first research trip to go ahead in July. We will use a mixture of convenience and random sampling approaches to recruit focus group and individual interview participants. Informed consent will be obtained from all interviewees and information captured from individuals will be anonymised for all reporting purposes. We will mostly focus on interviewing primary care givers, so mothers and fathers of children aged under five. However, we will also include elders and adolescents since other family members also play an important role in influencing the child care practices adopted by parents. We will also interview key stakeholders such as local health agents and village and religious leaders. More details on our proposed methodology and research tools can be found in the protocol in appendix 5 as well as monitoring guide which will be used by DMI's researcher to gather data.

## **4.4 Quantitative Evaluation**

In April our ethics application to conduct the quantitative evaluation of this project, was granted approval by the ethics review board at the Kinshasa School of Public Health (KSPH). The baseline survey of our impact evaluation was carried out in two areas of Bandundu province in April to early May, before broadcasting of the campaign began in May. The villages sampled in the Kenge area included: Bosenge, Bukaka, Butidi, Camp Congo, Camp Militaire, Kabangu, Kambamba, Kapitanzadi, Katoy, Kimbanza, Kimbunda, Kimona, Kimwamba, Kitsakala, Kitshona, Kivoko, Kiwana, Mayoko, Mbuyaseke, Misele, Mitsenge, Munikenge, Mupepe, Mupepe II, Nzumba, Pay Ki, Sadiba, Swamazinda, Tshonga, Waditanda. The villages surveyed in Popokabaka areas were Bikuku, Ferme, Ibiabi, Ijeremi, Ikialala, Ikomba, Imaki, Imbela Tsamba, Imbudi, Impolo, Indamba, Inkesa, Inkindi, Inkwati, Inzekete, Ipandii, Itietia, Itudi, Kalala, Kasanda, Kazika, Kimbunga, Mafula, Manianga, Masola, Mayanda, Mukula, Muteba, N'Saka, Ngoma Ngoma, Cite Popo, Timpolo and Tsengesi.

Data collection was carried out by an experienced team of supervisors, led by Professor Patrick Kayembe from KSPH. Fieldworkers were recruited locally and trained over a five day period. During training the questionnaire was piloted and minor revisions were made before the survey began.

During the fieldwork, Helen Vesperini (DMI Country Director) visited both Popokabaka and Kenge to monitor activities. Helen undertook spot checks to certify that the survey was being carried out in the correct areas and in accordance with the methods laid out in the research protocol. Road conditions in these remote areas can be challenging. There were some logistical issues with trying to get motorbikes that could travel up to 150km distance from the towns where they were hired. Despite this, the survey was completed with minimal difficulties, lasting around 7-8 days in each area. After completion of the field work, a team of data clerks at KSPH were then responsible for overseeing data entry and cleaning.

In total, 395 mothers of a child aged under five years were interviewed in Kenge (the intervention area) and 450 mothers were interviewed in Popokabaka (the control area). The survey captured basic demographic information (mother's age, ethnicity, education, religion, occupation) as well as data on radio ownership and penetration, listening habits, maternal and child health behaviours and knowledge (questionnaire, research protocol and ethical approval attached in appendix 6). The majority of women interviewed (73%) had lived in their village for 2 or more years, and most were of Lunda ethnicity (71%).

Detailed findings from the baseline survey will be shared in the third quarterly report. The endline survey is scheduled to take place in early December 2015. In addition to measuring maternal and child health knowledge, attitudes and behaviours, we will capture data on mothers' exposure to the DMI campaign. This will allow us to compare effects among different levels of campaign exposure, as well as comparing to the control areas, helping us to attribute any measured changes to the intervention.

#### **4.5 Spot Production**

The production of the radio spots for the campaign began in this quarter. Over the course of the campaign the DMI team will write and produce radio spots to cover 34 weeks of broadcasting. To do this, the creative team will write 30 radio scripts which will then be recorded in 4 languages (Lingala, Kiswahili, Tshiluba and Kikongo). By the end of October 2015 the DMI team aims to have produced 120 spots for the radio campaign.

During April and May our local scriptwriters were given intensive training on the writing and production of spots. The training was given by two experienced scriptwriters from our Burkina Faso project (appendix 3 contains the training schedule). Initially we recruited two local scriptwriters to work on the campaign, however midway through May one of these scriptwriters left DMI to join a TV show created by the Ministry of Culture. The campaign now had three scriptwriters producing the scripts; two experienced writers plus one DRC scriptwriter to provide local insight and knowledge. The scriptwriters also work closely with our radio producer and the assistant to the country director, both of whom are Congolese and can provide local knowledge (appendix 1 lists the DMI team).

The spot production process is as follows. The Research Consultant and Research Manager in London have created detailed message briefs outlining each health message, barriers and contributing factors to behaviour change (see 4.1 Formative Research). At the start of a scriptwriting cycle the scriptwriters are briefed by the Country Director and the Research Consultant on the health message to be covered using the message briefs. Once the scriptwriters fully understand the health message they will begin to brainstorm script ideas. The best of these ideas are developed into written scripts (in French) and reviewed by the DRC team. A selection of the best scripts is made and these are then sent to the Creative Director in London. The Creative Director will then make



comments on the scripts and select those scripts to be developed further. The local team will then make the revisions required and send the scripts back to the Creative Director for final approval.

Once the scripts have been approved for use they are then sent to translators to translate scripts into the 4 broadcast languages. The translated scripts are then reviewed by the DMI team. Whilst the translations are taking place actors are selected for each script to be recorded (from a pre-selected pool of actors recruited by DMI in quarters 1 and 2). On the recording day the actors will rehearse the spots and then record them in the studio. An edit of the spots then takes place, adding sound effects and the DMI ident. The DMI ident is the sound of a baby laughing, and is played at the start and end of spots in order to help listeners identify them. The recorded spots are then reviewed by the DMI team in country and sent to the Creative Director for approval to broadcast. Once they are approved they can then be distributed to the radio stations (in accordance with the broadcast schedule in section 3).

During quarter 2 the following spots have been produced in 4 languages (56 spots in total) and approved for broadcast:

<b>Topic</b>	<b>Title of Spot (French)</b>	<b>Broadcast Week</b>
Malaria prevention	La letter de Jeanne	W31 - 27 July
Antenatal care	Le bon marie responsable	W45 – 2 November
Antenatal care	Témoignage	W22 – 25 May
Diarrhoea treatment & rehydration	La diarrhée se fait avoir	W30 – 20 July
Diarrhoea treatment & rehydration	Un homme pas comme les autres	W34 – 17 August
Treatment seeking for pneumonia	Nsimba et Nzuzi	W20 – 11 May
Treatment seeking for pneumonia	L'ignorance	W28 – 6 July
Early and exclusive breastfeeding	Le mariage	W25 – 15 June
Handwashing with soap	L'Economie du savon	W21 – 18 May
Purification & conservation of drinking water	Chut mon mari dort	W23 – 1 June
Complementary Feeding	Beau comme son père	W32 – 3 August
Care for low birth weight infants	Un père jaloux	W27 – 29 June
Vaccinations – Polio	Decouvert	W24 – 8 June
Birth registration	La preuve	W26 – 22 June

As an example of the spots created below are web-links to some of the spots recorded. Please contact us if you would prefer an audio file to be shared by email. The French scripts for these spots are included in appendix 7.

Vaccinations, polio – Decouvert – Swahili

<https://soundcloud.com/dmidrc/vraiefinale-dmi-d-couvert/s-gKup6>

Treatment seeking for pneumonia - Nsimba et Nzuzi – Lingala

<https://soundcloud.com/dmidrc/vraiefinale-dmi-nsimba-et-1/s-4URWV>

Treatment seeking for pneumonia - Nsimba et Nzuzi – Kiswahili

<https://soundcloud.com/dmidrc/vraiefinale-dmi-nsimba-et/s-0afes>

Diarrhoea treatment & rehydration - Un homme pas comme les autres – Kikongo

<https://soundcloud.com/dmidrc/vraiefinale-dmi-un-homme-pas/s-PJe9Z>

#### **4.6 Spots Broadcast**

The campaign began broadcasting on 11 May 2015 and there were 8 weeks of broadcasting during the quarter. The spots broadcast during quarter 2 were:

<b>Topic</b>	<b>Title of Spot (French)</b>	<b>Broadcast Week</b>
Treatment seeking for pneumonia	Nsimba et Nzuzi	W20 – 11 May
Handwashing with soap	L'Economie du savon	W21 – 18 May
Antenatal care	Témoignage	W22 – 25 May
Purification & conservation of drinking water	Chut mon mari dort	W23 – 1 June
Vaccinations – Polio	Decouvert	W24 – 8 June
Early and exclusive breastfeeding	Le mariage	W25 – 15 June
Birth registration	La preuve	W26 – 22 June
Care for low birth weight infants	Un père jaloux	W27 – 29 June

DMI is undertaking extensive tracking of radio outputs to try and ensure that partner radio stations broadcast the right spots, at the right time, the correct number of times. Details of this work are included in section 5.2 Broadcast Partners.

#### **4.7 Predicted Campaign Results**

The project aims to reduce under-five mortality in target provinces of DRC by 11%, by promoting healthy behaviours through radio adverts. We expect to reduce maternal mortality in target provinces by approximately 2%.

## 5) PARTNERSHIP AND COORDINATION

### 5.1 Research Partners

DMI's research partner for the quantitative impact evaluation is the Kinshasa School of Public Health ("KSPH"). Professor Patrick Kalambayi Kayembe at KSPH was identified as a suitably experienced academic researcher with whom we could partner. Section 4.4 contains detailed information about the baseline survey. The raw data for the baseline survey was delivered to DMI at the end of June and will now be analysed by Dr Joanna Murray, DMI's Research Manager. The results will be shared in the quarter 3 report.

As there were some delays and logistical issues at the start of the baseline survey DMI has asked KSPH to prepare a report detailing the challenges faced and the changes KSPH will make to the organisation of the endline survey to ensure that this goes more smoothly. The Country Director will meet with Dr Kayembe of KSPH to discuss this at the start of quarter 3.

### 5.2 Broadcast Partners

DMI is partnering with Search for Common Ground ("SFCG") who have a radio network of over 100 community radio station in DRC. DMI has negotiated broadcast on 35 radio stations (the contract for the campaign is for 33 stations, we have been able to negotiate broadcasting on an extra 2 radio stations) throughout the 8 provinces. The full list of partner stations is included in Appendix 8 – List of Radio Partners.

The main challenge with most of our radio partners is ensuring they respect our '*Saturation +*' policy, i.e. that they broadcast each spot 10 times a day every day and that they stick to the spot scheduled for that week. Some stations, despite constant reminders, tend to broadcast a mixture of the week's spot and previous weeks' spots. Another persistent problem with a small number of stations is that they are not honest (with SFCG or DMI) about technical difficulties and power outages that prevent them from broadcasting.

In order to ensure that broadcast outputs are as programmed DMI have taken a number of steps. SFCG are contractually obliged to provide various pieces of data to show that broadcasting is taking place. This includes: data logs from 8 radio stations showing broadcast time of spots; feedback from radio listening groups confirming spots are being broadcast and; any feedback from listener groups or frontline SMS system relating to DMI broadcast. Due to a fire at SFCG during May this data was not available for the first month of broadcast, June data will be received by DMI during July.

In addition to data provided by SFCG DMI is undertaking its own monitoring of spot broadcasts. Firstly, the DMI team is calling the stations on a regular basis to check they have received the spot to be broadcast, to confirm which spot should be broadcast and to reiterate the broadcast instructions. These calls are intended to be another reminder to stations of their broadcast obligations and to allow DMI to confirm that SFCG have distributed the spots correctly and on time.

The second form of monitoring carried out by DMI is the use of trackers. We use trackers to monitor whether our radio stations are broadcasting DMI spots 10 times a day and to confirm whether the spots broadcast are the correct ones.

We have aimed to recruit an average of two independent trackers (i.e. not linked to one another or aware of their fellow tracker's identity) to monitor each radio station. In the occasional area where

we encountered problems with the radio we have three trackers. The ideal profile for a tracker is someone who already follows the partner radio every day. If they are in paid employment then it has to be a job that does not prevent them from following the radio. As at the time of reporting DMI has 61 trackers in place.

The trackers have been taught to identify DMI spots by the sound of the laughing baby at the beginning and the end of each spot. They have had this sound played down the phone to them. They have been instructed to record every day the number of times they hear a DMI spot played. They also have to resume the message they hear in the spot. Trackers are not told how many times a day the radio is supposed to play the spot, what the subject of the spot is or the times of day at which it is supposed to be played. Trackers are also asked to report if a station is off air or if its programming has been affected by technical difficulties or power outages. We have impressed upon the trackers that they must not tell the radio that they are working as a tracker. Likewise radio stations are not informed of the identity of trackers.

Trackers either send in data by SMS or are contacted by phone each Sunday evening or Monday. The data they give us is collated on Tuesdays. So far the data gathered from trackers has been of a patchy nature. In many areas we were only able to recruit multiple trackers towards the end of June so we have not been able to verify some of the data received (we need two trackers who provide similar data to be sure that what the tracker data shows is a reasonable reflection of the truth). In addition, many of the trackers took several weeks to learn how to identify a DMI spot so data gathered in the early weeks of broadcast was not always accurate.

As discussed above, the DMI monitoring process has led to a number of issues being identified with broadcasts. However there have also been issues with getting accurate tracker data. The issues identified were raised with SFCG in mid-June and they have been asked to resolve these issues during June and July. On DMI's side we are strengthening our tracking data in order to get a clear picture of outputs. Broadcast monitoring and ensuring the broadcasts meet the requirements of the campaign will be a key focus for DMI during quarter 3.

### **5.3 Government Partners**

DMI has had several meetings with government during quarter 2 of the campaign.

Lubunga Bya'Ombe and Helen Vesperini met with Information Minister Lamber Mende Omalanga (Minister for Communication and Media), who gave his full and enthusiastic support to the project. He notably asked to be kept up to date on progress. We plan to meet with him again in late August/September.

Lubunga Bya'Ombe and Helen Vesperini also met with Christophe Tito Ndombi, head of the regulatory authority Conseil supérieur de l'audiovisuel congolais (CSAC).

He said we were working on a very worthwhile project in a country where behaviour change spots are desperately needed but where most advertising is done by the breweries. We will meet with him again in September to discuss progress and future opportunities.

We are on standby to meet with Health Minister Felix Kabange Numbi. In the meantime we maintain good relations with Professor Vincent Lunkuku, who heads up the communications department at the ministry and who already organised meetings with several departmental heads for us.

**6) APPENDICES**

1. DMI project team
2. Message briefs:
  - Breastfeeding
  - Complementary feeding
  - Handwashing
  - Care for low birth weight infants
  - Malaria
  - Maternal health (antenatal care and giving birth in a health facility)
  - Vaccinations
  - Water purification
  - Diarrhoea treatment and oral rehydration
  - Birth registration
  - Family planning
3. Training schedule for DRC scriptwriter
4. Pretesting of spots on treatment seeking for malaria:
  - Pretesting guide
  - Scripts to be tested
  - Pre testing results
5. Qualitative research trips documents:
  - Research protocol for qualitative research trips
  - Monitoring guide for researcher
6. Baseline quantitative evaluation documents:
  - Baseline questionnaire
  - Research protocol for quantitative evaluation
  - Ethics approval for quantitative evaluation
7. Scripts for audio spots shared
8. List of radio partners

8) REPORT COMPILATION AND SIGNATURE

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Report Compiled By:

J. Steel

Jennifer Steel, Head of Operations & Finance

Date 15/07/15

