



**USAID**  
FROM THE AMERICAN PEOPLE

UNITED STATES AGENCY FOR INTERNATIONAL DEVELOPMENT  
BUREAU FOR GLOBAL HEALTH  
OFFICE OF HEALTH, DISEASE, AND NUTRITION USAID/GH/HIDN

**CHILD SURVIVAL AND HEALTH GRANTS  
PROGRAM (CSHGP)**

**TECHNICAL REFERENCE  
MATERIALS**

**2010**

**Behavior Change Interventions**

MCHIP is funded by the United States Agency for International Development, Bureau for Global Health's Office of Health, Infectious Diseases and Nutrition, Cooperative Agreement # GHS-A-00-08-00002-000. For further information on the Maternal and Child Health Integrated Program (MCHIP), please contact: ICF Macro International, 11785 Beltsville Drive, Calverton, Maryland 20705 (301) 572-0823 • Email: [csts@macrointernational.com](mailto:csts@macrointernational.com) • Internet: [www.childsurvival.com](http://www.childsurvival.com)

# Table of Contents

<b>Abbreviations and Acronyms .....</b>	<b>iv</b>
<b>Introduction to the Technical Reference Materials.....</b>	<b>vii</b>
New Additions to the Behavior Change Interventions Module: .....	viii
<b>Social and Behavior Change Interventions .....</b>	<b>1</b>
Steps for Incorporating a Social and Behavior Change Approach into Program Design and Implementation.....	2
Step 1: Understanding the context through situation & communication analysis .....	4
<i>Using Formative Research.....</i>	5
<i>Comprehensive Behavior Change Approach .....</i>	5
<i>The Right Tool for the Job: Choosing Activities that Address Identified Benefits and Barriers .....</i>	8
<i>Conducting Assessments for Planning Behavior Change Interventions (BCI) Strategies: Methods That Answer Key Questions .....</i>	10
<i>Common Behavior Change Determinants.....</i>	11
Step 2: Focusing & Designing the Communication Strategy .....	14
<i>Moving Toward a Social and Behavioral Approach: Restate Objectives in Behavioral Terms .....</i>	14
<i>The Behave Framework for Program Planning.....</i>	16
<i>Important Factors .....</i>	18
<i>Strengthening Health Systems to Promote Change.....</i>	18
<i>Encouraging Behavior Change at Community Level.....</i>	18
Step 3: Creating Interventions & Materials for Change .....	19
Step 4: Implementing & Monitoring Change Processes.....	19
Step 5: Evaluation & Re-planning .....	21
<b>References and Resources .....</b>	<b>23</b>

# Abbreviations and Acronyms

ACTs	Artemisinin-Based Combination Therapies
AFP	Acute Flaccid Paralysis
AI	Appreciative Inquiry
AIDS	Acquired Immuno-Deficiency Syndrome
AMTSL	Active Management of the Third Stage of Labor
ANC	Antenatal Care
ARI	Acute Respiratory Infection
ART	Antiretroviral therapy
ARVs	Antiretroviral drugs
BCG	Bacille Calmette-Guerin
BCI	Behavior Change Interventions
BHR	Bureau for Humanitarian Response
CA	Collaborating Agency
CBD	Community-Based Distributor
CDC	Centers for Disease Control
CDD	Control of Diarrheal Disease
CHW	Community Health Worker
CORE	Child Survival Collaborations and Resources Group
CORPS	Community Oriented Resource Persons
CQ	Chloroquine
CSHGP	Child Survival and Health Grant Program
CSTS+	Child Survival Technical Support
CYP	Couple-Years of Protection
DHS	Demographic and Health Survey
DIP	Detailed Implementation Plan
DOSA	Discussion-Oriented Self-Assessment
DOT	Directly Observed Therapy/Direct Observation of Treatment or Therapy
DOTS	Internationally recommended strategy for TB control consisting of 5 components (originally Directly Observed Therapy, Short-course, although current DOTS strategy is much broader now than these two concepts)
DPT	Diphtheria-Pertussis-Tetanus
DST	Drug susceptibility testing
DTP	Diphtheria-Tetanus-Pertussis vaccine [N.B. International terminology has now shifted so that the convention is to use DTP rather than DPT.]
EBF	Exclusive Breastfeeding
EMNC	Essential Maternal and Newborn Care
EmOC	Emergency Obstetric Care
EOC	Essential Obstetric Care
EPI	Expanded Program on Immunization
FE	Final Evaluation
FP	Family Planning
GAVI	Global Alliance for Vaccines and Immunization
GDF	Global Drug Facility
GEM	Global Excellence in Management
GFATM	Global Fund for AIDS, Tuberculosis, and Malaria
GIVS	Global Immunization Vision and Strategy
GLC	Green Light Committee

HB	Hepatitis B
HI	Hygiene Improvement
Hib	Haemophilus influenzae type b
HIF	Hygiene Improvement Framework
HFA	Health Facility Assessment
HIS	Health Information System
HIV	Human Immuno-deficiency Virus
HQ	Headquarters
HR	Human Resources
ID	Intravenous Drug
IEC	Information, Education and Communication
IMCI	Integrated Management of Childhood Illnesses
IMPAC	Integrated Management of Pregnancy and Childbirth
IPCC	Interpersonal Counseling and Communication
IPT	Intermittent Preventive Treatment
IPTp	Intermittent Preventive Treatment in pregnancy
IR	Intermediate Results
IRS	Indoor Residual Spraying
ISA	Institutional Strengths Assessment
ITM	Insecticide-Treated Material
ITN	Insecticide-Treated Nets
IUATLD	International Union Against Tuberculosis and Lung Diseases
IUD	Intrauterine Device
IYCF	Infant and Young Child Feeding
KPC	Knowledge, Practice, and Coverage Survey
LAM	Lactational Amenorrhea Method
LBW	Low Birth Weight
LQAS	Lot Quality Assurance Sampling
M&E	Monitoring and Evaluation
MCE	Multi-Country Evaluation
MCH	Mother and Child Health
MDR-TB	Multidrug-Resistant Tuberculosis (resistance to at least rifampin and isoniazid)
MIS	Management Information System
MNHP	The Maternal Neonatal Health Program
MOH	Ministry of Health
MPS	Making Pregnancy Safer
MTCT	Mother-to-Child Transmission
MTCT/HIV	Mother-to-Child Transmission of HIV
MTE	Mid-Term Evaluation
NACP	National AIDS Control Program
NGO	Non-Governmental Organization
NIDS	National Immunization Days
NMCP	National Malaria Control Programs
NMR	Neonatal Mortality Rate
NTP	National Tuberculosis Program
OPV	Oral Polio Vaccine
OR	Operations Research
ORS	Oral Rehydration Solution
ORT	Oral Rehydration Therapy
PAHO	Pan American Health Organization
PEPFAR	President's Emergency Plan for Aids Relief

PHC	Primary Health Care
PLA	Participatory Learning and Action
PMTCT	Prevention of Mother-to-Child Transmission
PVC	Office of Private and Voluntary Cooperation
PVO	Private Voluntary Organization
QA	Quality Assurance
QI	Quality Improvement
RED	Reaching Every District
RBM	Roll Back Malaria
RDT	Rapid Diagnostic Test
RFA	Request for Applications
RTI	Reproductive Tract Infection
SBA	Skilled Birth Attendance
SBCC	Social and Behavior Change Communication
SCM	Standard Case Management
SDM	Standard Days Method
SIAs •	Supplementary Immunization Activities
SNL	Saving Newborn Lives Initiative
SP	Sulfadoxine-Pyrimethamine
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
TB	Tuberculosis
TBA	Traditional Birth Attendant
Td	combination of Tetanus toxoid and a reduced dosage of diphtheria
TRM	Technical Reference Materials
TT	Tetanus Toxoid
USAID	United States Agency for International Development
VA	Vitamin A
VAD	Vitamin A Deficiency
VCT	Voluntary Counseling and Testing
VVM	Vaccine Vial Monitor
WHO	World Health Organization
WRA	Women of Reproductive Age

Caretaker: An individual who has primary responsibility for the care of a child. Usually, it is the child's mother, but could also be his or her father, grandparent, older sibling, or other member of the community.

# Introduction to the Technical Reference Materials

The Technical Reference Materials (TRMs) are a product of the Bureau for Global Health, Office of Health, Infectious Disease, and Nutrition Child Survival and Health Grants Program USAID/GH/HIDN/CSHGP. This document is a guide (not an authority) to help you think through your ability and needs in choosing to implement any one technical area of the Child Survival and Health Grants Program. An attempt has been made to keep the language simple to encourage translation for use as a field document.

The TRMs are organized into modules that correspond to the primary technical areas and key cross-cutting areas that are central to the Child Survival and Health Grants Program. Each module is designed to reflect the essential elements to be considered when implementing the given intervention or strategy, important resources that grantees should consult when planning their interventions. Grantees are encouraged to download the specific modules that are most relevant to their proposed programs, or to download the entire package of TRM modules as a zipped file. The TRMs presently include the following modules:

## Technical Areas

- Family Planning and Reproductive Health
- Maternal and Newborn Care
- Nutrition
- Immunization
- Pneumonia
- Diarrheal Disease Prevention and Control
- Malaria
- Tuberculosis
- Childhood Injury and Prevention

## Cross-cutting Areas

- Capacity Building
- Sustainability
- Program and Supply Management
- Behavior Change Interventions
- Quality Assurance
- Monitoring and Evaluation
- Integrated Management of Childhood Illness (IMCI)
- Health System Strengthening

The present TRMs are regularly reviewed and updated with input from technical specialists in the USAID Collaborating Agency (CA) community, CORE Working Groups, and USAID technical staff. The date of revision of each specific TRM module can be found at the bottom of each page of the module. The TRMs are updated regularly to ensure that they remain up to date and reflect current standards relevant, and useful to the PVO community. With this in mind, we ask that each user of this document over the next year please keep notes and inform us on the usefulness of these references, information that should be amended or changed, additions and subtractions, and general comments. This will help us keep this document alive and responsive to your needs throughout the life of your programs. Please share comments and any (electronic) translated copies with Michel Pacqué at MCHIP, [mpacque@mchip.net](mailto:mpacque@mchip.net).

CSTS is grateful for the many contributions and reviews by staff of the different Offices of the Bureau of Global Health, and many of their collaborating agencies, the CORE working groups and most of all to our PVO partners who continue to use this guide and provide valuable insight on how to improve it.

## **New Additions to the Behavior Change Interventions Module:**

The 2007 edition of the Behavior Change Interventions Technical Reference Material was updated slightly, utilizing the most recent research and guidance on strategies to improve behavioral change strategies within Child Survival and Health projects.

The 2010 edition of this document was updated again to reflect the repeated request for strategies to go beyond individual behavioral change strategies and to address social change.

The document now reflects the “6 Steps for Incorporating a Social and Behavior Change Approach into Program Design and Implementation” used by the C-Change project.

# Social and Behavior Change Interventions

Social and behavior change through the development of an evidence based strategy is essential to improving maternal, child, family, and community health. Selection and implementation of an appropriate set of social and behavior change interventions can help directly to improve a wide range of family care-giving and care-seeking practices, and enhance supportive environments for improved household health practices at community, institutional and policy levels. In addition social and behavioral change interventions can help improve the interaction between health service providers and community members as well as address advocacy and policy issues affecting the issue at hand.

## Essential Elements

- Address multiple levels to influence social and individual behavior change
- Use both qualitative and quantitative information to assess current behaviors and influencing factors
- Work from the community's perspective

Individual, family and community health outcomes are influenced by many factors. A comprehensive approach to social and behavior change recognizes that individual behavior change does not result from improved knowledge alone, and cannot be promoted in isolation from the broader social context in which it occurs. A social and behavior change approach explores the full range of factors that must be addressed at multiple levels to promote change, including behavioral changes effectively. These levels include: mothers and other caregivers; partner, families; communities; products, health services and systems and the policy environment. A standardized, step-by-step process is used to assess current social and behavioral factors that are barriers or incentives to people practicing them, propose key structures, policies or behaviors for change, and work with individuals, families, communities, health systems, and policymakers to develop effective, feasible behavior change interventions aimed explicitly at these factors.

A social and behavior change approach uses both a planned approach and uses a socio-ecological model to determine what type of change is needed. The model acknowledges four key facts about human behavior:

1. People make meaning of information based on their own context;
2. Culture and networks influence people's behavior;
3. People can't always control the issues that create their behavior; and,
4. People are not always rational in deciding what is best for their health and well-being.

This model helps shift our conceptual thinking about social and behavior change to a more holistic level. A Socio-Ecological Model for Change views individual behavior as a product of multiple, overlapping social and environmental influences. It shows how an individual (self) is influenced by family, peers, and community. It also shows other "rings of influence" on the individual: information, motivation, ability to act, and enabling environment, all of which can influence change. This Socio-Ecological Model for Change implies that programs should not only focus exclusively on individual change, but must aim to influence the social context in which the individual operates. The model also underscores the need to expand beyond ad hoc interventions to a coordinated social movement

Social and behavioral change communication applies three key strategies to be effective. These key strategies are advocacy, social mobilization including community mobilization and behavior change communication. By broadening the planning “lens” to a social and behavior change approach, individual behavior change communication becomes just one of several available strategies for social change. Sometimes information conveyed through education or behavior change communication will be critical to changing behaviors, but often other factors are also important, such as availability of products and services, national policies, or community support mechanisms. Focusing on the goal - social change - takes into consideration that both individual and group behavior change are more likely to take place within a supportive environment that results from interventions at multiple levels. Taking time to identify how best to influence structures, policies, social norms or target behaviors can increase program effectiveness.

The social and behavior change approach is a systematic process for analyzing a problem from various sides in order to define key barriers to change and for planning and implementing a comprehensive, strategic set of interventions and activities that focus on these barriers at multiple levels to achieve a health objective.

This document concentrates on what PVOs need to do to develop an effective social and behavior change strategy.

## **Steps for Incorporating a Social and Behavior Change Approach into Program Design and Implementation**

### **1. Understanding the Context through situation & communication analysis**

Review existing literature; identify information gaps relating to the structures, norms and behaviors that effect project outcomes.

Plan and conduct pre-implementation or formative research in order to fill information gaps. Choose from a variety of techniques (see Examples of Research Methodologies on page 14).

Analyze research results; develop a problem statement and include how communication or other interventions can address the desired change: agree on key structures, norms or behaviors to change and types of interventions required at each level.

### **2. Focusing & Designing the Strategy**

Formulate a comprehensive multilevel social and behavior change strategy, including the selection of relevant (communication) objectives and interventions needed to carry-out the strategy. These may include a communication component, links to training, improved quality of and access to services, products, policy change etc.

Include stakeholders to design an advocacy strategy to support policy changes as indicated by research.

(The BEHAVE framework helps program planners organize information needed to complete this step. See p. 17).

### 3. **Creating Interventions & Materials for Chang**

This step focuses on the creation communication materials and activities. Projects will have to produce, pretest and finalize intervention support materials: print and electronic communication materials, training designs, improved services, products, management and logistics as indicated by results of pre-implementation research.

Before creating anything new, we strongly suggest, as first step in creating project specific Social and Behavior Change Communication (SBCC) materials, doing an inventory to see what already exists.

### 4. **Implementing & Monitoring Change Processes**

Work with communities to negotiate, and implement activities to change social norms and behaviors and address barriers.

Work with authorities, partners and stakeholders to improve policies, quality of and access to services, management, logistics and other barriers.

Launch and implement communication interventions, conduct training, introduce and promote improved services and product(s), policy changes.

### 5. **Evaluation & Re-planning for Outcome and Sustainability**

Monitor and refine interventions throughout implementation phase, evaluate, and report.

For more details see also: <http://c-changeprogram.org/our-approach/capacity-strengthening/sbcc-modules>



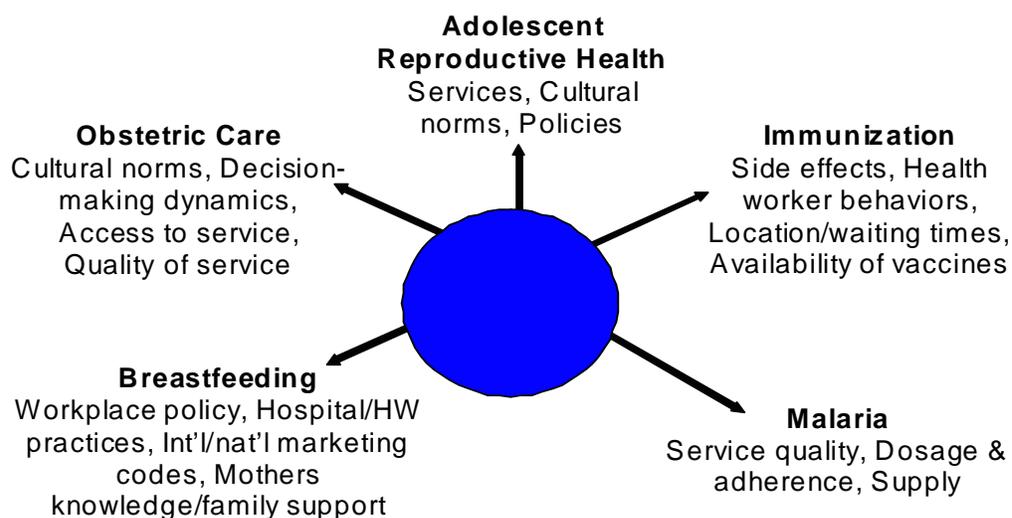
## Step 1: Understanding the context through situation & communication analysis

When taking a comprehensive social and behavior change approach, program planners need to consider and decide how to find answers for these four key decisions:

- **What structures, and whose social norms, or behaviors** need to change to bring about the desired health outcomes? (Parent’s; neighbors’; health workers’; Polity makers’?) Who is your audience?
- **What do you want to help them to do?** Is it technically correct? Is it feasible, can they do it? Is it effective?
- **Why aren’t they doing it now?** How can you best influence and support those behaviors? What barriers exist to people adopting an improved behavior? Consider both internal and external barriers. What incentives, what factors (in the broadest sense) exist that would help motivate people to change their behavior? Why are some people currently doing it and others not? What makes the difference?
- **What activities can you include in your program that would help you to address those factors** that you’ve identified as most influential in changing the behavior? Do you need materials to support those activities? Products?

The figure below provides some examples of factors influencing several of the health emphasis behaviors. *This chart is illustrative and does not apply to all audiences in all contexts.* It shows the range of factors (individual and within the “enabling environment”) and audiences that need to be addressed to see changes in key health-related behaviors.

### Illustrative List of Factors Influencing Key PVO Health Objectives



## ***Using Formative Research***

Information is needed to make the four planning decisions essential to any social and behavior change approach (Whose behavior? What do you want to help them to do? Why aren't they doing it now? What activities to include in your program?) Sometimes relevant information has already been collected and is available. A thorough review of the available literature will help to identify what is known about behavior and gaps in knowledge. New research may be required to fill in the gaps and give a more complete picture of the target behavior. Research that helps to plan or form an intervention is commonly referred to as formative research or intervention research, and is a critical/essential step in program design. Research results help program planners understand the feasibility of the behaviors they hope to promote from the point of view of the target audience whose behaviors are expected to change as a result of the program. Using formative research tools to understand the context of behavior contributes greatly to what can be learned from existing DHS/KPC data or from what the health facility/project staff feel are the existing barriers/benefits/key factors to improving behavior to achieve improved health outcomes.

Formative research will help program planners to—

- Understand the behaviors, benefits, barriers, and social context from the point of view of the target audience, rather than from that of the program planners and implementers;
- Give a clear sense of priority audiences and meaningful audience segments;
- Identify feasible and effective behaviors to promote;
- Clearly specify which factors influence those behaviors;
- Explore the issue of at what levels to focus program activities—individual, community, health system or other institution and/or policy;
- Identify preferred channels of communication.

For each behavior and audience planners should assess the range of contributing individual, family, community, health system, and policy factors that influence healthy outcomes BEFORE determining tactics or planning activities. Once the most important factors influencing behavior are identified through formative research, planners can develop activities at the various levels that best address these factors.

A behavior change approach, based on the results of your research, integrates findings from assessments to define priority behaviors for change, identify factors influencing these behaviors, define critical target audiences, and suggest a core set of behavior change intervention.

## ***Comprehensive Behavior Change Approach***

A comprehensive behavior change approach focuses on exploring factors that influence social and behavior change at multiple levels—among individuals, family and community influentials, health care providers, and policymakers—to devise a maximally effective behavior change strategy. The table below gives an example of one set of social norms and behaviors—appropriate “caretaking” in the household—that involve many intermediate outcomes. The third

column of the table shows the many factors that can affect these intermediate outcomes and the fourth column lists possible behavior change interventions that might be considered.

Program planners can also consult a number of useful training materials that provide additional examples of behavior change strategy matrices, such as the BEHAVE training materials (*Applying the BEHAVE Framework*), and training reports from Cambodia, South Africa and Mali. (See also our list of references at the end of this document—and consult the CORE Web site: <http://www.coregroup.org/component/content/article/111>.)

#### Example of Levels of an Intervention to Improve Caregiving in the Household

Level of Influence	Desired Intermediate Outcome	Areas of Assessment—(Factors) to Consider	Potential BC Interventions
Individual (chief caregiver)	Improved household “caregiving”  Increased knowledge, altered attitudes and beliefs; modified behaviors  Improved self-efficacy; improved links to household and community resources	Knowledge, predisposing, reinforcing, enabling factors (PRECEDE Model)  Perception of risks and consequences  Perceived severity  Personal self-efficacy  Personal networks  Resource distribution and access	Communication such as— <ul style="list-style-type: none"> <li>• Face-to-face, or group training and counseling</li> <li>• Mass media, community media</li> <li>• Events</li> <li>• Centralized information and referral</li> </ul> Non-communication interventions such as— <ul style="list-style-type: none"> <li>• Distribution, promotion or subsidizing of services</li> <li>• Community mobilization</li> </ul>
Family— household (other members of household and extended family)	Improved household caregiving (as alternate caregivers)  Supportive “household policy”;  Improved links to community resources	Sources of social identity, role models  Sources of social support and social pressure  Perceived and actual family hierarchy and social networks  Perceived social norms  Resource distribution and access; “assets”	Community mobilization skills-building; promote critical thinking (e.g., conduct community social and assets mapping)  Create enabling household environments; strengthen existing networks (e.g., form community health communities)  Negotiated behaviors and interventions

Level of Influence	Desired Intermediate Outcome	Areas of Assessment—(Factors) to Consider	Potential BC Interventions
Community (friends—peers, influentials, groups/orgs, businesses, public —private sector)	Change social norms; Increase sense of community and shared responsibility; Increased social support; Increased access and improved distribution of resources	Community social hierarchy and networks; “Assets” Social norms Sources of social support/social pressure	Negotiated behaviors and interventions; enabling community environment; Strengthen existing and create new social networks; develop community capacity to change;
Institutional systems (health and non-health) health care providers (modern and traditional)	Improved provider skills and attitudes; Improved client-provider relationships; Bridges between traditional and modern practitioners; Enhanced image of health services; improved products/services;	Current counseling attitudes, skill and practice Quality of care provided Product availability and acceptability Organizational and management factors	IPCC training; behavior change skills training; motivation and team building activities; management training; policy and advocacy; New systems (supply, supervision, etc.)
Policy (health planners, policymakers)	Restructured priorities Supportive policy environment Improved product development, pricing and distribution Reallocation of resources	Existing priorities and policies, and impact on recommended behaviors Current products availability, acceptability, cost; current resource allocation	Advocacy to inform and promote program; negotiation to reprioritize, reorganize systems, reallocate resources

The following chart, *The Right Tool for the Job* from *Applying the BEHAVE Framework: Workshop Guide*, participant’s binder, provides a useful tool to help program planners determine how to choose the best mix of interventions/approaches for their program.

***The Right Tool for the Job: Choosing Activities that Address Identified Benefits and Barriers***

<b>Type of Activity</b>	<b>Determinant Addressed through Activity</b>
<p><b>Small or Large Group Interventions</b>  <i>Can be very effective but require intensive effort to reach relatively small numbers. Need to design the activity to specifically address the targeted determinant. All small group interventions falling into this category address numerous determinants, individually or several at a time.</i></p> <ul style="list-style-type: none"> <li>• Peer- or non-peer-led workshops</li> <li>• Lectures, panel discussions</li> <li>• Testimonials</li> <li>• Video presentations/discussions</li> <li>• Live theater</li> <li>• Events (such as health fairs)</li> <li>• Single or multiple session</li> <li>• Community, work, school or clinical setting</li> </ul>	<p>Enhance positive attitudes.            Provide normative support.            Model desired action(s).            Build skills (small group).            Improve knowledge/awareness.            Increase sense of importance.            Increase intentions to act.</p>
<p><b>One-on-One Interventions</b></p> <ul style="list-style-type: none"> <li>• Counseling and referral</li> <li>• Home outreach</li> <li>• Event-based outreach (fair, booth)</li> <li>• Community, work, school or clinical setting</li> </ul>	<p>Deliver complex information.            Provide application assistance.            Answer questions.            Assess potential eligibility.            Enhance positive attitudes.            Build skills.            Increase sense of importance.            Increase intentions to act.</p>
<p><b>Centralized Information and Referral</b></p> <ul style="list-style-type: none"> <li>• Information, counseling, or referral hotline</li> <li>• Clearinghouse</li> </ul>	<p>Knowledge/Awareness.            Access to materials or support.            Perceived risk/degree of importance.</p>
<p><b>Distribution, Promotion or Subsidizing of Products or Services</b></p> <ul style="list-style-type: none"> <li>• Free distribution</li> <li>• Price supports</li> <li>• More/different distribution outlets</li> <li>• More/different brands</li> </ul>	<p>Access to materials or support.            Norms.            (Policy, requirements, and processes, in the long run)</p>

Type of Activity	Determinant Addressed through Activity
<b>Advocacy</b>	Policy, requirements and processes. Access to materials or support.
<b>Community Mobilization</b> <ul style="list-style-type: none"> <li>• Endorsements/testimonials</li> <li>• Involvement by opinion leaders</li> <li>• Coalition building</li> </ul>	Laws/Policies. Access to materials or support. Knowledge/Awareness. Social norms.
<b>Mass Media and Small Media</b> <i>Depending on the media selected</i> <ul style="list-style-type: none"> <li>• Paid electronic media advertisements</li> <li>• Public service announcements (free)</li> <li>• Media relations</li>   <li>• TV/Radio soap operas</li> <li>• Video</li>   <li>• Brochures and flyers</li> <li>• Posters</li> <li>• Flipcharts (as part of a small group intervention)</li> </ul>	Knowledge/Awareness (limited). Attitudes. Perceived risk/degree of importance. Social norms. Perceived consequences of action.  Social norms. Perceived risk/degree of importance. Perceived consequences of action. Skills (modeling basic skills). Attitudes. Intentions to act. Knowledge/awareness.  Knowledge/awareness. Attitudes. Perceived risk/degree of Importance. Simple skills (illustrating those not requiring much practice). Intentions to act.

## ***Conducting Assessments for Planning Behavior Change Interventions (BCI) Strategies: Methods That Answer Key Questions***

Key factors influencing health behaviors can only be determined by analyzing available data and/or collecting new information. Some data are already available, such as from national Demographic and Health Surveys (DHS) or from Multiple Indicator Cluster Surveys (MICs). PVO child survival projects already conduct a baseline (KPC) survey as part of initial project activities. This KPC survey provides basic information on current knowledge, attitudes, behaviors and practices at household level for many behaviors that correspond to each PVO project health objectives. A thorough review of available literature supplements the baseline information provided by the KPC study, helps to clarify remaining information gaps, and identifies questions that additional research can address.

Several assessment types (formative research) can be used to determine convincing ways to reinforce enabling factors, address barriers, overcome resistances and effectively motivate desired behavior changes. Program managers should pick and choose among the available methods depending upon information needs and available resources. Conducting research in each category is not required if the information is already available in another way.

A behavior change approach broadens the information needed to change identified behaviors (see table 2 on the right.) The approach explores factors that influence behavior at multiple levels—among individuals, family and community influentials, health care providers, and policymakers—to devise a maximally effective behavior change strategy. A list of possible factors (or determinants) influencing behaviors follows.

**Table 2: Ten Questions to Plan a BCI**

1. Who (which population segments) are most at risk by NOT practicing the behaviors?
2. Do current behaviors closely approximate the recommended behaviors? Are they widely practiced?
3. How are decisions made for routine health maintenance behaviors, household caregiving and care seeking outside the home? By whom? What “triggers” caregiving or care seeking? Where do people go for health care outside the home? Why?
4. What is the subset of behaviors required to achieve the recommended behavior? (behavior subanalysis)
5. Who has influence on whether or not people practice the recommended behavior?
6. What barriers to practicing the recommended behavior do people themselves identify?
7. How do they and those who influence them think those barriers could best be addressed?
8. What other factors (beliefs, social norms, laws, resources) might also influence whether people practice the recommended behavior?
9. Who is already practicing the recommended behavior? What motivated them to adopt that behavior? (positive deviants) Who is not practicing the recommended behavior? Why not? What makes the difference between the two groups?
10. If people don't think the recommended behavior is practical or achievable, what similar behavior would they be willing to try? (Negotiation.)

## *Common Behavior Change Determinants*

<b>Determinant</b>	<b>Brief Definition or Comment</b>
<i>Internal Determinants (individual or group)</i>	
Awareness of a problem	Perception that something is indeed a problem and not just “the way it’s always been.”
Perceived severity	Of the problem or issue.
Perceived personal (or group) risk	It’s not unusual for people to be aware of a risk for people like me or near me but not strongly believe that they themselves are at risk.
Perceived control	The jargon is “locus of control.” Perception that the situation is or is not fixed by a god or destiny, that one/one’s group may legitimately address it.
Self-esteem	Perception that person(s) affected are worthy of efforts to address the problem.
Self-efficacy	Perception that the person/group can do something about the problem.
Practical knowledge	This refers to knowledge of what to do, when, and how, not to knowledge of the “scientific” explanation of why they should do something.
Skills	To carry out new practice(s).
Values	Frame of reference, which may affect both perception of problem and perception and nature of acceptable solutions.
Beliefs	About problems and possible solutions.
Perceived social norm	Regarding the current and possible new practice(s).
Perceived feasibility/acceptability	Of possible new practice(s).
Expected negative consequences	May include sanctions.
Expected benefits	Of possible new practice(s).
Intention to change	A calculation of expected benefits, consequences, feasibility.
Expected social support	Of family, friends, community.
<i>Additional Internal Determinants for Group Change</i>	
Leadership	How strong, wise, democratic (?)
Collective capabilities	To assess, plan, and act.
Collective sense of ownership	Feeling that the problem/issues belong to the majority and that they are committed to addressing it.
Group cohesion	
Consensus regarding action to take	

Determinant	Brief Definition or Comment
<i>External Determinants (individual or group)</i>	
Resources	Time, money, access to water, etc.
Access to appropriate— • Technologies, • Services,  • Providers	<ul style="list-style-type: none"> <li>• Soap, bed net, vitamin A, iron pills, contraceptives, etc.</li> <li>• Roads, transport, distance, service hours, waiting time, medicine and supplies, cultural sensitivity of service norms</li> <li>• Cultural sensitivity, empathy, lack of prejudice, abilities to listen, inform, and negotiate</li> </ul>
Actual social support	Positive endorsement and/or practical support of family, friends, community, leaders.
Actual negative consequences	e.g. side effects when taking drugs
Complexity of action	Following IMCI protocol vs. dealing with main complaint/symptom(s)
Frequency of action/difficulty of recall	Single dose/combo drug vs. several drugs to be taken at different times
Policies	Re: Taxation, charges for services, sanctions, what providers may offer what services.
System support to providers and services	Basic supplies, encouragement of client orientation, sufficient funding, effective, and appropriate technical norms.
<i>Additional External Determinants of Group Change</i>	
Equity of participation	Inclusion of marginalized members of larger community and diversity of activities in which members are involved).
Information equity	Awareness and knowledge about an issue or problem shared among different individuals within a group or between different groups in a community.
Strength of social, political, and/or other opposition	

Below is a list of the assessment types—

- **Health risk assessments**—to determine the relative priority (in terms of magnitude and severity) of health problems according to members of the community, including among those belonging to various segments, in order to prioritize project health objectives. This assessment will yield the “perceived” assessment of risk and needs to be considered along with the “epidemiological” assessment of risk, which may be quite different.
- **Behavioral or audience assessments**—to identify key behaviors relevant for the health problems of greatest interest and the most influential factors associated with them—the barriers that keep people from practicing them as well as factors that make it easier for people to practice them (incentives to practice e.g., thru doer/non-doer and barrier analysis studies); to identify and profile audience segments and needed levels of intervention; and assess preferences for various kinds of interventions and channels.

- **“Environmental” assessments**—assessments of community structures and assets, health systems and/or policy issues affecting health behaviors. (The *health risk assessment* yields community preferences and perceptions about which health problems should be given priority, the *behavioral/audience assessment* yields community preferences and perceptions concerning intervention approaches).
- **Pretests and trials of improved practices**—to assess the feasibility and effectiveness of proposed behaviors. The purpose is to identify strengths, assets and resources available among families and communities to foster collaborative development of indigenous solutions.

A growing number of innovative tools are available to ensure that methods are appropriate to the research questions asked, that the questions asked are appropriate to inform the proposed behavior change, and that proposed interventions respond to the complexities of multilevel interventions. The following box gives examples of research methods that can be used for each type of assessment.

Types of Assessments	Examples of Research Methodologies
Health risk assessments	DHS surveys; MIC Surveys, other national surveys—nutrition surveys, coverage surveys; surveillance data
Behavioral or audience assessments	KPC surveys; doer/non-doer analyses; barrier analysis, positive deviant or discovery inquiries; focus groups (for specific subsets of information); in-depth interviews
Environmental Assessments	PRA or action research; policy environment scores; missed opportunity surveys; focus groups; Integrated Health Systems Assessment
Pretests or trials of behaviors	Trials of Improved Practices (TIPS); observation studies; HEARTH Model

## Step 2: Focusing & Designing the Communication Strategy

### *Moving Toward a Social and Behavioral Approach: Restate Objectives in Behavioral Terms*

The performance indicators for PVO projects are stated as health objectives – e.g. to prevent or improve home care and case management of childhood diarrhea; to increase the proportion of pregnant women assisted by a skilled birth attendant; or to increase the number of mothers who exclusively breastfeed their babies.

The initial step in applying a social and behavior change approach is to analyze these health objectives by their social and *behavioral determinants* and then *develop a set of social and behavior change objectives for each health outcome*.

The broad categories of behaviors to improve maternal and child health include—

- Healthy preventive/promotive household, community and institutional behaviors
- Timely, appropriate family-provided care at household level
- Early recognition of danger signs at home, timely care-seeking, decision making and use of appropriate health services if possible in the community
- Adherence to treatment recommendations/referral after receiving care from health workers, and provision of timely, appropriate, good-quality community-level health care, counseling, education, and referral by traditional and modern care providers.

Specific examples of objectives restated in behavioral terms are found below:

Health objective	Refocused in behavioral terms
Improve home care and case management of childhood diarrhea	Mothers and other caretakers should <ul style="list-style-type: none"> <li>• Wash hands, with soap, before preparing, feeding or eating food, and after using the toilet/handling children’s feces.</li> <li>• Continue feeding and increase fluids during diarrheal illness.</li> <li>• If breastfeeding, increase the frequency of feedings.</li> <li>• Breastfeed on-demand, day and night.</li> <li>• Mix and administer oral rehydration solution, or appropriate home-available fluids.</li> <li>• Seek appropriate care from a trained health worker when the child suffers from certain specific symptoms.</li> </ul>
Increase the percentage of mothers who exclusively breastfeed their babies	Mothers should <ul style="list-style-type: none"> <li>• Initiate skin-to-skin immediately and initiate breastfeeding within 1 hour of birth.</li> <li>• Breastfeed exclusively for the first 6 months. This means no other food or liquid—even water—is given to the baby.</li> <li>• Practice frequent, on-demand breastfeeding, day and night.</li> </ul>

After “translating” health objectives into behavioral terms, the next critical step in developing a behavior change approach is to identify the key factors related to the target behavior that most influence our particular audience. These are the range of factors (individual and within the

“enabling environment”) and audiences that need to be addressed comprehensively in order to see changes in key health-related behaviors.

### **A Program Example of Multilevel Behavior Change Interventions**

Lessons have been learned from programs that have been unable to improve household health practices, or to increase demand for and appropriate use of health services. For example, in a South East Asian country, program planners knew that maternal deaths were unacceptably high. A health communication strategy to increase knowledge about obstetric danger signs, a known contributing factor to delay in emergency care seeking, was implemented, with pregnant women as the primary audience. Local doctors were trained to upgrade emergency obstetric skills. After three years, very little change in use of services had occurred.

A behavior change approach was applied, and results of a broader range of formative research assessments were charted using a behavior change intervention matrix. Analysis showed that mother-in-laws were the ultimate household decision makers regarding obstetric emergency care seeking, that families delayed care seeking because they were routinely required to purchase expensive essential supplies and medicines themselves, and that doctors were often unavailable when community midwives needed assistance.

Gradual increases in utilization were noted after implementation of a multilevel behavior change strategy that educated all family and household members about obstetric danger signs; worked with communities to identify resources for producing and distributing “birth preparedness kits” containing essential obstetric supplies; and advocated for policy change to allow midwives to perform routine emergency care.

The table below suggests a framework (based on the four key questions) for charting and analyzing assessment results into a social and behavior change intervention matrix. This matrix helps to identify a broad range of interventions that might be required to change behaviors directly as well as to create a community and policy environment supportive of change.

The framework provides a rationale for expanding the range of behavior change activities beyond communication, and for linking and coordinating communication activities with training, health systems support, product and service improvements and policy changes that may not otherwise have been recognized as essential components of a behavior change strategy.

*The Behave Framework for Program Planning*

Audience	Structures, Social Norms or Behaviors	Key Factors	Interventions
<p><b>Defining <i>who</i>:</b></p> <p>An audience segment should be as large a group as possible that will still react in a similar and desired way to a certain “stimulus.” In this case, the stimuli are program activities. Some criteria to consider include—</p> <ul style="list-style-type: none"> <li>• Relative risk</li> <li>• Potential impact on program objectives (How many? How badly at risk? How likely to change)</li> <li>• Feasibility (NGO access to audience, resources to reach/work with audience; community politics).</li> </ul>	<p><b>Determining <i>what</i>:</b></p> <p>Based on literature, research, TIPS or other behavioral trials. Determined by considering ideal behaviors and current practices, and negotiating with audiences to identify a feasible behavior that will improve health outcomes.</p> <p><b>Behavioral objectives must be—</b></p> <ol style="list-style-type: none"> <li>a) an action</li> <li>b) observable</li> <li>c) specific</li> <li>d) measurable</li> <li>e) feasible</li> </ol> <p>Feasible behaviors are determined by considering the:</p> <p><b>Ideal Behavior</b> Based on international guidelines and national policies And comparing it to—</p> <p><b>Current Practices</b> Based on available routine data from e.g. surveillance, DHS, other HH and community-based studies.</p> <p>Selected behaviors need to balance the ideal behavior with what is likely to be possible; and be grounded in existing practices.</p>	<p><b>Determining <i>factors</i>:</b></p> <p>Based on literature, research, TIPS or other behavioral trials, and perceived benefits and barriers to performing the behavior.</p> <p><b>Factors may be—</b></p> <ol style="list-style-type: none"> <li>a) Interpersonal</li> <li>b) Intrapersonal (between the individual and family, health workers, community members, others)</li> <li>c) Health system (supplies of products, health center hours); or policy factors (health center policies, national guidelines, import policies)</li> </ol> <p><b>Common Factors Influencing Behaviors:</b> Demographics; knowledge and attitudes of individual, family, health workers; perceived risk; self-efficacy; culture and (perceived) social norms; intentions; access to services and products; policy; community organization and support; actual skills; perceived consequences.</p>	<p><b>Selecting <i>interventions</i>:</b></p> <p>Interventions should be directly linked to key factor, address all levels identified as most influential in changing the behavior (individual, household, community, health service, other institutions, policy); should be “the right tool for the job.” (see also right tool worksheet on page 8.)</p> <p>Broad categories of activities to address interpersonal, intrapersonal, health system and policy factors include—</p> <ul style="list-style-type: none"> <li>• Large or small group interventions (peer workshops, events, theater, fairs, etc.)</li> <li>• One-on-one interventions (counseling and referral, outreach, care groups etc.)</li> <li>• Centralized information and referral</li> <li>• Distribution, promotion or subsidizing of products or services (free distribution; price supports; more/ different outlets, brands); community mobilization</li> <li>• Mass media and small media</li> <li>• Advocacy for policy change</li> <li>• Improved quality of care</li> <li>• Improved supervision.</li> </ul>

**The Behave Framework for Program Planning - example**

<b>Audience</b>	<b>Structures, Social Norms or Behaviors</b>	<b>Key Factors</b>	<b>Interventions</b>
<p><b>Who?</b> A specific target audience.</p>	<p><b>What?</b> Do a specific action that protects or has a positive health outcome.</p>	<p><b>Factors</b> A few specific key factors that address barriers, enhance benefits, and are most influential to the target behavior from the point of view of the target audience.</p>	<p><b>Interventions</b> Selected activities that address those key factors.</p>
<p>In order to help—  Women pregnant for the first time and young mothers under 20.</p>	<p>To—  Give colostrum starting within one hour of birth and continuing until “regular” milk comes in.</p>	<p>We will focus on—</p> <p>Increasing knowledge about the benefits of colostrum, stressing it is sufficient nourishment for the newborn</p> <p>Changing attitudes about the need to “clean the stomach of the newborn”</p> <p>Increasing the knowledge/attitude that colostrum is the “first vaccine”</p> <p>Changing health worker knowledge/attitudes about poor, malnourished mothers being able to provide sufficient infant nutrition through breast milk</p> <p>Strengthening hospital and community center policies.</p>	<p>Through—</p> <p>Small group workshops</p> <p>Midwife talks</p> <p>Stickers for immunization cards (the first vaccine!)</p> <p>Promoting colostrum during prenatal visits</p> <p>Assuring adherence to hospital policies through monitoring</p> <p>Identifying “positive deviant” mothers (poor, malnourished mothers) who exclusively breastfeed and whose infants are thriving; build a community-health center showcase to demonstrate effective strategies.</p>

## ***Important Factors***

These next sections summarize some of what has been learned about factors that are important to consider at the different levels addressed by projects.

### ***Strengthening Health Systems to Promote Change***

Behavior change to increase demand for and utilization of health services is influenced by access factors and acceptability of services. Access factors include concrete barriers such as hours and location of services as well as a sense of “welcome” at the point of service. Service acceptability from a client perspective is often based on perceived quality, availability of drugs, health worker attitudes and client-provider interactions. Comprehensive strategies to change utilization of health services require interventions that address some or all of these factors.

For health service providers as with individuals, knowledge alone does not change behavior. Training programs to improve technical skills and interpersonal counseling and communication (IPCC) skills alone are unlikely to result in sustained change in behavior or practice. Long-term changes in performance of health service providers are more likely when training includes analytical skills, addresses underlying attitudes, values and cultural norms, includes behaviors that are feasible in the clinical setting, and gives health workers skills to manage organizational problems such as a lack of time or staff for counseling. In addition, ongoing supervision of some type is likely to be important for sustaining changes in clinical behavior. (See also Quality Assurance and M&E TRM modules.)

Behaviors identified for change at individual and community levels should be systematically reflected in and linked to clinical protocols and training guidelines for health care providers. Motivational activities and team building initiatives help build bridges between communities and health services and empower health service providers to recognize the need for changes within the health system and be more able to implement those changes. Dialogue between professional health service providers and community/traditional health workers and between public and private sector providers supports effective institutional level behavior change. The Partnership Defined Quality methodology is effective in supporting this level of behavior change. (For more information, see also [www.savethechildren.org/technical/health/PDQ\\_Final\\_Manual.pdf](http://www.savethechildren.org/technical/health/PDQ_Final_Manual.pdf)).

### ***Encouraging Behavior Change at Community Level***

One fundamental behavior change principle is promoting social change. Community engagement, efficacy and empowerment are key to community’s being able to adopt and sustain new behaviors. Often, programs must reexamine current approaches and rebalance strategies to integrate community mobilization and advocacy activities more effectively with conventional strategies such as health communication aimed at individual behavior change.

A behavior change approach aimed at the community focuses on activities that create and sustain an enabling environment for social change, build partnerships with communities, and develop interventions that respond to the community’s own assessment of its needs and priorities. Community-centered behavior change programs empower community partners, and encourage collaborative design and implementation of local programs.

Rather than imposing predetermined behavior change activities, communities identify problems or goals, mobilize resources and develop and implement strategies to achieve their goals. Communities use a variety of tools to help identify their own problems, recognize barriers to necessary behavior change, find appropriate solutions, and mobilize necessary resources. An asset-based approach helps communities identify, strengthen and utilize resources and knowledge that exist within the community itself to support behavior change and improve health outcomes. Key to these approaches is ensuring that a balance exists between problems perceived as important by communities, and the public health problems as identified from local data.

### **Step 3: Creating Interventions & Materials for Change**

Once the strategy is agreed upon, based on results of pre-implementation research, effective communication products, materials products and activities need to be defined and created, including: toolkits, facilitation manuals for group interaction, training manuals for counseling, job aids for services providers, improved services and products, TV or radio scripts, comic book or drama scripts, posters, brochures and much more....

Developing communication products combines science and art:

- There is science in creating concepts, visuals and text which are based directly on your **analysis of the situation** (Step 1): the people, their culture, existing policies and programs, active organizations, and available communication channels.
- There is art in the creation of products which evoke emotion, motivate audiences, and fit within the **strategy** you've carefully designed (step 2)

Before creating anything new, we strongly suggest doing an inventory to see what already exists. Most health issues we are addressing now have been around for a while. Search for communication products that have been, or are being, created by others. How might you complement what exists with something new? Adapt it? Build on it? Improve on it?

Once you're confident with your analyses, your strategy, and your inventory of existing products, you are ready to create, but please note that that this is a long and complex process for which it might be necessary to get "professional" help.

### **Step 4: Implementing & Monitoring Change Processes**

In this fourth step of the C-planning process, plans turn into action! During this step the project will launch and implement communication interventions, conduct training, introduce and promote improved services and product(s) and will initiate policy changes. Plans will require some flexibility: be ready to change plans when necessary and stop doing unproductive activities. Allow the project to change course due to the results of monitoring and mid-term evaluation and adjusted implementation plans based on anticipated costs.

Start with a rough implementation plan and refine it during or shortly after the DIP workshop into a detailed workplan including targets, resources and timeline. During implementation, monitor processes and quality of all SBCC activities.

Four aspects of implementation are critical to success: 1) Sequencing program elements, 2) Timing against other events, 3) Making activities mutually-supportive, and 4) Integrating complementary programs.

**Sequencing** is the order in which activities are implemented. In the case of SBCC interventions, you will need to assure that interpersonal support materials are ready for use in time to correspond with a campaign launch. Assure that facility based health workers are properly informed about community health worker programs, supplied with necessary drugs and material, and trained (e.g. as supervisors) before community health workers refer patients to them.

By “**timing**” we mean, the scheduling of activities within your project in relation to events happening in the community, region or country **outside** of your project. Your program is not being implemented in a vacuum. Think ahead of time about other, unrelated events, such as holidays, celebrations, school or university schedules or political events that could compete for time, attention of your target audience(s), broadcast space, or space/facilities.

**Synergy** is the added benefit you get from activities or materials which enhance each other. For example, if you train facility based midwives in active management of the third stage of labor (AMTSL) and also have a community based program that encourages mothers and families to make a birth plan that includes delivery at the facility level, you might find that the efforts reinforce each other. Check also that channels are truly interactive and actually promote the same messages in a concerted fashion.

No matter how strong your SBCC messages, materials and/or activities, they will not ultimately lead to change unless they are integrated with other programs. Here are two examples:

- Ensure that enough commodities are ready to support your efforts to promote their use. For example, are there enough long lasting insecticide treated nets available for National Child Health Day? If not, audiences will be even harder to convince to use such commodities if their last experience in trying to get them was in vain.
- Ensure that services are of quality and can meet demand. If providers are promoted as friendly, but have not been trained to be friendly, a backlash can result that will make future efforts to promote their services far more difficult. If there is not enough staff to provide quality counseling, potential clients will turn away and be much harder to convince to access those services in the future.

### **Five Tips to Strengthen the Implementation of SBCC Programs:**

1. Involve audience participation at every step: work with communities to negotiate, and implement activities to change social norms and behaviors and address barriers.
2. Learn from those who are doing the work;
3. Encourage initiative and resourcefulness among staff;

4. Demonstrate management's commitment by constantly seeking excellence in design, production processes and services, not just in products; and,
5. Consistently seek quality solutions, which are often not the cheapest option.

#### **Four Tips to Improve Work Systems:**

1. Critically review the tasks at hand and how the team tries to accomplish them;
2. Assess how tasks and work systems fit with each other;
3. Clarify responsibilities and strengthen links across teams;
4. Focus on increasing capacity, rather than only outputs.

And remember: *Partners can help with implementation, but they are unlikely to reduce your workload. Developing and maintaining partnerships is itself very labor intensive, and your role in leading, coordinating, and monitoring program operations is essential.*

### **Step 5: Evaluation & Re-planning**

*Projects should also consult the Monitoring and Evaluation (M&E) module of the Technical Reference Materials.*

**Monitoring** is routine data collection to check process and quality:

- To what extent are planned activities actually realized?
- How well are the activities implemented?

It may also include how the population reacts to the activities implemented. Monitoring measures our progress toward program objectives.

**Evaluation**, on the other hand, is data collection at discrete points in time to systematically investigate a program's effectiveness. Evaluation usually requires a comparison (of two or more things) and the measurement of change over time.

A bulk of M&E work happens well before data collection begins. To begin, programs must draft SMART communication objectives and define data uses and users. Once these steps are complete, programs need to decide on:

- Indicators;
- Research methods and tools;
- Steps to ensure quality of data;
- Ways to analyze the data; and,
- How to report M& E results to community, partners, and donors.

Then, data collection can begin. Most **monitoring** needs are met through quantitative research methods. These methods allow programs to collect numerical data that can be combined and

summed up for any given time period. The information can come from many different sources such as:

- Attendance sheets or in-take forms,
- Notes from a supervisory site visits,
- Journal entries made by outreach workers,
- Radio spot coverage statistics.

Qualitative methods produce in-depth, descriptive information and can provide information on how well things are being carried out. They are invaluable for learning and replanning.

Some **evaluation** questions may also be answered through quantitative methods. Common quantitative evaluation methods include:

- Population based surveys, and
- Components of health facility surveys

Qualitative evaluation methods help to explain how well the program achieved certain outcomes. Keep in mind that all evaluation methods must compare collected data to ascertain whether or not there has been any change.

Some common monitoring and evaluation challenges that many projects face include:

- Rigorous study design that includes a comparison or control group
- Finding a way to measure the effects of your project or program separate from other projects and programs in the same target group or geographic area
- Insufficient staff (who can coordinate and guide evaluation design and implementation, including when evaluation is conducted by an external body)
- Lack of skill in evaluation design, data collection methods (both quantitative and qualitative), analysis, write-up, and dissemination
- Insufficient financial resources (NGOs face many pressing priorities and may not be able to spare or raise the extra money needed).

# References and Resources

## Introduction

Many of the references listed below are now web-based and contain their highlighted (in blue) “hyperlinked” website address. To access them, use an electronic copy of this document (which you can access from our website: <http://www.childsurvival.com/documents/usaaid.cfm>). Simply click on the blue highlighted website address of the reference that you want to find in this document, and you will automatically be connected to that site/reference online. Another option is to be online using your browser, and manually cut and paste/or type in the website address for the reference you want to find from this document.

Some of the references still remain available only in hard copy, and an attempt has been made to provide information on how to obtain them. All documents published under USAID-funded projects can be obtained from USAID’s Development Experience Clearinghouse (DEC), <http://www.dec.org>. The order number of each document begins with PN- or PD- and appears in parentheses at the end of the citation.

This reference and resource list is by no means the last word on any of these interventions or cross cutting strategies. This annex cannot possibly be exhaustive, but rather can help steer the user in the right direction when researching these areas.

This is a dynamic list, as are the TRMs in general. We ask that throughout the year you provide us with information on the availability and usefulness of each entry, as well as additional resources that you think should be added to this list, as appropriate, so that next year we can continue to update it. Please send comments and recommendations to Michel Pacqué at CSTS+ <mailto:Michel.C.Pacque@macrointernational.com>.

### Essential References

THE COMMUNICATION INITIATIVE partnership <http://www.comminit.com/index.html>.

Stetson, Valerie and Rob Davis. Health Education in Primary Health Care Projects: A Critical Review of Various Approaches. Washington, D.C.: CORE 1999.

Murray, John, et al. Emphasis Behaviors in Maternal and Child Health: Focusing Caretaker Behaviors to Develop Maternal and Child Health Programs in Communities: Technical Report. Arlington VA: BASICS Project Academy for Educational Development, September 1997. (already listed and annotated).

Community Centered Approaches to Behavior and Social Change: Models and Processes for Health and Development. Washington D.C.: CORE/NGO Networks for Health, 2000.

**The CHANGE Project** <http://www.changeproject.org/>.

**Communication for Change:** Improved Social and Behavior Change Communication (SBCC) in the Health Sector: <http://c-changeprogram.org/our-approach/capacity-strengthening/sbcc-modules>

Seidel, R. Behavior Change Perspectives and Guidelines on Six Child Survival Interventions: Health Communication Partnership, 2005.

Applying the BEHAVE Framework: A Workshop on Strategic Planning for Behavior Change, Facilitator and Participant Guides, 2004.

Davis Jr., T. Barrier Analysis Facilitator's Guide: A Tool for Improving Behavior Change Communication in Child Survival and Community Development Programs, Washington, D.C.: Food for the Hungry, 2004.

Favin M. et al. Guidelines for Developing Home-based Reminder Materials: Helping Families Save Sick Children, Project Hope, 2004.

Parlato, R. et al. Qualitative Research to Improve Newborn Care Practices, Washington, D.C. Saving Newborn Lives Initiative, 2004.

Contreras, A et al Operationalizing Key Family Practices for Child Health and Nutrition at Scale: The Role of Behavior Change, BASICS II, Arlington, VA, 2004.

O'Sullivan G. A. et al. A Field Guide to Designing a Health Communication Strategy, Baltimore, MD: Johns Hopkins Bloomberg School of Public Health/Center for Communication Programs, 2003.

Hill, Zelee. Family and Community Practices that Promote Child Survival, growth and development: a review of the evidence. WHO, 2004.

CORE, BEHAVE optional night session, from HH/C IMCI Framework, A Facilitator's Guide for Conducting Country Meetings on HH/C IMCI, March 2003.

Lisa Howard-Grabman (Save the Children) Bridging the Gap Between Communities and Service Providers: Developing Accountability Through Community Mobilization Approaches. Contact: lhowardg@dc.savechildren.org at Save the Children.

The Basic Education and Policy Support (BEPS) Activity is a new, worldwide, five-year effort by the U.S. Agency for International Development (USAID) to help developing and newly independent nations to improve the quality, access to, management and effectiveness of their educational systems, particularly non-formal and formal basic education systems. <http://www.beps.net/>.

Education Development Center, Inc. (EDC) is a non-profit education and health organization that brings researchers and practitioners together to create tools and conditions for learning, is committed to education that builds knowledge and skill, makes possible a deeper understanding of the world, and engages learners as active, problem-solving participants. <http://www.edc.org/>.

- De Negri, Berengere, Lori DiPrete Brown, Orlando Hernandez, et al. 1997. Improving Interpersonal Communication Between Health Care Providers and Clients. Johns Hopkins University School of Public Health; Academy for Educational Development. Washington: USAID (PN-ACE-294).  
[http://www.dec.org/pdf\\_docs/pnace294.pdf](http://www.dec.org/pdf_docs/pnace294.pdf).
- Glanz, Karen, and Barbara K. Rimer. Theory at a Glance: A Guide for Health Promotion Practice. Bethesda, MD: National Institutes of Health, July 1999.
- NGO Networks for Health Technical Approach to Behavior Change Programs Washington, D.C. July 2000.
- Epstein, T Scarlett. Ed. A Manual for Culturally-adapted Social Marketing: Health and Population. New Delhi/Thousand Oaks/London: Sage Publications, 1999.
- Ogden, L. Shepherd, M. Smith W.A.. The Prevention Marketing Initiative: Applying Prevention Marketing. CDC National Prevention Information Network, 1996. 200 pages.
- The Challenge: Rethinking Behavior Change Interventions in Health from the Behavior Change Intervention Forum April 7-8 1999. Washington, D.C.: NGO Networks for Health.
- A Toolbox for Building Health Communication Capacity. Washington, D.C.: HealthCom, BASICS Project, Academy for Educational Development, USAID, 1995.
- Graeff J.A., J. Elder, and E. M. Booth. Communication for Health and Behavior Change: A Developing Country Perspective. San Francisco, CA: Jossey Bass Publishers, 1993.
- AIDSCAP. How to Create an Effective Communication Project: Using the AIDSCAP Strategy to Develop Successful Behavior Change Interventions. Arlington, VA: Family Health International, 1996. also available at [www.fhi.org](http://www.fhi.org).
- Green, Lawrence, and Marshall Kreuter. Health Promotion Planning: An Educational and Ecological Approach. 3rd ed. Mountain View, CA: Mayfield Publishing Company, 1999.
- Day, Brian A., and Martha C. Monroe, (Eds.) Environmental Education Communication for a Sustainable World: Handbook for International Practitioners. Washington D.C.: GreenCom, Academy for Educational Development, and Environmental Education and Communication Project, United States Agency for International Development, 2000.
- Sharma, Ritu R. An Introduction to Advocacy: Training Guide. Washington D.C.: AED SARA Project, HHRAA, and USAID Africa Bureau, 1997.

- Porter, Robert, and Suzanne Prysor-Jones. *Making a Difference to Policies and Programs: A Guide for Researchers*. Washington D.C.: SARA Project, HHRAA, and USAID Africa Bureau in collaboration with Joint Health Systems Research (HSR), Essential National Health Research (ENHR) Africa Secretariat, and Council on Health Research and Development (COHRED), July 1997.
- Vella, Jane and Valerie Uccellani, *Learning to Listen to Mothers*, Washington, D.C.: Nutrition Communication Project, Academy for Educational Development, 1994.
- Favin, Michael and Marcia Griffiths. *Communication for Behavior Change in Nutrition Projects: A Guide for World Bank Task Managers*. Washington D.C.: Human Development Network, World Bank, August 1999.
- Sy, Maty Ndiaye, and Micheline K. Ntiru. *Using Consultative Research to Adapt the IMCI Feeding Recommendations to Local Context: Training Guide*. Washington D.C.: SARA Project, Academy for Educational Development, SANA, and USAID, Office of Sustainable Development, July 1999.
- Favin, Michael and Carol Baume. *A Guide to Qualitative Research for Improving Breastfeeding Practices*. Washington D.C.: The Manoff Group and Wellstart International, Expanded Promotion of Breastfeeding (EPB) Program, June 1996.
- Baume, Carol, and Patrick S. Kachur. *Improving Community Case Management of Childhood Malaria: How Behavioral Research Can Help*. Washington D.C.: SARA Project, Academy for Educational Development, October 1999.
- Behavioral Dimensions of Maternal Health and Survival in MotherCare Matters Volume 9 no 3*. Arlington V.A.: JSI, September 2000.
- An Inventory of Tools to Support Household and Community-Based Programming for Child Survival Growth and Development* New York: UNICEF, December 1999.
- Howard-Grabman, and Gail Snetro. *How to Mobilize Communities for Health and Social Change* Save the Children and JHU/PCS4 Project, Westport and Baltimore, 2003.
- Kretzman, John, and John Mcknight. *Building Communities from the Inside Out: A Path Toward Finding and Mobilizing a Community's Assets*. The Asset Based Community Development Institute Evanston Il. 1993.
- de Negri, Berengere, et al. *Empowering Communities: Participatory Techniques for Community Based Programme Development Vol 1(2) Trainers Manual (Participants Handbook)* Nairobi: Center for African Family Studies (CAFS) AED / JHU CCP, December 1998.
- Welbourn A. *Stepping Stones: A Training Package on HIV/AIDS; Gender Issues, Communication and Relationship Skills Workshop Manual and Video*. London: Teaching Aids at Low Cost, 1996.

Minkler, Meredith. *Community Building and Community Organizing for Health*. New Jersey: Rutgers Press, 1999.

Haarland A., and C. Vlasoff. *Health workers for change: a workshop series to improve quality of care for women*. Geneva: WHO Division for Tropical Disease Research, 1995.

AIDSCAP. *Assessment and Monitoring of BCC Interventions: Reviewing the Effectiveness of BCC Interventions*. AIDSCAP Project. Family Health International, [www.fhi.org](http://www.fhi.org).