



NGO Networks
for Health

Behavior Change Intervention Forum
April 7—8, 1999 Washington, D.C.

The Challenge:

Rethinking Behavior Change Interventions in Health

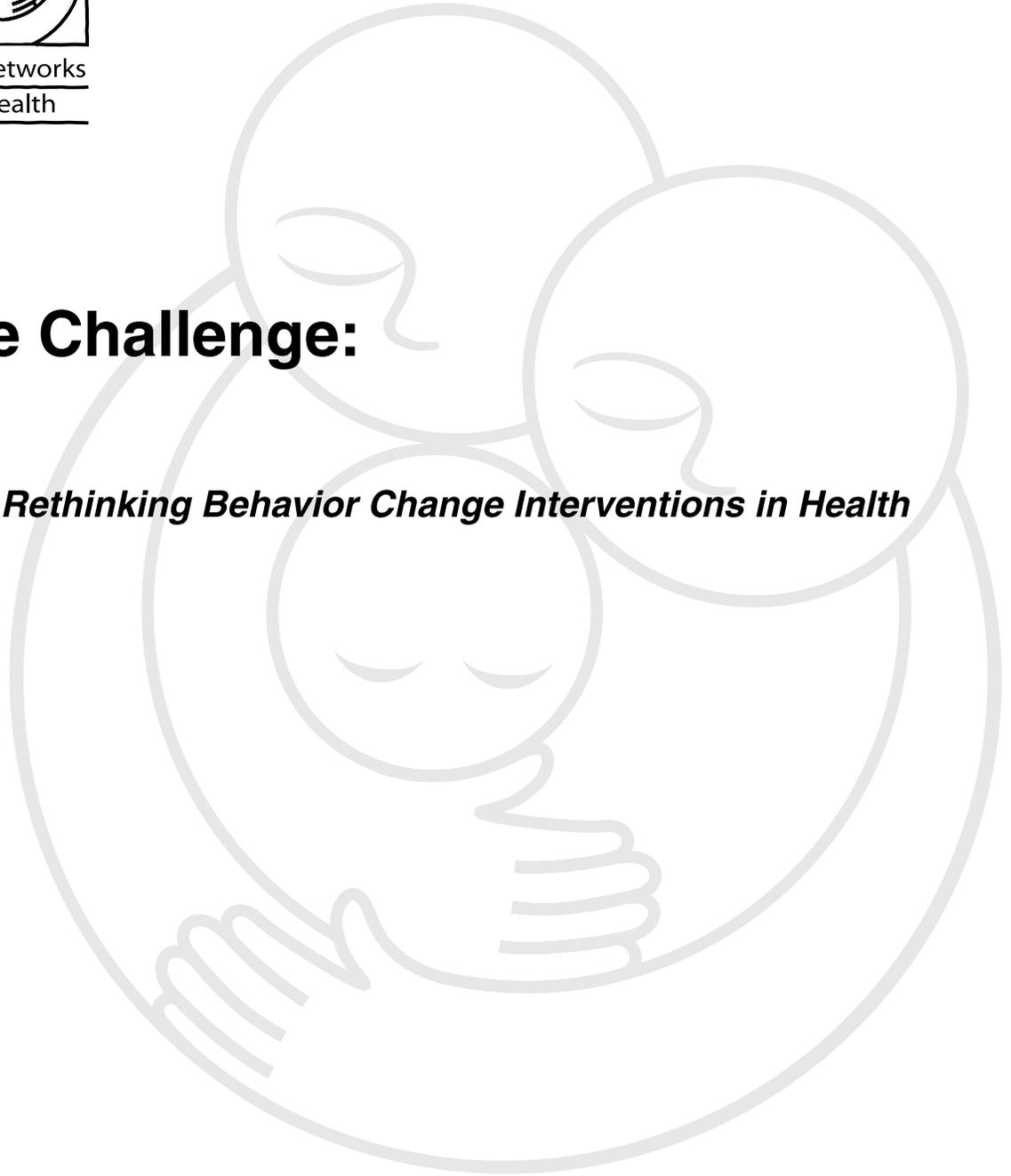
Proceedings and Recommendations



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for Health

The Challenge:

Rethinking Behavior Change Interventions in Health





NGO Networks for Health (*Networks*) is a worldwide project to improve health services by building or strengthening partnerships at the community level between organizations that are already working there. These partnerships provide a range of services, including family planning, maternal and child health, and HIV prevention, that are relevant to the local situation. This five-year effort began in June 1998, and brings together five development organizations—the Adventist Development and Relief Agency (ADRA), Cooperative for Assistance and Relief Everywhere (CARE), PLAN International, Program for Appropriate Technology in Health (PATH), and Save the Children USA. *Networks* is supported by USAID's Global/Population, Health, and Nutrition Center.

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NGO Networks for Health (*Networks*) would like to acknowledge the generous support and assistance of all those who made the Behavior Change Intervention (BCI) Forum a success. Thank you to Ronnie Lovich, Lisa Howard-Grabman, Don Graybill, Julia Rosenbaum, Robb Davis, Lyra Srinivasan, Don Levy, Everold Hosein, Elaine Murphy, Carol Hooks, and Anne Wilson for their expert advice and guidance in developing the Forum agenda. A special thank you to the forum presenters: Dana Faulkner, John Strand, Julia Rosenbaum, Collins Airhihenbuwa, Asha Mohamud, Everold Hosein, Stan Yoder, Jodi Jacobson, Nancy Russell, Lisa Howard-Grabman, Don Graybill, Elaine Murphy, Anne Wilson, Doug Storey, and Ricardo Wray. We appreciate their valuable contributions, which stimulated thoughtful and meaningful discussion among the participants.

Particular thanks to all the forum attendees (listed in Annex A) whose ideas and experiences added significantly to the rich exchange and provided *Networks* with additional insights as we proceed with the development of *Networks*' BCI Technical Approach. We are especially appreciative of the participation of the representatives of DIFID (UK bilateral donor, Department for International Development) and the United Nations Children's Fund (UNICEF). And of course, we would like to thank USAID, in particular, Maureen Norton, Lisa Childs, and Sigrid Anderson at the Center for Population, Health, and Nutrition for their ongoing support and assistance.

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Finally, a sincere thank you to Karen Lombardi, the rapporteur and author of this report; to Elaine Murphy and Carol Hooks for reviewing the draft document; and to Cecilia Snyder for the report design and layout.

Premila Bartlett
Behavior Change Communications Advisor





Behavior change is an essential component of effective development efforts; in fact it is likely *the most* essential component if development efforts are to be sustainable. The challenge of behavior change is a complex and dynamic one because people are complex and dynamic. While theories, strategies, approaches, and tools exist to facilitate the implementation of behavior change interventions (BCIs), experience has shown that no one combination of these results consistently in the desired behavioral outcomes.

Precisely what triggers behavior change Whose behavior is to be changed What is the desired outcome of BCIs Who makes these determinations And how are these determinations made At what point of development is the field of behavior change and how did it arrive there What remains to be done What are some new ways to think about behavior change How have some interventions attempted to bridge the gap between knowledge, attitudes, and practice, i.e., the KAP GAP Why does the KAP GAP still exist What are some of the behavior change vehicles and how do they effect behavior change What are some lessons learned in monitoring and evaluating behavior change in health How do behavior change experts move from the various theoretical frameworks to practical application

Concern about these and related questions prompted *Networks* to hold this forum, *The Challenge: Rethinking Behavior Change Interventions in Health*. Its goals were:

- ❑ To establish a forum for critical thinking and dialogue regarding current approaches to behavior change in health; and
- ❑ To recommend a behavior change intervention approach that results in sustained behavior change, which *Networks* should adopt and promote.

The two-day forum held in Washington, DC, April - , , brought together representatives of non-governmental organizations (NGOs), private voluntary organizations (PVOs), community-based organizations, government agencies, the private sector, academia, and other development-related entities. Through presentations and group discussion and exercises, participants shared their knowledge of and experiences with behavior change. Working in small groups, they developed recommendations for *Networks*' behavior change intervention approach. This document records the forum's proceedings and these recommendations. Annexed are the list of the forum's participants and agenda.

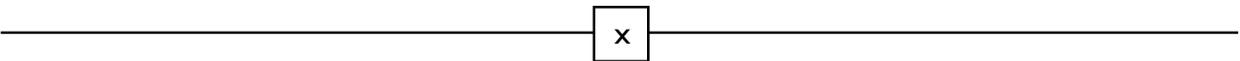


**Organizations/Agencies**

AED	Academy for Educational Development
ADRA	Adventist Development Relief Agency
CARE	Cooperative for Assistance and Relief Everywhere
CEDPA	Centre for Development and Population Activities
JHU/CCP	Johns Hopkins University/Center for Communications Programs
PATH	Program for Appropriate Technology in Health
USAID	United States Agency for International Development
WHO	World Health Organization

Technical Terms

AIDS	Acquired Immunodeficiency Syndrome
BCC	Behavior Change Communication
BCI	Behavior Change Intervention
CA	Cooperating Agency
CPI	Client-Provider Interaction
CS	Child Survival
FGM	Female Genital Mutilation
FP	Family Planning
IEC	Information, Education, and Communication
IMC	Integrated Marketing Communication
IPC/C	Interpersonal Communication and Counseling
HIV	Human Immune Deficiency Virus
KAP GAP	Knowledge, Attitudes, and Practices Gap
NGO	Non-Governmental Organization
PVO	Private Voluntary Organization
STI	Sexually Transmitted Infection





NGO Networks for Health (*Networks*) is a five-year global health project funded by the United States Agency for International Development's (USAID) Division of Global Population, Health, and Nutrition. It became operational in June 1998. The project is being implemented through a unique partnership of five large NGOs, of which Save the Children is the lead implementing NGO. The other partners are Adventist Development and Relief Agency (ADRA), Cooperative for Assistance and Relief Everywhere (CARE), PLAN International, and Program for Appropriate Technology in Health (PATH). This project gives its partner agencies the opportunity to come together to build their respective capacities and to work collaboratively so that the sum is greater than its parts—to achieve more together.

The *Networks* project will build the technical capacities of these partner agencies in family planning, reproductive health, child survival, and prevention of sexually transmitted infections including human immune deficiency virus/acquired immunodeficiency syndrome (FP/RH/CS/HIV/AIDS). Partner field offices will join with other community development agencies and the private and public sectors at the country level to develop and strengthen FP/RH/CS/HIV information and services to underserved populations. As a result, 10 to 20 percent more people in each of the six *Networks* focus countries will have access to quality FP/RH/CS/HIV information and services.

Since the project's initiation, discussions with *Networks* Partners, other cooperating agencies (CAs), and international development organizations revealed that they were grappling with questions about what triggers and sustains behavior change, and related dynamics. Partners and others raised questions about the reconciliation of top-down

with bottom-up approaches, the latter more accurately reflecting NGOs' core values, but not always feasible. More questions were raised about how to factor in true stakeholder participation while getting results within a realistic time frame. Still other questions addressed the real meaning of community participation/mobilization, and whether the impetus of behavior change is/should be community-based or external.

The two-day forum entitled "The Challenge: Rethinking Behavior Change Interventions in Health," provided an opportunity to revisit and challenge some current assumptions about behavior change interventions in health. The forum brought together PVO partners and behavior change experts who placed on the table their best thinking about technical approaches to behavior change. Participants then extracted from this the key elements for the *Networks* behavior change intervention approach that would best empower communities to identify problems and solutions, and to mobilize resources.

**NGO Networks for Health
Strategic Objective**

Increased use of FP/RH/CS/HIV practices and services through enhanced capacities of PVO/NGO Networks.

In her introductory remarks, Premila Bartlett, *Networks*' Behavior Change/Communications Advisor, addressed the rationale for the focus on behavior change. Behavior change plays a pivotal role within *Networks*. While the attainment of the project's strategic objective depends on many things, behavior change is an impor-



tant factor. This behavior change needs to occur at the organizational level of the *Networks*' Partners, at the level of the service providers involved in *Networks*' efforts, and at the level of individuals and families in the communities served by the *Networks* project.

Within USAID's results framework, the second intermediate result is "promoting accurate knowledge and sustained behavior change at the community level." While knowledge is integral to behavior change, as are other factors, triggering and sustaining behavior change requires more than only knowledge. Most enduring health behavior change is voluntary in nature. Much research supports this; behavior change is most likely and lasting when people have actively and freely (as opposed to responding to campaigns) participated in considering and making decisions to change their behavior.

Even though there has been an evolution in the design and implementation of BCIs, behavior change is not a clear-cut discipline and those involved in it use different and varied combinations of approaches. Thus far, behavior change in the health sector has tended to focus narrowly, mainly on service delivery. Individuals who work in behavior change need to look more at how other sectors—especially agriculture, and democracy and governance—have approached behavior change, and learn from these experiences. They also need to reconcile some of the unresolved differences in approach.

The purpose of this report is to document the forum's proceedings and participants' recommendations. It summarizes presenters' remarks and group participatory exercises. The discussion that ensued among participants following presentations and during group exercises is synthesized in boxes

headlined "Think About it." "Think About it" boxes highlight the key issues that emerged and prompted substantial reflection among participants during the forum's two days.

FORUM OBJECTIVES

The objectives of the *Networks* Behavior Change Intervention Forum were:

- ❑ To establish a forum for dialogue and critical thinking about current BCI approaches; and
- ❑ To recommend a behavior change intervention approach that results in sustained behavior change, which *Networks* should adopt and promote.

FORUM PARTICIPANTS

Forum participants included a range of experts and resource people with significant interest and expertise in behavior change. They represented NGOs, universities, USAID collaborating agencies, and the international development community. Participants, likely collaborators with *Networks* activities, were invited to discuss current thinking about behavior change. Key *Networks* staff participated in the forum to ensure that a critical mass within the *Networks* team would be sensitized to current behavior change concepts and thinking in order to contribute to the development of the *Networks* behavior change intervention approach. A list of participants is included as Annex A.



FORUM PROCESS

The forum combined formal presentations by experts in the field of behavior change and participatory small and large group activities and feedback to achieve its objectives. The unrevised forum agenda is included as Annex B.

The purpose of the presentations was to prompt participants to reflect on the best of current thinking about BCIs. Small group work and discussions were designed to synthesize from the presentations the elements needed to construct the *Networks* BCI approach. Dr. Don Graybill, *Networks* Institutional Development Advisor, was master of ceremonies. He also led two sessions, Search for the Pearls I and II, that sought to glean specific recommendations—pearls of wisdom—from participants for inclusion in the *Networks* BCI approach.

Dr. Graybill welcomed participants to the forum. His greetings were followed by remarks from Ms. Anne Wilson, *Networks* Partnership Council chairperson; and Betsy Bassan, *Networks* director. Ms. Wilson described the project's purposes: to increase the capabilities of consortium members to carry-out high quality reproductive health and child survival activities, and to develop networks to more effectively and efficiently carry-out such activities. Ms. Bassan introduced the project's behavior change challenge—to collaboratively build a bridge between grassroots communities and the world of behavior change ideas and sources of expertise, tools, and methodologies, and to make a place for the NGO community in the marketplace of ideas about behavior change. She commented that this forum is the opportunity to create the *Networks*' own behavior change intervention approach.

The forum's second day began with the first "Search for the Pearls" session, followed by additional presentations and small group activities. The forum closed with the second "Search for the Pearls" session and concluding remarks from *Networks* staff.



SUMMARY OF PRESENTATIONS AND GROUP DISCUSSION



The Challenge of Behavior Change

Dana Faulkner

Director, The CHANGE Project

Academy for Educational Development (AED)

Ms. Dana Faulkner spoke about the role and importance of the evolution of behavior change communication (BCC)/BCIs, and the challenges for behavior change.

Alone, the provision of technology is insufficient to produce changes in people's behaviors. The application of behavior change theory to health intervention challenges such as oral rehydration therapy, immunization campaigns, family planning, and HIV/AIDS improves the effectiveness of such programs. A prime example is the eradication of smallpox. The immunization technology was available. Communication efforts put people in touch with this technology through the health system and people acted to obtain the immunization. Behavior change efforts have been less successful in the case of slowing down the AIDS pandemic. No effective HIV vaccine has yet been developed and the only available treatment does not cure AIDS but prolongs and improves the quality of life of those infected. The only feasible intervention, therefore, is the prevention of sexually transmitted and HIV infections by changing people's sexual habits and behaviors. Sexual behavior is extremely complex and difficult to change because it is determined by a variety of individual/psychological/emotional and socio-economic factors. It also requires change within power structures such as gender relations.

BCC/BCI has gone through several evolutionary stages to arrive where it is today. Initially, BCC/BCI meant information, education, and communication (IEC) and focused on mass media and materials. Later,

the concepts of integrated marketing communications and of multilevel BCI were added, the latter forcing consideration of questions of the level of influence (physical, psychological, emotional) and level of change (sectoral, home, community, health center, policy) of BCIs. Multilevel interventions identify sustained behavior change as the focus and aim to mobilize appropriate resources to support preventative and promotive health behaviors at the home and community levels. Policy change that supports the program intervention is often an integral component of multilevel interventions.

“People working in behavior change need to take a step back and reflect on what they are trying to accomplish instead of defining behavior change as a goal.”

Effective BCIs focus on key behaviors, which are categorized as follows: preventive/promotive behaviors in the home and community, such as hygiene and breastfeeding; preventive/promotive care-seeking or product-seeking behaviors, such as bednets and immunizations; problem recognition and care-seeking for illness, such as acute respiratory infections and malaria; home treatment/treatment adherence; and the provision/support/mobilization of appropriate resources to effect behavior change.

Additionally, BCIs face the challenges of integrating across levels; and ensuring scale, sustainability, replicability, and cost effectiveness. Other challenges include finding balance between the attainment of results and technical efficacy while ensuring full participation and empowerment of stakeholders, and scaling up successful pilot programs.



Think About it:

Behavior Change Across the Board:

While behavior change at the community level is often assumed—community members are the intended beneficiaries of BCIs—the behavior change of service providers needs a closer look. Service providers, the gatekeepers to the health system, are often barriers to the use of services because of negative attitudes and behavior towards their clients. Additionally, behavior change experts need to assess their own behaviors. The fact is that some who work in behavior change are guilty of not always adopting the healthy behaviors that they promote—e.g., they know that smoking is harmful to one's health yet there are many who continue to smoke. The credibility of experts and of service providers to successfully promote health behaviors is at stake.

Behavior Change Theories

John Strand

Technical Advisor for Social Marketing; and

Julia Rosenbaum

Deputy Director, The CHANGE Project

Academy for International Development (AED)

The objective of behavior change theory as applied to reproductive health is to identify how best to influence positive behavior changes leading to better reproductive health outcomes. Behavior change theory offers clues and starting points for behavior change planners, helps to determine focal points when promoting specific health behaviors, and suggests monitoring and evaluation indicators. Mr. John Strand and Ms. Julia Rosenbaum addressed the commonalities among many behavior change theories and the practical application of behavior change theory.

One of the benefits of using behavior change theory is that it slows the rush to action. Prior to focusing program efforts on activities to achieve a particular behavior change, it is essential to first identify a specific audience, specify exactly what you want them to DO, and sort out the specific factors or determinants that both support and prevent the adoption of the intended behavior. These four key elements of audience, behavior(s), factors, and activities in the planning process are summarized as the BEHAVE Model for Program Effectiveness.

The presenters reviewed a methodology for identifying behavioral determinants that builds on commonalities of the major behavior change theories.

Three theories have had major impact on the field of behavior change in health: the *Health Belief Model*, *Social Cognitive Learning Theory*, and *Theory of Reasoned Action*.

The Health Belief Model assumes that health behavior is a function of four key beliefs: (1) perceived personal susceptibility to a health threat, (2) perceived severity of the condition, (3) perceived efficacy of a particular behavior in dealing with the condition, and (4) perceived barriers to that behavior. Together, these mental factors account for a person's inclination to act.

The Social Cognitive Learning Theory assumes that people need not only reasons to change their health behaviors but also the means, psychological resources, and social supports to do so. This theory focuses on the potential barriers to personal change.

The Theory of Reasoned Action provides a social-psychological approach to understanding behavior. It deals with the relations among beliefs, attitudes, intentions, and



behavior, and assumes that changing a given practice requires changing the cognitive structure that underlies that practice (Ajzen and Fishbein 1975 and 1980).

There are eight variables that underlie the performance—or nonperformance—of any behavior: intention, environmental constraints, ability/skills, anticipated outcomes, norms, self-standards, emotion, and self-efficacy. The first three are necessary and sufficient to produce a behavior. The last five are viewed as influencing the strength and direction of the intention to perform a behavior. These factors will differ for each behavior and each audience. To measure these factors' influence on behavior, researchers developed the “Simplified Elicitation Methodology.”

Consisting of a series of questions that enable researchers to identify the range and intensity of variables influencing key behaviors, the Simplified Elicitation Methodology cuts across many of the seemingly conflicting behavioral theories and can be utilized in a relatively short amount of time by community members themselves. The key is always to identify differences between those doing the behaviors and those not doing the behaviors; thus you can identify those variables with the strongest influence on performance of behavior, which helps to target behavior change activities.

Analysis of responses identifies a set of circumstances that increases or reduces the likelihood of the behavior occurring. Assessing each of the eight potential variables empirically identifies the ones that most strongly influence performance of a given behavior in a given population. These variables can then serve as the primary focus of a BCI.

Simplified Elicitation Methodology

[To ascertain anticipated outcomes, self standards, emotions]

What are the good things that happen when/if you **adopt a specific behavior**, e.g., *use a condom each time you have sex?*
What are the bad things that happen when/if you **adopt a specific behavior**, e.g., *use a condom each time you have sex?*

[To ascertain environmental constraints, ability/skills, norms, self-regulation]

How would doing the behavior make you feel? How would it make others feel? How would they react? How would you describe someone who **practices the specific behavior**, e.g., *uses a condom each time s/he has sex?*
What makes it easy to **practice the specific behavior**, e.g., *use a condom each time you have sex?*
What makes it difficult to **practice the specific behavior**, e.g., *use a condom each time you have sex?*

[To ascertain norms, self-regulation]

Who approves/would approve of you **practicing the specific behavior**, e.g., *using a condom each time you have sex?*
Who would disapprove of you **practicing the specific behavior**, e.g., *using a condom each time you have sex?*

Also ask about personal characteristics and possible solutions.



Mr. Strand and Ms. Rosenbaum provided the following recommendations for the *Networks* BCI approach:

- ❑ Apply behavior change theory to slow the rush to action: first identify audience, behaviors for change, and key factors influencing these behaviors.
- ❑ Apply behavior change theory to help determine the focus of programs; this specifically helps with third program decision of the BEHAVE Model, identifying the key factors that influence target behaviors.
- ❑ Note useful commonalities among theories that account for perceptual (individual), community, organizational, and political factors affecting particular behaviors in specific audiences.
- ❑ Revisit the menu of determinants to modify for a range of cultural contexts.
- ❑ Identify most influential variables influencing behaviors through comparing doers and non-doers.

discussion

Think About it:

Behavior Change by the People, of the People, and for the People:

The community is key to absolutely all components of any and every BCI. The community is the best source of information and data when planning a BCI. Community members provide good input and feedback in identifying the real problems (as our problems may not be theirs) and problem-solving approaches. Where guided by theory, a planning framework, and some real data, solutions generated in a participatory fashion represent the best chance for behavior change sustainability.

Health and Culture: Beyond the Western Paradigm

Collins Airhihenbuwa

Associate Professor of Behavioral Health
Pennsylvania State University

Dr. Collins Airhihenbuwa addressed the question of the cultural appropriateness of health behavior. Our collective sense of consciousness, or culture, conditions the way we make decisions and these are influenced by societal expectations. Dr. Airhihenbuwa maintained that discussions about health behavior draw much from health, psychology, and medicine, but not enough from the humanities.

His proposed model (PEN-3) challenges people to rethink actions and to be concerned with issues beyond individual behavior, i.e., culture mediation—government/policy, socioeconomic status of the individual and of the government, culture, gender relations, spirituality, and context within which health decisions are made. Its intent is to identify what guides people's behavior within a context or culture and its implications for message design and evaluation indicators.

Traditionally, the analyses of health have been euro-centric and done in the context of development and globalization, and the individual-focused medical model. The culturally appropriate model for health interventions challenges the traditional model and is the theme of Dr. Airhihenbuwa's book entitled, *Health and Culture: Beyond the Western Paradigm*.

Who is supposed to benefit from globalization? What is underdevelopment? Is it what happens in Africa? Or is it the questionable decisions made by Western politicians that



deny effective solutions to development problems? The development community has been doing development since the 1960s and is moving toward the globalization of development. We should first address

“It is assumed that beliefs have no value, only knowledge has value. When grandma says chicken soup is good for you, it’s a belief; you don’t buy it. When the doctor says chicken soup is good for you, it’s knowledge; you eat chicken soup.”

questions about the effectiveness of efforts that do not consider culture and how these affect those who are supposed to be its beneficiaries.

Analyses of eurocentrism and patriarchy have raised questions about culturally specific ways of knowing and behaviors that are grounded in particular cultural ethos or values. Questions have also been raised about how actions are influenced by the context within which people operate. These concerns can be addressed through culturally appropriate health interventions.

The individual-focused medical model for health intervention assumes that because people “should” change a behavior, they will. However, experience has shown that knowledge does not necessarily translate into action. For example, many people know that smoking is harmful to one’s health. They make New Year’s resolutions they know will benefit them—e.g., quit smoking—and do not implement them. In many cases of health behaviors, action precedes knowledge, such as in the area of sexuality.

Each of these analyses points up the need to understand culture in order to develop more appropriate, and hence effective, BCIs. While the important role culture plays in

behavior change is acknowledged, culture is often seen as a constraint. This model also questions why culture is always looked at as negative, as in the common reference to “cultural barrier.” Rarely is appreciative inquiry of culture done and the positive aspects noted. The process of appreciative inquiry engages people in the process of trying to understand, which is part of making the change in behavior. “Cultural empowerment” must therefore be recognized.

The culturally focused assessment of health behaviors needs to include consideration of perceptions—of individuals and group identity, emotions, and reason; of enablers—those with resources, policy, and power; and of nurturers—family, community, empowerment, and spirituality. Within the domain of health education, consideration must also be given to the cultural constructs around personhood—seniority/decision-making and roles and responsibilities within the culture; to the extended family—communication channels, gender roles in negotiation, and face-saving behaviors; and to neighborhood, including the political and economic power structure.

Bridging the KAP GAP

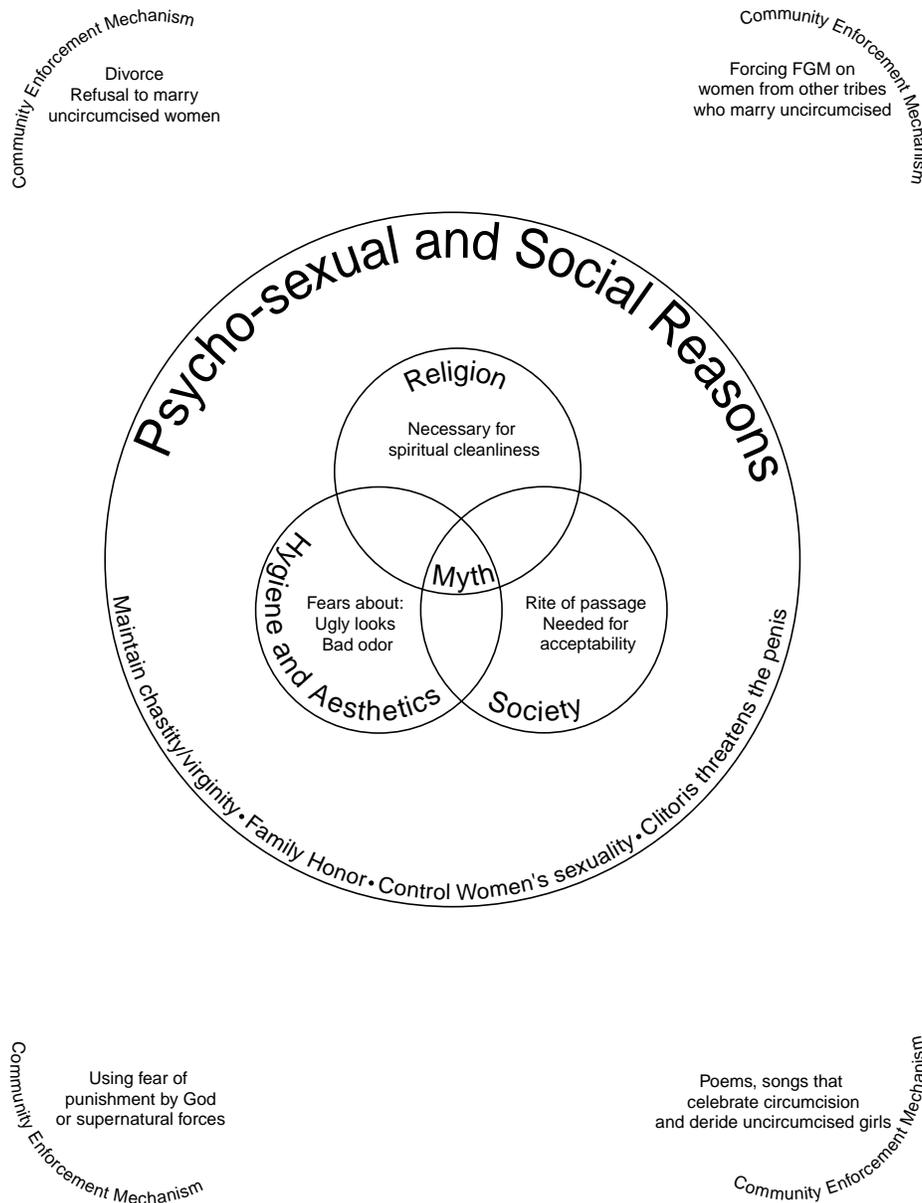
Asha Mohamud
Senior Program Officer
Program for Appropriate Technology in Health (PATH)

Dr. Asha Mohamud presented the results of a recent PATH survey of Female Genital Mutilation (FGM) programs that was done for the World Health Organization (WHO). Three hundred and sixty five national and international organizations working to eradicate FGM in Ethiopia, Uganda, Egypt, Burkina Faso, Mali, Senegal, and Kenya were interviewed.



FGM is a practice that is part of a complex cultural belief system as illustrated by the mental map below. This mental map includes the myths, beliefs, values, and codes of conduct that indoctrinate people of all ages to view the woman's external genitalia as a potentially dangerous body part, which, if not eliminated, can have the power to negatively affect the woman, her family, her husband, and her community. The commu-

nity has also put in place both incentives to practice FGM and disincentives for stopping the practice. Some of the rewards include public recognition and celebrations, gifts, increased marriage prospects, and the respect and ability to participate in adult social functions. The disincentives include inability to marry or get divorced, forced circumcisions, and the threat of punishment by God or ancestors.





Most of the organizations that were interviewed indicated that they were more successful in increasing awareness, knowledge, and disapproval of the practice and less so in reducing the number of circumcisions. This was due to the fact that the organizations still used an IEC approach aimed at sensitizing and raising awareness about the harmful effects of FGM instead of the behavioral goals to be achieved. They also did not target their messages to the specific stages at which their communities might be. The specific stages are:

1. **Being aware of the problem**
2. **Seeking information**
3. **Processing and personalizing information**
4. **Examining options**
5. **Reaching a decision**
6. **Trying the new behavior**
7. **Receiving positive reinforcement**
8. **Sharing information in a multiplier effect**

Despite the slow progress of the overall movement to eradicate FGM, there were four programs that seem to have succeeded in bridging the gap between knowledge, attitudes, and practices—KAP GAP—and stopping the harmful cultural practice of FGM.

- ❑ In one program, the change was the result of a social movement.

A group of village women in Senegal, who had been exposed to a one-year modularized training program that taught problem-solving, self-awareness, and assertive skills through guided group discussions mobilized their community to declare FGM banned. Since September 1996, when this village of Maliconda Bambara pledged to refrain from FGM, an event known as the Maliconda Commitment, more than 35 villages—some

of which have marriage ties—decided that they would ban FGM. This multiplier effect and social movement emboldened the Government of Senegal to pass a law criminalizing the practice. The one-year training program is implemented by TOSTAN (Breakthrough), a Senegalese NGO, and includes topics such as sanitation, disease prevention, child health, women's health, human rights, project planning and implementation, and book-keeping techniques.

- ❑ In two other programs, one in Kenya and the other in Uganda, the change resulted from negotiating alternative rights of passage with the community.

Maendeleo Ya Wanawake Organization in Kenya, with technical assistance from PATH, found in their initial research that adolescent girls valued the recognition from peers and adults, and the gifts and other privileges associated with the traditional circumcision ceremonies. In partnership with the community, an alternative one-day coming of age celebration, which included poem recitals, anti-FGM songs, feasting, dancing, and gift giving, was established. Since August 1996, over 1,500 girls were saved from the irreversible damage of FGM by going through the alternative rights of passage program. The group of mothers who participated in the first ceremony registered themselves as an NGO called Ntaniro Na Mugambo, which means circumcision with words, are implementing the program throughout the district. In addition, other agencies have also adopted the alternative rights of passage as a program priority in Kenya.

Members of the Sabinu community in Uganda, with funding from the United Nations Population Fund (UNFPA), are implementing a general reproductive health



project, which includes an FGM eradication component. This program, like the one in Kenya, has succeeded in substituting FGM with the use of alternative rights of passage. Since this program's initiation in 1996, FGM has declined by 36 percent.

- ❑ The fourth program was implemented by the Coptic Evangelical Organization for Social Services in Egypt.

This program assigned a man and woman to educate each of the communities and to assign at-risk girls between eight and 13 to community leaders for protection. The community leaders were expected to monitor these girls and ensure that they were not circumcised by their parents. This system of monitoring is complemented by seminars and meetings to educate religious leaders and the community. The reported incidence of circumcisions declined dramatically in the program areas.

The lessons learned from the FGM survey suggest the following for BCIs to be effective:

- ❑ Go beyond awareness and focus the messages on the communities' stages of behavior adoption.
- ❑ Support all stages of a program with research (stages of the mental map).
- ❑ For entrenched cultural practices such as FGM, increase work at the interpersonal level and promote positive aspects of culture.
- ❑ Involve all stakeholders in the design of the program including alternative rites of passage.
- ❑ One can increase demand for a program.
- ❑ One can gain community acceptance.
- ❑ One can prepare for and counteract opposition.
- ❑ One can create a critical mass of non-circumcising families/communities and

perhaps reach success by fostering community level decision-making and commitment.

- ❑ One can prevent girls from forced excision by in-laws.
- ❑ One can develop a sustainable program.

Bridging the KAP GAP

Everold Hosein
Senior Counselor, Social Development
Burson-Marsteller, Inc.

Dr. Everold Hosein presented an overview of some of the concepts applied to behavior change in the private sector. The private sector employs a behavior change methodology called Integrated Marketing Communication (IMC) which has evolved over 100 years of influencing consumer behavior. IMC analysis and planning always begins with the "intended effect"—it seeks first to answer the question, "What is the desired behavioral result?" Behavioral result is a private-sector alternative to the term behavior change. In IMC, the process of adopting a behavior, or achieving the behavioral result, is captured by the acronym "HIC DARM."

IMC Process of Adapting a Behavior

H—**HEAR** about behavior
I—become better **INFORMED**
C—**CONVINCED** it's a good thing
D—take a **DECISION**
A—**ACT**
R— wait for **RECONFIRMATION**
M—then **MAINTAIN** behavior

If a gap exists, it commonly exists between the HIC and the DARM; the term "KAP GAP" is an unfamiliar one in the private



sector. Traditional IEC has been successful at dealing with the HIC but less so with the DARM.

First and foremost, IMC works with existing demand (latent or otherwise) and channels that demand to specific products and services. IMC depends on market situational analysis to determine the products and services to be offered to the consumer as solutions to their needs, wants, or desires. Situational analysis is accomplished through market research (“arm-chair” analysis, walking around, secondary sources, anthropological surveys, focus groups, force-field analysis, behavioral trends, and market segmentation studies).

IMC is a multifaceted, strategically planned approach integrating the disciplines of health education, adult education, mass communication, folk media, public relations and public advocacy, counseling, client/customer relations, client/customer education, and market research to achieve the ultimate goal of getting the behavioral result. This approach utilizes a blend of communication methodologies (presentations, group communication, public relations/journalism, community mobilization, advertising, mass media, point-of-service promotion, and personal selling/counseling) to achieve its behavioral development objectives. IMC emphasizes that to achieve large-scale behavioral impact, one must approach the process in a Massive, Repetitive, Intense, and Persistent (M-RIP) fashion.

Evaluation within IMC consists of process and impact assessment: baseline and final surveys, tracking surveys, and services/sales statistics. In IMC, impact evaluation is often less concerned with tracking impact of specific media intervention as such exercises tend to be costly and experience has shown that impact comes from the integrated blend of communication actions.

discussion

Think About it:

Where Does Demand Come From?

Is demand for a particular practice or service being created, or is existing demand being channeled to the appropriate outcome? The IMC camp believes that interventions should link people with an unmet need (latent demand) with the appropriate products and services. For instance, women who say they want to avoid parenthood or the birth of a next child need to be provided the means to do so—some contraceptive method. In so doing, the consumer and the solution are brought together. Ultimately, the consumer makes the choice to use or not use a contraceptive method. Others, who work in advocacy, mobilize people to make them aware of options and provide needed tools and strategies to facilitate behavior change. Ultimately, the consumer makes the choice. Either way can lead to achieving the desired behavioral result.

Whose Knowledge Counts?

Stan Yoder
Qualitative Research Specialist
MACRO International

The KAP GAP has been defined as the gap between knowledge and attitudes, and practice. This term initially came into existence to capture the disparity between the percentage of women wishing (attitude) to avoid pregnancy who could cite a certain number of family planning methods (knowledge) and the percentage of these women who actually used one (practice). While many look for effective strategies to bridge the gap between knowledge and practice, others question the very notion of the KAP GAP. Dr. Stan Yoder maintained that the



KAP GAP is really the construction of research people, an artifact of how researchers do their work. It was developed as a way to predict behavior.

The challenge for behavior change experts is to put aside the idea that attitude and knowledge will predict individual behavior and take note of what emerges as a new kind of model. To accomplish this, behavior change experts must reexamine their assumptions about behavior change and health communications and their beliefs about human interactions. Experts must resist the temptation to constantly expect that behavior can be predicted from knowledge and attitudes, and must drop the idea that epidemiology provides all of the information necessary for behavior change. Knowledge and attitudes can influence behavior, but not predict it. This is especially true since the statistics that are generated in surveys do not pertain to individuals.

“The KAP GAP may have outlived its usefulness.”

Experts must reexamine assumptions that situate discussion in a realm that they can easily manipulate but that is quite distanced from people’s everyday experiences. For example, the one underlying assumption in health education and health communications is that people can be persuaded to see things in a different way if messages are properly formulated. Another assumption under which those involved in behavior change may operate is that culture is cognitive and behavior is guided by beliefs. Hence, these factors can be manipulated to effect behavior change. Part of the KAP GAP relates to these assumptions; it is a product of the questions we ask, especially in surveys.

Instead of talking about individual behavior change, those who work in behavior change should:

- ❑ Rethink what is considered relevant to a situation.
- ❑ Search history for local models of behavior change.
- ❑ Include local considerations and make them primary.
- ❑ Study actual health-related behaviors and not behavioral outcomes. For example, research actual episodes of long-term parental behaviors and not of child survival. With that information in hand, behavior change experts should discuss with parents the possibilities of changing behavior.

Think About it:

Do Outside Models Help or Hinder Access to a Community’s Knowledge?

Some behavior change interventionists attach importance to using a model to assure a systematic and comprehensive approach at all levels. However, models only provide a framework of behavior change components and underlying assumptions. The NGO community is not really good at working with models and needs to be able to honestly admit this. It also needs to consider that models and frameworks are insufficient. An alternative is the integrated community health approach. More a community-driven planning process, it does not permit prediction and may not result in the need for outside assistance. It does, however, define the relationship that an outsider has with the community. Listening should be the most utilized skill and outsiders need to adopt a systematic approach to listening to and learning from the community. Outsiders must be able to listen beyond words to ascertain the worldview behind what people say.



Advocacy

Jodi Jacobson
Co-Director
Center for Health and Gender Equity

Communication strategies are fundamental to the promotion of reproductive and sexual health and rights. A variety of approaches, which can be used incrementally in even the most conservative environments are used: formal, informal, mass media, village theater, and small group interaction are among them. The process via which these strategies are developed and implemented is as important as their outcomes.

Ms. Jodi Jacobson outlined some of the most creative examples of the use of communications strategies for advocacy around women's rights and women's health that are resulting in changes in communities and policy. The main aims of communications strategies for women's rights and health are to instill a sense of efficacy and entitlement, challenge social and cultural norms, foster gender equity/equality, challenge the political power structure, and foster greater individual and group participation in civil society.

In India, the Center for Health and Gender Equity collaborated with a partner NGO to identify a problem—women were restricted from community/economic activities during their menses. Women were isolated during this time because menstruation was considered dirty. Through the Center for Health and Gender Equity's work with a small women's group and the community, it was determined that this isolation was a form of the community's control over women's sexuality, and could be overcome. A local women's NGO came up with an answer—

**Community
Self-Identification**

The center is making use of a community self-identification methodology called "Stepping Stones." Developed by ACTIONAID, an NGO in the United Kingdom, "Stepping Stones" is a package for facilitators. It is used to help run community workshops on HIV/AIDS. The specific skills include engaging communities in dialogue, and employing feedback mechanisms such as drama so that people are able to report back to the community what was said without the discomfort of being identified as the one who said it. The methodology starts by gathering the community's input on a certain issue. For example, community members are asked to diagram what they think is going on concerning HIV/AIDS. Then the methodology asks, "Why is this dynamic happening and how can we begin to solve it as a community?"

sanitary napkins fabricated using local resources.

In Nicaragua, the Center for Health and Gender Equity worked to develop grassroots/national-linked media campaigns about the issue of domestic violence, a rampant problem. Involvement in the project ranged from grassroots communities to epidemiological researchers who worked to determine the extent of domestic violence. This information was used to create a public



information campaign at both the local and national levels, to generate public awareness and knowledge and to change attitudes. It included the extent and costs (physical, economic, and social) of domestic violence.

The project educated people via the national media, *El Boletín*, which has the highest circulation among magazines in Nicaragua. An educational pamphlet was developed to communicate with low-literate populations and was used to prompt discussion in communities. A countrywide petition was circulated to increase understanding of domestic violence. Women decided they needed a law to deal with domestic violence. The effort then went to the next level, where policy-makers presented a bill in the parliament, which was passed.

Critical issues for the success of communication strategies include the availability of good data on the situation to be addressed and the research capacity to secure such data. These two factors are especially important in the women's community because the burden of proof, in a world where men dominate, has always been on women themselves. Other critical issues include an accurate understanding of the "market," access to tools, communications methods, and expertise in the topic that is accompanied by the building of internal capacity. Formative and evaluation techniques that involve individual or community participation and identification of problems are also important.

discussion

Think About it:

Mandated Behavior Change and Altering the Balance of Power

A key component of advocacy is affecting changes in legislation and policy, the implementation of which is par with mandated change. Does this mean that advocacy promotes coercion? Some of the greatest behavior change success stories, such as the use of seat belts and the anti-smoking efforts in North America, have been due to behavior change mandated through legislation. Have these efforts succeeded because of coercion? Advocacy efforts in many development programs have revolved around empowering disenfranchised or disadvantaged people. When one group of people advocate and achieve an alternative that empowers them, those who previously held power become, to some extent, disempowered. If laws then uphold this, are they altering the balance of power? Is it fair that the tobacco industry is being regulated or "disempowered" to the benefit of public health?



Empowerment and Behavior Change

Nancy Russell

Senior Advisor for Community Development,
Centre for Development and Population Activities
(CEDPA) ENABLE Project; and

Lisa Howard-Grabman

Community Mobilization Specialist

Save the Children

Ms. Nancy Russell and Ms. Lisa Howard-Grabman renamed this session, “Empowerment is not for sissies.”

They led forum participants in a small group exercise to establish definitions of “empowerment.” The results follow:

- ❑ Empowerment is an avenue to decide, express, and act on personal choices
- ❑ Empowerment is the inherent, informed, independent ability to solve problems as individuals and groups, with dignity
- ❑ Empowerment is a process of developing tools and skills, helping ourselves, determining our own destiny, speaking and acting on personal choices
- ❑ Empowerment is self-determination
- ❑ Empowerment is the importance of informed decision-making and action at community and individual levels
- ❑ Empowerment is the ability, physically, socially, and culturally, to act on one’s intention and goals
- ❑ Empowerment is a process that starts at the individual level that involves understanding of self, relationship with others, and one’s own rights
- ❑ Empowerment is having the ability to make choices for one’s own life, for one’s community, and beyond

Subsequently, the presenters posted several value statements and asked participants to gather at the one best reflecting their own values. The value statements follow in italics:

- ❑ *Empowerment is a process not an outcome.*

Participants gathered near this value statement noted that we cannot empower others but can help others to empower themselves.

- ❑ *Empowerment itself is the most important outcome. Changing health behaviors is secondary.*

Participants gathered near this value statement commented that health behaviors are only one aspect of human behavior. Empowerment is the greater goal.

- ❑ *Empowerment requires an intersectoral approach.*

Participants gathered near this value statement commented that, alone, the use of family planning can not empower a woman. Change must also occur at other levels, such as that of the community. The role of people involved in BCI is to facilitate the intersectoral approach.

- ❑ *Empowerment is necessary for sustained behavior change.*

Participants gathered near this value statement clarified it: when we deal with socially charged issues such as sexual practices, people have to overcome major barriers. An investment in social change through an empowering process is needed for long-lasting change.



discussion

Think About it:

Is There Only One Truth about Empowerment?

There seems to be no universal definition of empowerment, leaving it open to various interpretations. Nor are there universally accepted indicators to measure empowerment, or a single approach to integrating it into behavior change processes. There are ways to help people empower themselves, e.g., through skill-building, participatory design and evaluation, micro-credit, etc. But how do we know when a person is empowered? What is an indicator for empowerment? If people are motivated to do something because of financial incentive, are they empowered? One opinion holds empowerment to be a goal, another that it is a means to a gain, e.g., better health. Yet others see empowerment as a fundamental component of the social development process. Even within the field of behavior change there is some resistance to couching empowerment as a purely behavioral issue. In so doing, one does not do justice to the political, cultural, and economic components of the concept of empowerment. Empowerment should not be dismissed simply because there is no single definition. All of those mentioned herein have much in common. And all noble concepts embrace several definitions and viewpoints, e.g., “freedom,” and even “health.” Despite the lack of universal definitions, we aspire to attain freedom and health. We should do likewise with empowerment.

The Development Continuum

Don Graybill
Institutional Development Advisor
NGO Networks for Health

Dr. Don Graybill facilitated a session designed to gauge participants’ opinions about the initiation point of BCIs. The scenario presented two camps of opinion: (1) the need and locus for behavior change should be initiated locally; (2) the need and locus for behavior change should come from outside experts who predetermine the behavior on which they want to have an impact. Participants were asked to place themselves along a continuum in which one end represented local control, and the other represented outside intervention. Every participant placed himself or herself between the halfway point and the local control extreme. No participants situated themselves at the end representing outside intervention.

“I’ve grown to see my role as a bridge between the knowledge, ‘expertise,’ and the community.”

Participants at the extreme local/community end of the continuum noted that “ownership is sustainable,” therefore behavior change efforts initiated by the community had the greatest potential staying power.

However, other participants commented that “not everything at the community level is right,” with one participant giving the example of FGM: “There’s a lack of equity in many societies. I’m thinking about the case of female circumcision in which the community’s knowledge of the harmful effects of this practice and the human rights violation of bodily integrity is lacking. The community may be unaware of women’s rights as human rights, as part of a universal set of human rights.”



Participants in the middle raised questions about the legitimacy of having their own agendas, which they bring to behavior

“Participation is about being frank... about what I bring as an outsider to the situation. There is a difference between pretending to be community-driven but really going in with some predetermination. First you need to recognize your own belief system.”

change efforts at the community level. While acknowledging that the community is central, these participants realized that behavior change is not entirely community-driven. The role of outside interventions is to help develop the tools, the strategies, etc., to help the community to realize behavior change.

Think About it:

Who Knows Best? Insiders and Outsiders Both Contribute to Behavior Change and Development.

While acknowledging that community knowledge, needs, and wants are always paramount, and that efforts must be made to access, understand, and respect these, behavior change is not entirely community-driven. A legitimate role for outsiders is to bring new and different ideas to a community. They present options to a community's current reality. In fact, in certain instances, external ideas are necessary to achieve better health outcomes, such as in the case of FGM. Outside expertise can contribute tools and strategies to help a community to realize behavior change. It can transfer these to the community, thereby building its technical capacity and moving the community towards independence of the need for outside expertise. Insiders and outsiders both know best—they know different things best.

Community Mobilization

Everold Hosein
Senior Counselor, Social Development
Burson-Marsteller, Inc.

Dr. Everold Hosein discussed community mobilization from the private-sector perspective, citing it as one of the three pillars of the integrated marketing communications approach: public relations/advocacy, advertising, and community mobilization. He provided several examples to illustrate community mobilization applied with a private-sector marketing sensibility.

Within a wider campaign to “Strengthen the Family” for the Ministry of the Family in Venezuela under a World Bank-financed program, the firm Burson-Martseller, Inc. was asked to develop a program to promote “fidelity” in Venezuela as one of several behavioral goals. Part of the program design was mobilizing communities through the multilevel training of local NGO leaders to talk about fidelity and other issues of family well-being, and to organize small community discussions in the provinces of Venezuela. Within the private-sector framework, this training of “field counselors” constituted community mobilization.

In South Africa and Swaziland, community mobilization took the form of a “road show.” A flat bed truck went from village to village performing an entertaining show. During the performances, opportunities were created to talk about nutrition and health. This too, from the private-sector perspective, is a common form of community mobilization and involvement of the community.

In more conventional marketing, the classic community-mobilization approach is that utilized successfully by Tupperware™ wherein individuals selling



Tupperware™ food storage containers host Tupperware™ “parties” to which they invite neighbors and other potential buyers in the

“Tupperware™ is the classic community mobilization approach. It works.”

hope that they will see the benefit of and purchase the products. This approach has been tried in addressing good nutritional behavior. A nutritionally knowledgeable person invites a group to their home and cooks with them. It is hoped that in the process, those invited will become interested in good nutritional behavior. In the Gambia, for another World Bank-financed population, health, and nutrition marketing program, Burson-Marsteller, Inc. has developed a program for working with community NGOs, mosques, and Imams on family planning and nutrition using the Tupperware™ personal communication and community-mobilization approach.

The concept of community-based educators, product distributors or volunteers also qualifies as community mobilization within the private sector. In Indonesia, this took the form of the traditional grouping of 10 families in a village, which meet every several weeks to discuss and resolve community issues, facilitated and assisted by a community-based educator or community welfare officer. Over time people lost interest. The BCI challenge was finding ways to revive that interest. Essentially, the community meeting had to be promoted and marketed as a kind of event worth people’s time and effort to leave their homes to attend. The community-based facilitator needed to approach the meetings with a marketing sensibility.

Community Mobilization

Lisa Howard-Grabman
Community Mobilization Specialist
Save the Children

Ms. Lisa Howard-Grabman addressed the issue of community mobilization, which she defined as a “process through which action is stimulated by a community itself or by others, that is planned, carried out, and evaluated by a community’s individuals, groups, and organizations on a participatory and sustained basis to improve health. This process helps to produce a growing autonomy and conscience.” This definition, and the key elements of community mobilization that she outlined, suggested that community mobilization is an empowering process with a range of benefits for health including improved program design, quality, and evaluation; cost-effective and sustainable results; increased capacity among individuals and groups to identify and satisfy their needs; and increased community ownership of programs.

The “Field of Dreams,” an allusion to a popular US movie about baseball, is an approach to community mobilization that assumes “if you build it, they will come.” This focus on the supply side of services does not always result in use of services. Other programs have promoted key behaviors through a variety of strategies such as IEC and social marketing. While these approaches can be successful in changing some behaviors, they often do not reach marginalized populations or address underlying causes of health problems such as gender; class or race discrimination; or social, economic, cultural, political, or other inequity. Additionally, these approaches generally do not provide community members with the skills and systemic support they need to improve their health and well-being on a sustained basis.

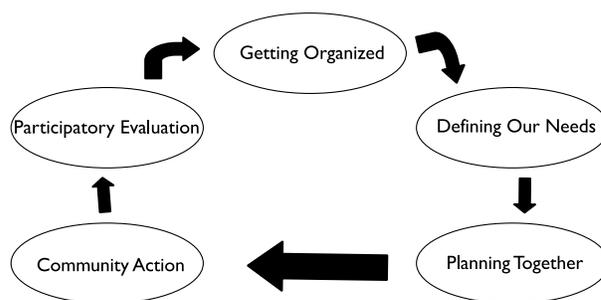


Key Elements of Community Mobilization

Citizenship
Communication
Community
Culture
Dialogue of knowledge
Education
Equity
Ethics
Gender
Health
Human Rights
Leadership
Mobilization
Participation
Power
Role of institutions

Save the Children's community-mobilization method starts with existing practices, reaffirming healthy practices, and negotiating "new, improved" practices when existing practices are harmful. Save the Children's Warmi (Quechua for "woman") Project in Bolivia utilized a "community action cycle" to improve maternal and newborn health, which focused on improving women's status and participation in community decision-making and action. Operating in the remote province of Inquisivi, Bolivia, the Warmi Project demonstrated that, with training and technical assistance, communities can identify and prioritize problems and develop community-based action plans to improve maternal and neonatal health outcomes. Additionally, the project trained community members in safe birthing techniques in case of obstetric emergencies. The project's pilot phase was so successful that it was scaled up nationally in Bolivia and has been adapted for use in other countries in Latin America, Africa, and Asia.

Trends toward decentralization and democratization require increased community-level decision-making, management, and control of resources. Engendering community-mobilization processes can strengthen community skills and increase marginalized groups' participation. Community-mobilization can also strengthen community members' skills and capacity to address the underlying causes of health problems and reduce barriers to access to information and services. Community mobilization also helps to develop shared responsibility and accountability for health between service providers and community members. Communities can mobilize resources that may not be available to the health system alone. They can also apply political pressure to improve services.





discussion

Think About it:

Are they Mobilizing, Participating, or just Showing-up?

Community is not necessarily determined by geographical boundaries. Nor do those who make up a community necessarily share common interests and characteristics. In fact, Alcoholics Anonymous (AA), which has been hailed as one of the most successful BCIs, defines “community” as fellow alcoholics. In the private sector, community mobilization is used to refer to a one-time event or “blitz” about a health or development issue, at which the community is present. Many in the NGO community define community mobilization as an empowering process—it is about the community coming together around a single issue in a long-term and sustainable process. If community members merely show up at meetings and then disband, is this considered participation? For some, this kind of participation is valuable because it opens the door to further participation, but it is not considered community mobilization in itself because it does not lead to long-term change. That which the private sector calls community mobilization, the NGO community considers community participation. Social mobilization, on the other hand, tends to deal more with what is sometimes referred to as “grass-tops” mobilization—mobilizing organizations that work with people at the community level and not the communities directly.

Client-Provider Interactions

Elaine Murphy
Senior Technical Advisor
PATH; and
Anne Wilson
Vice President
PATH

Dr. Elaine Murphy set the stage for Ms. Anne Wilson’s presentation by summarizing briefly the client-provider interactions (CPI) approach to successful family planning counseling. The CPI approach consists of six key processes noted in the accompanying box. In Ms. Wilson’s presentation, “When the C’ in CPI is an adolescent,” she commented that those involved in BCI have not done a good job applying what we know to more effectively reach adolescent clients. However, we are getting closer to understanding that many of the social behaviors of adolescents, primarily in the United States, are much more universal than we believed.

Key Processes in Client-Provider Interactions for Family Planning

- Treat the client well.
- Provide the client’s preferred contraceptive method.
- Individualize counseling.
- Aim for dynamic interaction.
- Avoid information overload.
- Use and provide memory aids.



discussion

Think About it:

“Being nice is being effective.”

Currently adolescents are 1/5 of the world population. They are not only our future but also our present. They fall into the following categories: are not yet sexually active, sexually active by choice or not by choice, married or in union, rural, urban, or refugees. Many adolescents think that adults want them to believe that sex is bad and abstinence is good. They often think that adults neither trust them nor believe they are able to make responsible choices. What adolescents really want from adults are answers to questions regarding the perplexing physical and emotional changes they are experiencing and sources to which they can turn for help.

Adults involved in BCI can more effectively address the concerns of adolescents, especially the primary question that adolescents ask themselves, “Am I normal?” by paying more attention to adolescents’ questions and feelings. Adults can also admit that they may be uncomfortable dealing with adolescent sexuality, albeit stressing that sexuality is a life-long issue and is positive. Let adolescents know that questions are good and help is available.

Using Niceness to Motivate Clients and Providers

The private sector spends a lot of money training staff to be nice to their clients or customers. In many public sector programs, however, we often find that client-provider interactions are poor and are often cited as a major barrier to the use of services and to behavior change. Some believe that the lack of emphasis on interpersonal communication and listening skills in the training of these providers is the problem. Better interviewing skills such as probing, observing, and listening could also be encouraged as could some empowering model of counseling. However, these are many skills to apply within the time-constrained environment of counseling. Is it realistic to expect public sector service providers in developing countries, who are often overworked and underpaid, to be motivated to be nice to people? Is niceness really a question of respect for human dignity? Is there anything we can do to encourage niceness in CPIs?



Mass Media

Doug Storey
Senior Research Officer
Johns Hopkins University
Center for Communications Programs (JHU/CCP)

Dr. Doug Storey re-titled his session “Mass Communication” to avoid the idea communicated by the forum agenda’s title, “Mass Media,” that only technology is being addressed. From a mass communication perspective, the main issues for behavior change programs are: (1) how information reaches and circulates within large groups of people; and (2) how that information is processed, understood, and responded to in the context of social groups, such as the family or the community. He illustrated these issues using the example of a behavior change project in Nepal, the Radio Communication Project (RCP).

The RCP project relied primarily on one form of mass communication—radio. In Nepal, radio is the most common source of health information. The project used a combination of radio-based activities to shift the concept of family planning away from a narrow focus on sterilization to a broader focus on planning for the well-being of one’s family and community. The components of the project included a weekly radio soap opera for the general public, which ran for one year; a bi-weekly distance education serial for health workers focusing on interpersonal communication and counseling (IPC/C); radio spots and jingles; formal district-level IPC/C training workshops; supplementary print materials; and community interactivity sessions which gave community members an opportunity to discuss the program with program officers and provide feedback. The radio distance education serial, originally intended only for health workers, proved to be so popular that

one in five members of the general public also listened to that serial.

The organizing theme of the project was to foster discourse. Messages emphasized the interaction between spouses about aspirations and needs and the interaction between women and men with the service providers in their community. To extend the value of the program for audiences with limited Nepali language skills, the project worked with Save the Children and CEDPA to develop RCP messages into storybooks for newly literate women and men. These were then distributed in tin-trunk libraries and through community action groups. In so doing, the project tried to answer the question: “Does indirect exposure make a difference in terms of behavior?”

The integrated project evaluation design included focus groups with clients and health workers; secondary analysis of 1991 Demographic Health Survey data; baseline and impact panel surveys of clients and health workers; pre- and post-tests of health worker knowledge, attitudes, and practices; community interactivity sessions with rural audiences; a clinic-based monitoring study of client-provider interactions; and analysis of feedback letters from listeners of both radio serials.

The distance education project increased health worker knowledge of family planning technical information and counseling skills. The use of client-oriented IPC/C skills by health workers also increased, as did client verbal participation and involvement in interactions with providers. The average number of positive provider IPC/C skills per interaction increased with exposure to the IPC/C workshops and the radio distance learning, as did the average number of positive client IPC behaviors per interaction. Both direct exposure (through listening to



the radio programs) and indirect exposure (through discussion of the programs with listeners) resulted in an increase in family planning behaviors such as discussing family planning with one's husband, current use of family planning, and met need for family planning.

The RCP project shows that, of the various forms of mass communication, radio in particular has potential to engage communities and families in the development process. Through the use of community-based and clinic-based messages, radio can foster discourse in the family, among friends and neighbors, and between clients and providers. This discourse, in turn, leads to more informed decision-making by members of the community. Besides the obvious effectiveness of a well-designed radio program, radio—unlike some other mass media like television—is relatively low cost, requires relatively little technical training to operate, and does not require audiences to be literate. These characteristics create not only better opportunities for information dissemination, but opportunities for greater public involvement in community health and health communication. This makes radio an ideal medium for community-mobilization projects that aim to increase community participation in development.

Evaluation of Behavior Change Interventions

Asha Mohamud

Senior Program Officer

PATH;

Doug Storey

Senior Research Officer

Johns Hopkins University

Center for Communications Programs (JHU/CCP); and

Ricardo Wray, Evaluation Specialist

Annenburg School of Communication

Drs. Asha Mohamed and Doug Storey and Mr. Ricardo Wray led participants through two group exercises to examine issues involved in the evaluation of BCIs. The first was designed to address the needs of the various constituencies (community members, grantees, and donors) in designing and implementing evaluation. The second addressed the need for observable, measurable indicators for empowerment which is a very important issue for participatory community change but often left out of evaluations.

In the first exercise, the facilitators broke participants into three groups (donors, grantees, community members) and asked them to brainstorm responses to the following question: "What do you want to get out of the evaluation?" Responses from each group follow:

COMMUNITY MEMBERS

- More development assistance
- New opportunities
- Increased prestige/recognition
- Solutions
- New skills



GRANTEES

- ❑ Results from evaluation process that are programmatically meaningful
- ❑ Measures of qualitative and quantitative gains
- ❑ To know whether we're doing the right things to achieve our objectives and goals
- ❑ To determine if the implementation process is correct
- ❑ To learn lessons that can be applied in future work
- ❑ To avoid withdrawal of funding

DONORS

- ❑ To know if the project's objectives have been met. If not, why not? If so, how?
- ❑ To determine whether there is a plausible association between activities and outcome
- ❑ To justify the investment to the public
- ❑ To determine the project's contributions to the larger field
- ❑ To gather input into decision-making for future funding and policies

Processing this exercise, the facilitators noted the points of convergence among the suggestions by all three constituencies. Evaluation should respond to the needs of all three groups and be conducted through meaningful collaboration between these groups. Additionally, it was emphasized that project designers and implementers should be very specific about the project's behavioral goals to be achieved and share this information with evaluators and donors.

In terms of behavior change, evaluation has to determine if the intended changes in behavior occurred and also assess if these changes represent what we can agree on is empowerment. The empowerment concept is complex and multifaceted and it means

different things to different constituencies, nevertheless it is often used for rhetorical purposes as a global concept. As a global concept, it is virtually impossible to evaluate reliably. Therefore, an important first step in the evaluation of empowerment is to break the concept down into separate observable components that represent what different constituencies or perspectives hope to achieve through empowerment. It is likely that not all of these components will be relevant or measurable in every empowerment project, but discussion about the evaluation of empowerment will be more productive if we can approach it as a related set of measurable concepts rather than as a global rhetorical concept. The use of multiple measures representing different aspects of empowerment, then makes it easier to talk in concrete terms about how various factors come together to result in greater capacity or opportunity for community-level participation in social change. This move will also make it easier to develop generalizable models (e.g., which factors are important under which conditions?).

Evaluation is often the first item to be slashed from BCI budgets—leaving the successes of worthy interventions to anecdotal information. While this issue is gaining increased recognition from both donors and program implementers, the empowerment aspects of BCIs are less recognized and evaluated. Indicators of success for empowerment either do not exist or are not well known to program implementers and evaluators of BCIs.

With this in mind, the second group exercise was to examine the evaluation of behavioral aspects of empowerment, that is, what people are actually doing that indicates they are empowered.



Facilitators asked participants to identify some possible, specific, observable outcome indicators of empowerment and then to identify one, concrete, observable aspect of empowerment they would like to be able to evaluate. The facilitators provided the following example:

In terms of behavior change, evaluation has to both determine if these things happened and draw the conclusion that empowerment has occurred as a result. It is essential to desegregate these factors because each is a separately observable variable. Many of the things we desire to happen will occur to varying degrees but they must occur in combination if we are to conclude that empowerment has taken place. We need to

Determining Measurable Indicators of Empowerment

A community organization has diverse representation, has prepared plans, and implements the plans. Is this an empowered community? What are some of the behaviors in this situation?

- Process of organizing*—people come together as a body with a joint purpose. Example of a measurable indicator: Are meetings held among constituents in the community for the purpose of planning?
- Process of creating a diverse representation*—identifying the different people/diverse groups and recruiting them. Representation in a group can be evaluated—did it occur and to what extent did it occur? Example of a measurable indicator: How many of the different (potential) constituencies are represented in planning meetings and in what proportion?
- Process of decision-making*—programmatic decisions are made jointly by representatives of the various constituencies. Example of a measurable indicator: plans/decisions for a program are prepared in the form of a consensus document of which all relevant constituencies are signatories.
- Process of implementing the plan*—to what degree has the plan been implemented in a participatory manner? Examples of measurable indicators: At the end of a specified period of time, how many of the jointly agreed to activities have been carried out? How many of the different constituencies were involved in the implementation process? How evenly distributed across constituencies was responsibility for implementation activities?



develop some consensus of the components of empowerment and of valid, observable measures of empowerment.

Indicators to measure empowerment are often context-specific. Illustrative examples of some indicators of women's empowerment in Bangladesh (Schuler and Hashemi, 1994) include:

- Political and legal awareness
- Involvement in major decisions affecting the household
- Mobility
- Freedom from family domination and violence within the household
- Economic security
- Ability to make purchases
- Participation in political activities

Illustrative indicators of community empowerment include:

- Attitudinal dimensions; e.g. self-efficacy, collective efficacy, intent to change, etc.
- Consciousness dimensions; e.g. awareness of the extent of the problem, awareness of other agencies, organizations' activities and commitments to action.
- Skill dimensions; e.g. advocacy, how to access information, how to use the media, how to lobby decision-makers, how to lead, how to plan, how to take action, etc.
- Structural dimensions; e.g. resource distribution, composition of decision-making groups, participation in decision-making, organizational structures, organizational networks, organizational practices.

(From P. Hawe (1994) summary of work of M. Minkler (1990), Gruber and Trickett (1987), Heller (1989), Swift and Levin (1987), Biegel (1984), immerman and Rappaport (1988), immerman (1990), Craig and Maggiotto (1982), Gordon (1985), Friere (1973), Balcazar (1990)).

discussion

Think About it:

Donors versus Communities and Process versus Outcome

Does it not behoove donors, grantees, and communities to work collaboratively? After all, we all seek a common goal—the success of a project. It is the means to achieving that goal, the milestones along the way, and the indicators of success that differ. Surely a project design that incorporates all concerns would be the most comprehensive. The centrality of community-driven and designed projects sometimes conflicts with a donor's requirements for funding. Many donors, due to their own mandates, are focused on product/outcome rather than on process. Yet, the process is often as important or more so than the outcome. There is a need to conduct process-oriented social development and to identify resources with which to do so. This means challenging donors to allocate funds for the exploration of creative ways to do process-oriented social development.

PARTICIPANTS' RECOMMENDATIONS FOR THE NGO NETWORKS FOR HEALTH BCI APPROACH



Recommendations for the *Networks* approach were gleaned from the presentations, the discussions, and the “Search for the Pearls” exercises. The key ones are as follows:

Fully involve the community in behavior change efforts

- ❑ *Networks* should state goals to the community at the onset of a BCI.
- ❑ *Networks* should stay focused on goals and work with the community to realize these goals.
- ❑ *Networks'* BCI approach should be a process through which the desired behavioral objective or result is identified in a participatory and empowering way.
- ❑ The approach should include participatory and learning processes that permeate all levels of the program.
- ❑ *Networks'* technical approach should have a BCI framework using participatory social change and advocacy strategies and not be limited to IEC.
- ❑ *Networks'* assumptions about change should be made explicit and should be modified in consultation with all partners, including the community.
- ❑ The approach should use self-assessment of community participation.
- ❑ The approach should recognize that the community can offer expertise and solutions.
- ❑ The approach should involve stakeholders in design and implementation of BCIs, including the development of monitoring and evaluation indicators.
- ❑ The approach should include community determination of empowerment indicators.

- ❑ The approach should incorporate community-mobilization processes that facilitate behavior change, especially when paired with other strategies.
- ❑ The approach should be predominantly community-oriented or -driven, with elements of marketing, disease control, and ideology.
- ❑ *Networks* should value local knowledge and encourage an open listening process to determine the priorities of the people.

Consider the contextual factors influencing behavior change

- ❑ *Networks* should consider the individual, group, community, and cultural context, and the interaction among these, when developing BCIs.
- ❑ The approach should address context as much or more than the individual.
- ❑ *Networks* should plan strategically to acknowledge and respond to local cultural factors, including family and societal relationships that inhibit or facilitate desired behavior change.
- ❑ The approach should understand and build on cultural strengths rather than constraints and build programming on this foundation.
- ❑ The approach should take an appreciative stance towards traditional beliefs and practices.
- ❑ *Networks* should learn about and develop communication strategies that build on naturally occurring informal social networks (in a non-manipulative way).



**Recognize and respect the
community-based origin of demand
for behavior change**

- ❑ *Networks* should promote behavior change that is linked to existing demand and not necessarily *Networks'* own behavioral objectives.
- ❑ The approach should select the most crucial starting point/focus (the gap), and find the intervention that makes a difference.

**Ensure that behavior change
interventions allow people to
empower themselves in the process**

- ❑ *Networks* should make empowerment the most important outcome; changing health behavior is secondary.
- ❑ The approach should recognize that empowerment is not just a means to a health gain but a fundamental component of the development process.
- ❑ The approach should focus on strategies that promote empowerment.
- ❑ The approach should recognize the difference between participatory strategies and truly empowering strategies.
- ❑ *Networks* should work with women's groups to share information about women's rights. Adopting the human rights perspective often leads to women's collective self-empowerment and activism.

CONCLUSION AND FOLLOW-UP ACTION



The purpose of the *Networks* BCI Forum was to initiate discussion about the different approaches to behavior change among PVOs and other participating organizations and accordingly, to inform the *Networks*' BCI approach. As with behavior change itself, this discussion is an ongoing and dynamic process. It will include a series of activities, meetings, and case studies to inform and further define and refine the BCI approach, especially as it relates to the mix of approaches such as community mobilization, advocacy, and marketing.

Behavior Change is...

...part of a process of social change, not an outcome in itself. The overall goal of behavior change is empowered individuals whose behavior results in healthful outcomes that have been self-identified. The process of behavior change is an empowering process for all those involved. In BCIs, community members have a key and participatory role from the onset. The need for behavior change and the BCI's behavioral result should be identified by the community. The role of outside expertise in BCI is to introduce new ideas, listen respectfully, facilitate a participatory process, and provide the tools necessary to achieve behavior change, such as techniques of mass communication, community mobilization, marketing, and skill-building of community groups and individuals.

Synthesized from all of the very rich presentations and participant discussion, the accompanying statement about behavior change and BCIs emerges. It reflects the sentiment exhibited during the forum and touches on many of the issues with which forum participants grappled. Surely, these will arise again in continued dialogue.

Results from participants' evaluations of the forum were very positive. Participants felt that the forum established a positive space for dialogue and critical thinking. They also felt that the forum achieved its objective to recommend a BCI approach for *Networks*.

In general, sharing was the most valuable part of the forum. There was an overall feeling that two days was too short a time to sufficiently address the topics in their full richness. A majority of participants appreciated the interactive small group discussions and would have preferred more time for discussion. They also appreciated the nuances of the private-sector perspective on behavior change and information about cultural paradigms. They noted the enlightening moments when PVO ideals bumped into field realities and the unexpected overlap between the IMC and the community-organization approaches to behavior change.

Rated "least valuable" by participants were concerns such as the distribution of copies of presenters' remarks and the temperature of the meeting room.

Evaluations also provided recommendations to improve future meetings. Among these were:

- Hold longer meetings with shorter presentations to allow for more in-depth discussion.
- Incorporate more small group work and case study analysis.



-
- ❑ Secure representation of other specialty fields such as service delivery and organizational development.
 - ❑ Include project field staff as participants.
 - ❑ Provide preparatory materials in advance.

Overall, participants complimented organizers and presenters on a job well done. In the commentary provided in the evaluation, participants repeatedly emphasized the need for continued examination and in-depth analysis of BCI and related themes, and the need for synthesis of the newly discovered building blocks of the BCI approach. It is hoped that this report addresses the latter suggestion and that future dialogue, incorporating participants' suggestions, will satisfy the former.

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**DAY ONE:
WEDNESDAY, APRIL 7, 1999**

- 8:30 **Conference Registration**
Coffee/Tea, Continental Breakfast
- 9:00 **Welcome**
Anne Wilson, Vice President, PATH and Chairperson, Networks Partnership Council
Betsy Bassan, Director, NGO Networks for Health
- 9:10 **Behavior Change Forum Background and Context**
Premila Bartlett, Behavior Change/Communications Advisor, NGO Networks for Health
- 9:20 **Icebreaker and Introductions**
Don Graybill, Institutional Development Advisor, NGO Networks for Health
- 9:35 **Behavior Change Forum Goals and Agenda**
Don Graybill, Institutional Development Advisor, NGO Networks for Health
- 9:45 **The Behavior Change Continuum (Group Exercise)**
Don Graybill, Institutional Development Advisor, NGO Networks for Health
- 10:00 **Setting the Stage**
Dana Faulkner, AED, Director, CHANGE Project
- 10:30 **Break**
- 10:45 **Behavior Change Theories**
John Strand, AED, Technical Advisor for Social Marketing
Julia Rosenbaum, AED, Deputy Director, CHANGE Project
- 11:45 **Health and Culture: Beyond the Western Paradigm**
Collins Airhihenbuwa, Associate Professor of Behavioral Health, Pennsylvania State University
- 12:30 **Lunch**
- 1:30 **Bridging the KAP GAP**
Everold Hosein, Senior Counselor, Social Development, Burson-Marsteller
Asha Mohamud, Senior Program Officer, PATH
- 2:30 **Whose Knowledge Counts?**
Stan Yoder, Qualitative Research Specialist, MACRO International
- 2:50 **Break**
- 3:00 **Advocacy**
Jodi Jacobson, Co-Director, Center for Health and Gender Equity
- 3:30 **Empowerment and Behavior Change**
Lisa Howard-Grabman, Community Mobilization Specialist, Save the Children
Nancy Russell, Senior Advisor for Community Development, CEDPA, ENABLE Project
- 4:15 **Guidelines for Action in Designing and Implementing Behavior Change Interventions Group Work**
Premila Bartlett, Behavior Change/Communications Advisor, NGO Networks for Health
Don Graybill, Institutional Development Advisor, NGO Networks for Health
- 5:15 **Day I Summary, Conclusions, Evaluation**
- 5:30 **End of Day I**



**DAY TWO:
THURSDAY, APRIL 8, 1999**

- 8:30 **Coffee/Tea, Continental Breakfast**
- 9:00 **Overview of Day's Activities**
- 9:05 **Guidelines for Action in Designing and Implementing Behavior Change Interventions in Behavior Change (continued)**
Conclusion of Group Work from Day 1 Afternoon
Small Group Report-Outs from Day 1 Afternoon
- 10:30 **Break**
- 10:45 **Community Mobilization**
Everold Hosein, Senior Counselor, Social Development, Burson-Marsteller
Lisa Howard-Grabman, Community Mobilization Specialist, Save the Children
- 11:25 **Client-Provider Interactions**
Elaine Murphy, Senior Technical Advisor, PATH
Anne Wilson, Vice President, PATH
- 11:55 **Mass Media**
Doug Storey, Senior Research Officer, JHU/CCP
- 12:20 **Summary Comments**
- 12:30 **Lunch**
- 1:30 **Evaluation of Behavior Change Interventions**
Asha Mohamud, Senior Program Officer, PATH
Doug Storey, Senior Research Officer, JHU/PCS
Ricardo Wray, Evaluation Specialist, Annenberg School of Communication
- 2:30 **Guidelines on NGO Networks' Technical Approach to Behavior Change Interventions**
Don Graybill, Institutional Development Advisor, NGO Networks for Health
Premila Bartlett, Behavior Change/Communications Advisor, NGO Networks for Health
Small Group Work
Report-Outs
Summary Discussion
- 3:15 **Break**
- 3:30 **Small Group Report-Outs and Discussion**
- 4:10 **Summary Comments**
- 4:25 **Towards Refining the NGO Networks' Technical Approach to Behavior Change Interventions**
Don Graybill, Institutional Development Advisor, NGO Networks for Health
Premila Bartlett, Behavior Change/Communications Advisor, NGO Networks for Health
- 5:00 **Keeping the Momentum: Post-Forum Next Steps**
- 5:15 **Final evaluation, feedback**
- 5:30 **Close of workshop**



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