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Abbreviations and Acronyms

ARR	Annual Results Report
BA	barrier analysis
BE	Behavioral Economics
CII	Center for Accelerating Innovation and Impact
CCFLS	community complementary feeding and learning sessions
DBC	designing for behavior change
DFSA	development food security activity
DRR	disaster relief reduction
EBF	exclusive breastfeeding
FANTA	Food and Nutrition Technical Assistance III Project
FFP	Office of Food for Peace
FGD	focus group discussion
FR	formative research
IP	implementing partner
IPC	interpersonal communications
IYCF	infant and young child feeding
KII	key informant interview
M&E	monitoring and evaluation
MCHN	maternal and child health nutrition
MOH	Ministry of Health
MTE	mid-term evaluation
PAR	Participatory Action Research
PLW	pregnant and lactating women
RFA	Request for Application
SAA	Social Analysis and Action
SBC(C)	social and behavior change (communication)
SWE	Stories Without an Ending
TOPS	Technical and Operational Performance Support
USAID	United States Agency for International Development
WASH	water, sanitation, and hygiene

Executive Summary

Within Food for Peace (FFP) Development Food Security Activities (DFSAs), social and behavior change (SBC) activities are designed to help support adoption of new practices and foster new social norms contributing to those aims. Nutrition practices, while grounded in strong evidence of health benefits, can be very hard to change. In recent years, there has been growing concern about issues for which SBC is highly relevant, including sustainability, capacity building for implementation to high technical standards, and provision of non-food assistance as a complement to food aid. As a reflection of these institutional interests and a commitment to applying the latest evidence, conceptual thinking, and best practices to maximize the quality and effectiveness of approaches used in DFSA programs to bring about sustainable social and behavioral change, FFP requested Food and Nutrition Technical Assistance III Project (FANTA) to conduct a review of SBC methods and approaches within DFSAs. FFP expressed particular interest in moving beyond the traditional information and communication-based approaches to embrace those more oriented to community mobilization for sustainable systems-level change and to understand the extent to which current programs were using approaches consistent with best practices.

Objectives. Given these interests and aims, the objectives of the review and this report were to:

1. Describe the fundamentals of SBC theory and practice and identify current consensus on evidence-based global best practices.
2. Identify the SBC approaches being used by current and recent DFSAs.
3. Identify how well those approaches are aligned with best practices.
4. Identify the common strengths and weaknesses in the implementation of the SBC activities and the quality of implementation where it was possible to observe.
5. Recommend steps FFP may consider pursuing to improve the impact of DFSAs' SBC activities.

Method. Eleven programs that were past their midpoint were selected for review to maximize diversity across implementing partners and geography. The process involved review of documents (annual results reports, midterm evaluations, formative research and other reports, SBC strategies, program documents and tools), interviews with implementing partner staff, and site visits with four programs in two countries. The results of a review of global SBC literature and consultations with SBC experts provided the basis for the SBC best practices against which the program findings were analyzed.

SBC BEST PRACTICES

A review of broadly applied definitions, principles, processes, and theories in the field of SBC grounded the review of DFSA particulars. SBC is the systematic application of iterative, theory-based, and research-driven processes and strategies for change at the individual, community, and social levels.

1. Individual behavior change communication for changes in knowledge, attitudes, and practices of specific audiences
2. Community mobilization for wider participation, collective action, and ownership
3. Advocacy to increase resources and political/social commitment for change goals

SBC programs work best when they work through multiple channels at these different levels, and always based on evidence (Communication for Change 2011; Lamstein et al. 2014). Theory and practice in the fields of public health and human behavior have evolved. Practitioners now realize that providing information is not enough to change behavior and that interventions must respond to contextual factors.

The socio-ecological model is the gold standard for conceptualizing and responding to layers of influence on individual behavior. A rich array of approaches to research and implementation (e.g., community dialogue and human-centered design), are being drawn upon to engage audiences and tailor activities and messages and to pursue change at social as well as individual levels. To obtain results, interventions must follow SBC's systematic process, and ensure implementers have the necessary skills to deliver high quality activities.

Key steps of SBC program implementation are:

1. Understanding the situation/context through formative research
2. Strategic program design/strategy development
3. Creating tools, materials, and interventions
4. Implementation and monitoring
5. Evaluation and re-planning

FINDINGS

Formative Research. Virtually all of the DFSAs reviewed have done some kind of formative research to inform the design of their program, although the quality varied. Most followed best practices in using multiple methods to triangulate data. Table ES1 lists the methods and number of programs (out of 11 reviewed) that reported using each. Barrier Analysis (BA) was the method most frequently used. TIPS generated valuable results but was only used by one program. Community Consultations and Participatory Action Research-type methods represent an underutilized opportunity to inform design while also mobilizing support for interventions. The strongest programs did a good job analyzing the results from formative research and explicitly linking them to activities through carefully tailored tools and messages, while others remained superficial accounts of barriers (e.g., women lack knowledge of the benefits of breastfeeding, so the program must explain the benefits of breastfeeding).

Table ES1. Research Methods

Research methods	# of programs
Desk Study	8
Barrier Analysis	7
Focus Group Discussions	7
Individual Interviews IDI, KII	6
TIPS/SIPS	1
Community Consultations/SAA	1
Observation	1
KAP (knowledge, attitudes, practice) studies	1
No research conducted	1

SBC Strategy. All but one program had some kind of SBC strategy although the format, complexity, clarity, and quality vary greatly. Many do an excellent job of articulating how activities and messages will address needs identified. The strongest demonstrate a conceptual grasp of SBC principles and present detailed frameworks to guide a variety of tailored interventions at different levels. But even a well-designed SBC strategy does not necessarily translate into effective implementation by staff. Some staff were unfamiliar with the strategies developed by outside experts, while in at least one case, a relatively poorly written strategy was implemented with effectiveness by staff who had been involved with its development and demonstrated both understanding and skills to implement it.

Most DFSA strategies focus on individual level change, although growing attention within FFP and among implementing partners to social change and norms has led some to design strategies that engage influential groups and use community-based methods. All DFSA strategies identified generally similar maternal and child health nutrition (MCHN) behaviors to promote, related to the first 1,000 days, and all identified some barriers, by far the most common being knowledge. Fewer enabling factors were

identified, and programs were generally weak on mobilization of community assets for SBC. Advocacy was an underutilized element of programs' SBC strategies, and target group profiles were a potentially valuable element which none included.

SBC Approaches Used. DFSA programs are using an impressive array of approaches. Most are based on interpersonal communication (IPC), whether in counseling, peer group activities, or community meetings. Community mobilization and media approaches were used less frequently, always combined with an IPC approach. A few projects used radio or community video, powerful methods when linked with discussion groups. Farmer field schools and cooking demonstrations are commonly used in DFSAs and present opportunities for SBC activities that are not usually captured in their SBC strategies and reports. Advocacy can help address the enabling environment for SBC and promote more sustainable changes. Most projects are doing some degree of advocacy with their government partners although advocacy approaches are rarely captured explicitly in a SBC strategy.

The Care Group model (with varying details) is being used by all of the DFSAs reviewed, so the approach requires special attention. Virtually all partners use the basic structure of Care Groups based on the cascade of training from paid promoters to volunteer leaders to neighbor mothers. The main benefit of the Care Group model voiced by many implementers and government partners is the wide coverage possible, while the downside is the deterioration of quality through the cascade approach. Also, despite guidance on interactive facilitation approaches, IPC skills are weak, and facilitators typically use directive techniques to deliver module content rather than engage participants in active learning.

A galvanizing power of Care Groups is being unleashed by the current generation of DFSAs that have all expanded the Care Group model beyond just pregnant and lactating women (PLW) by engaging other influential groups. Projects link MCHN activities with those in other project domains, positioning Care Groups as a "hub" for interrelated community-wide activities including male engagement and couples work, village savings and loan groups, youth theater, and grandparent clubs. This demonstrates very effectively the "layering" and integration that FFP seeks from implementers, and which holds promise for maximizing results. Community-wide activities also play an important role, and most DFSAs are using some type of community mobilization methods to engage members of a community with an aim for broader social change. However, DFSAs generally do not demonstrate the skills to facilitate real engagement in a reflective, participatory, process of enacting a self-defined change agenda. Most programs hold community meetings in the early stage of a project to "sensitize" the community members to generate support, and periodically throughout the project to broaden exposure to key messages. It is hard to know how well community dialogue and mobilization methods are being implemented, and what change they bring about, without systematic, observation-based evaluation.

IPC Quality. Since almost all the methods used by DFSAs depend on interpersonal communication, it calls for quality assessment. The review found that most programs have tools and guidance reflecting global best practices on how to facilitate group meetings and conduct counseling in an interactive manner. The Care Group guidance[1] and many programs' training curricula, present the recommended process of facilitating a group meeting, which involves a lot of interaction with these elements: games, songs, activities, troubleshooting discussions, learning new lessons, discussion of barriers and solutions, practicing counseling skills with coaching, and committing to specific action.

[1] The Technical and Operational Performance Support (TOPS) Technical and Operational Performance Support Program. 2016. *Care Groups: A Reference Guide for Practitioners*. Washington, DC: The Technical and Operational Performance Support Program.

Only observation can ascertain how well programs followed this guidance and demonstrated IPC skills. This review's observations of Care Group sessions, household visits, and community meetings in 15 communities with four projects in two countries found that guidance to be largely un-operationalized. Key findings on IPC were identified:

- Most facilitators focus on delivering messages rather than engaging people in a process of learning to solve their problems or develop skills.
- There is a notable lack of probing questions and missed opportunities to uncover relevant details and support problem solving.
- Quality of counseling tends to deteriorate at the community level, even when expertise is evident at the train the trainer level.
- In program discussions, staff and stakeholders talk most about content, emphasizing the *what* rather than the *how* of group facilitation.
- One crucial skill for counseling and group facilitation was almost completely absent: "teach back" to verify learning. In only one case observed did the Care Group facilitator perform the "practice-and-coach" step. The ENSURE project trained and supported participants to do this as part of their Dialogue Counseling Process through training simulation exercises and continual coaching. Notably this program was exceptional for *not* using information-heavy flipcharts in Care Group meetings. The effective facilitation using only a simple cue sheet indicates the value of focusing on the dialogue process rather than the content of Care Group meetings.

SBC Capacity Development Systems. Partners consistently report that they use participatory methods and some mention adult learning principles. Many programs use the Care Group Quality Improvement Verification Checklist for monitoring the quality of group facilitation. But it is not clear how systematically it's used, whether teams value it, and most importantly, how is it being applied. Programs are also developing SBC capacity through USAID/FFP support and cross learning opportunities with other DFSAs in country and other USAID partners. Support from the HC3 project, and trainings on Make Me A Change Agent and the Essential Nutrition Actions are excellent programs for which DFSAs expressed appreciation.

Sustainability. DFSAs are responding in varying degrees to FFP's call for sustainability planning. Some projects developed specific exit plans, the most developed being Swaki's, but often sustainability is more hoped for than planned for in the context of SBC. Amalima's "no free inputs" policy and de-linking of Care Group participation from food aid are strategies to support sustainability. Most DFSAs implement their Care Group activities in collaboration with the government health system, but continued funding remains the challenge, and concrete solutions beyond hopeful talk about UN agencies or other donors are elusive. All DFSAs are cultivating local leadership for SBC activities to some extent, and many make efforts to connect them to the formal system for longer-term roles. How to sustain motivation for volunteers is an unanswered question.

DISCUSSION

Common Strengths. There is much about the DFSAs' SBC work that is commendable and working well. Following are strengths that apply generally, although the degree to which they are evident varies widely across programs:

- Program designs apply lessons learned in previous programming and respond to guidance from FFP.
- SBC strategies reflect best practices, conducting and applying findings from formative research, using proven-effective approaches along with more innovative approaches.

- Programs integrate approaches in well-designed project structures that implement layers of mutually reinforcing activities.
- Community-wide learning is taking place, and positive role models are spurring shifts in attitudes and norms around things like male participation in child care and grandparents' support for maternal nutrition.
- Programs are working through existing community groups and developing local leaders and capacity.

Common Weaknesses

- The quality of SBC implementation varies widely, and often does not live up to designs.
- Strong research and SBC plans are handled by experts removed from direct implementation, so the vision presented in documents does not always translate to the staff and field workers who run activities.
- IPC, the most basic ingredient to the success of SBC activities, represents the most notable weakness of DFSAs.
- Implementers lack sufficient training in SBC and adult learning principles, and do not receive the ongoing mentoring and coaching for skills development needed for successful SBC interventions.

Formative Research. Barrier Analysis has proven beneficial to implementers seeking to identify specific behavioral determinants. But its highly structured methodology presents limitations. It should be combined with other methods, such as unstructured in-depth interviews, participant observation, focus group discussions, TIPS, and participatory action research methods, to uncover unexpected socio-cultural details beyond barriers that can help shape the design of activities and messages and catalyze change. Consultative, audience-centered methods have dual value in both the formative research and implementation stages and through deeper ownership, contribute to more sustainable change.

Capacity. Since demonstrated SBC capacity is so important to the success of DFSA implementation and given the capacity gaps evident among some implementing partners, it may help for requests for applications (RFAs) to require applicants to include either a concrete demonstration of their capacity or a plan for conducting SBC capacity assessments and training to fill gaps before implementation begins. More technical support may be needed to help implementing partners develop "low-dose/high frequency" approaches to in-service training to address specific weaknesses in a practical, targeted way. Encouraging implementing partners to have high-capacity field officers live in proximity to communities they support, and implementing fun team awards for key skills, could help spur continual improvement.

Care Groups. The Care Group model has some advantages that help explain its ubiquity, along with some disadvantages as an SBC approach. Care Groups are judged as a great way to achieve wide coverage, but reach does not necessarily translate into behavior change. Another potential disadvantage is the highly structured nature of Care Group module content that can create inflexibility. These drawbacks of the Care Group model can be mitigated by 1) improving the quality of IPC skills to ensure that counseling is done well, and that groups learn in a more participatory way; and 2) continuing to invest in complementary, community-driven activities that bring synergistic impact from the Care Group experience—as has been noted as a great strength of DFSA programs. Care Groups hold potential to be a shining light in a country's health system, but only if done well. FFP can play a role to develop systems for accountability to measure and improve quality implementation.

RECOMMENDATIONS

Two key take-aways from this review are:

1. While there is much similarity of approaches across programs, and, generally, many strengths found in program designs, the quality of implementation varies greatly. At this stage in the evolution of FFP's programming it may be more helpful to increase focus on implementation quality and capacity.
2. Analysis in this limited review has focused on how these programs stand against SBC best practices, but more systematic study would be necessary to determine what approaches are delivering better outcomes.

Recommendations for FFP and the broader implementing partner community to consider in future programming fall into several categories, as follows:

Reframing SBC in FFP programming:

- Focus more on quality of implementation and the necessary resources and capacities. Shift the balance of thinking from the "what" and "how much" to the "how."
- Prioritize focus on areas of strategic change likely to be impactful.
- Think more about demand than supply. Define local people as active change agents rather than "beneficiaries."
- Think of culture as an asset, not an obstacle.

RFAs, Applications and Guidance:

- Ensure designs follow best practices regarding the SBC process, but allow freedom to prioritize objectives and tailor designs for messages, tools and interventions to fit each situation.
- Require implementation planning that articulates a sound rationale for approaches proposed, and timelines, resources, and capacities to implement at a high level of quality. .
- Require formative research that includes sufficient desk study and primary data collection using a mix of methods following a comprehensive research protocol that justifies methods and maximizes efficiencies.
- Encourage maximum active involvement in the research process from local implementing partners' staff, community members, and government partners.
- Require an SBC strategy that is explicitly grounded in formative research and identifies key elements of the plan, including the target audiences, behavior change objectives, barriers and enabling factors, the key content, and activities or channel mix. Ensure that local staff, government partners, and community members are actively involved in the design of the strategy.
- Allow sufficient time and resources during the start-up period for all the staff and government partners to be trained on the strategy and ensure they know how to operationalize it.

Capacity Development:

- Implementers should be prepared to demonstrate their capacity in adult learning and SBC best practices from the outset. In the absence of such capacity, FFP should consider requiring implementing partners to conduct an SBC capacity assessment to ascertain needs, and then develop an appropriate plan for training project staff.
- Invest more in SBC capacity development with government partners who train or support community-level workers and volunteers.
- Invest more in ongoing coaching systems to ensure quality is developed and maintained from staff through to community volunteers.

- FFP should consider expanding TOPS-type technical assistance to ensure implementers can deliver adequate training of trainers for adult learning as well as ongoing quality improvement coaching. Mobilizing high-capacity peers within the DFSA/USAID network could be part of this effort.

SBC Best Practices:

- Promote use of more consultative, community dialogue methods for both the research and implementation processes.
- Use SBC approaches focused on all three levels.
- Promote the use of particularly promising approaches current DFSAs have used, including grandparents groups, Social Analysis and Action (SAA), couple dialogues, agriculture SBC agents, community drama, and other forms of edutainment.
- Segment and profile target sub-groups and ensure tailored activities, particularly for adolescent females.

M&E and Learning for SBC in FFP Programming:

- Require use of meaningful SBC indicators.
- Commission qualitative research on SBC impact among DFSAs, in particular, a systematic study of Care Group effectiveness in DFSA contexts.

Introduction

Background

The USAID Office of Food for Peace (FFP) supports nongovernmental organizations (NGOs) to undertake multi-year Development Food Security Activities (DFSAs) in sub-Saharan Africa, Asia, Latin America, and the Caribbean. These complex, multi-sectoral programs integrate nutrition and food security activities across a range of project platforms to achieve objectives in maternal and child health and nutrition (MCHN), water, sanitation, and hygiene (WASH), agriculture and livelihoods strengthening, governance, and disaster risk reduction (DRR). Social and behavior change (SBC) activities are designed to support DFSAs adopt new practices and foster new social norms contributing to the objectives. SBC is the systematic application of iterative, theory-based, and research-driven processes and strategies for change at the individual, community, and social levels.2 It is guided by an ecological approach addressing both individual-level change and change at broader environmental and structural levels to create an enabling environment for nutrition.

Evidence-based nutrition practices can be very hard to institute when faced with long-standing local practices. FFP's latest Technical Reference Guide (Food for Peace 2018) articulates the role for SBC in FFP programs and hints at the complexity of the endeavor:

> *Social and behavioral change is important in all sectors of FFP programming and can lead to improved food security practices at the community, household and individual levels. Engaging communities is an important part of social/behavioral change as it builds on local knowledge and provides key information to communities for solutions that last. Engaging persons of influence is also important. For example, grandmothers can serve as allies to young mothers for new child feeding practices. SBC approaches should pay attention to contextual factors such as culture, social structure, gender and age dynamics, and the realities of everyday life. Eating well in difficult circumstances is challenging and the solutions are not simple. There is a need for SBC approaches that leverage existing community resources and networks with new resources and information, and move beyond messaging to catalyze lasting change.*

In recent years, there has been growing concern about issues for which SBC is highly relevant, including sustainability, capacity building for implementation to high technical standards, and provision of non-food assistance as a complement to food aid. USAID's *Multi-Sectoral Nutrition Strategy 2014–2025* outlines six outcome-level indicators that are either behavioral or directly influenced by behavior, further highlighting the relevance of SBC program components that systematically address nutrition-related behaviors as well as the social and environmental factors that influence the adoption and maintenance of these behaviors.

The *Second Food Aid and Food Security Assessment* (*FAFSA-2*) (Van Haeften et al. 2013), citing persistent lack of improvement on nutrition and food security indicators, encouraged investment in proven-effective approaches for community-based health and nutrition activities. It called for formative research and cross-program learning that develop targeted and tailored SBC activities such as counseling and community mobilization for complementary feeding. The report highlights the need for improved

[2] FANTA/FHI 360. 2013. Food for Peace Brownbag session: "Elements of a Social and Behavior change Communication (SBCC) Program." Tara Kovach. Presentation October 2013.

counseling skills among community health workers as a "top priority." Systematic mid-term reviews of DFSA programming since 2016 have noted low-quality SBC interventions overly focused on "messaging." FFP's establishment of the *Refine and Implement* approach in 2017 presented an opportunity to address some of these weaknesses by integrating formative research and SBC strategy development before launching implementation.

As a reflection of these institutional interests and a commitment to applying the latest evidence, conceptual thinking, and best practices to maximize the quality and effectiveness of approaches used in DFSAs to bring about sustainable social and behavioral change, FFP requested FANTA to conduct a review of SBC methods and approaches within DFSA programs. FFP expressed particular interest in moving beyond the traditional information and communication-based approaches to embrace those more oriented more to community mobilization for sustainable systems-level change and to understand the extent to which current DFSAs were using approaches consistent with those best practices.

Objectives

Given these interests and aims, the objectives of the review and this report were to:

- Describe the fundamentals of SBC theory and practice and identify current consensus on evidence-based global best practices.
- Identify the SBC approaches being used by current and recent DFSAs.
- Identify how well those approaches are aligned with best practices.
- Identify the common strengths and weaknesses in the implementation of the SBC activities and the quality of implementation where it was possible to observe.
- Recommend steps FFP may consider pursuing to improve the impact of DFSAs' SBC activities.

Methodology

The review process began with a series of consultations with FFP/Washington, DC-based technical staff to agree on the scope and conceptual approach, as well as develop a list of key questions to guide the inquiry.

Sample Selection. The following criteria for the selection of programs to review (listed in Table 1) aimed to ensure enough data would be available and maximize the diversity of programs represented:

- Programs at least in year 3 of implementation, ideally with a mid-term evaluation completed.
- If a project had finished, implementing partner staff had to be available for interview.
- Geographic diversity: Asia and Latin America, as well as different regions of sub-Saharan Africa.
- Diversity of implementing partners, considering both the primes as well as the sub-partners leading on MCHN/SBC activities.

Table 1. DFSAs Reviewed

	Country	Project name	Implementing Partner
1	Bangladesh	Shouhardo III	CARE
2	Burkina	VIM	ACDI/VOCA
3	Guatemala	PAISANO	SC
4	Madagascar	Asotry	ADRA

	Country	Project name	Implementing Partner
7	Niger	PASAM-TAI	CRS
8	Niger	Swaki	Mercy Corps
9	Uganda	GHC	Mercy Corps
10	Zimbabwe	ENSURE	World Vision

5	Malawi	Njira	PCI
6	Malawi	UBALE	CRS

11	Zimbabwe	Amalima	CNFA

Topics Investigated. For each program reviewed, the following domains were investigated.

1. Formative research conducted and how applied
2. SBC strategy
3. SBC approaches used
4. Quality of SBC implementation
5. SBC capacity and systems for its development
6. Sustainability plans and potential

Data collection. Tools were developed to collect and organize data and the following data collection activities were undertaken:

- Review of program documents from 11 FFP programs in 8 countries
- Phone interviews with implementers from 7 programs and dozens of implementing staff in the field
- Site visits and observations of SBC activities in 15 communities with 4 projects in 2 countries (Malawi and Zimbabwe)
- Review of global SBC literature
- Consultation/interviews with SBC experts and FFP stakeholders, including TOPS advisors, FFP AORs, and community-based organizations

Data sources: Document review included key documents for each of the programs such as Annual Results Reports, and other documents as available. Most programs had a mid-term evaluation (MTE report and a formative research report. Many had SBC strategy documents, some had impact stories or other publications related to the program. All documents available that were relevant to SBC were reviewed.

Limitations: DFSAs are very complex projects, and SBC cuts across all program areas. Time and resources limited the depth and scope of the review. There was only one implementer interview for most of the programs, presenting a heavy reliance on documents. There is variation among programs in the quality of documentation and the degree of correspondence between what is in reports and what is done in practice, which makes it difficult to make judgments. Even systematic program evaluations have limitations, including variation of focus and scope, as noted in the FAFSA-2. Annual reports vary year to year, and don't always describe all the interventions or methods in detail. Terminology is inconsistent across programs, and indicators are not always standardized. All this variation makes comparisons difficult, if not unfair. The limitations of data available in a review like this make it impossible to determine what drives results.

Because of these limitations and also because of the FFP institutional/programming context/interests, this review was not comprehensive so can't offer definitive conclusions. It is designed to open up a discourse by sharpening the lens on an area of FFP programming that is not generally given attention in reporting and evaluation. It lays out the key domains essential to consider when evaluating SBC activities, but provides only some indication of what the programs reviewed are doing, and how well, drawing on examples in a way that may not fairly capture the full reality of any given program. As a result, the findings should be taken as illustrative of areas of success and concern, as issues that could benefit from more systematic study, rather than a definitive, comprehensive picture of the programs.

SBC BEST PRACTICES

SBC initiatives use a variety of approaches (see Figure 1) working at three levels:

- Advocacy to increase resources and political/social commitment for change goals
- Community mobilization for wider participation, collective action, and ownership
- Individual behavior change communication for changes in knowledge, attitudes, and practices of specific audiences

Three Facts About Human Behavior

1. Culture, norms, and networks influence people's behavior.
2. People cannot always control the issues that affect their behavior.
3. People are not always rational in deciding what is best for their health and well-being.

Advocacy addresses factors in the enabling environment to support broad change. Community mobilization provides an avenue for collective solutions and ownership of a problem and can help ensure design based on locally defined needs. Interpersonal communication approaches are most common for individual behavior communication change and are often shown to have the most impact in terms of behavior change, but they can be time and resource intensive, therefore more difficult to reach large audiences. Research shows that SBC programs work best when they work through multiple channels at these different levels and are based on evidence (C-Change 2011; Lamstein et al. 2014).

SBC for Nutrition

During the past decade, the global nutrition community, which had been focused on organization-specific efforts, has been converging on a common nutrition agenda to include micronutrient deficiencies, breastfeeding promotion, complementary feeding, and others. For instance, efforts such as the World Bank's 2006 strategy on "Repositioning Nutrition As Central to Development," the establishment of the U.N. Secretary-General's High-Level Task Force on Food and Nutrition Security, the Copenhagen Consensus (which concluded that nutrition interventions were among the most cost-effective in development), and the *Lancet* series on maternal and child nutrition (which provided a new evidence base for action on nutrition)—all occurring in 2008—helped drive the formation of this common agenda. Initiatives such as the SUN (Scaling Up Nutrition) Movement and REACH (Renewed Efforts Against Child Hunger) have supported country-owned, country-led strategies for addressing undernutrition.

Figure 1. Key SBC Components

SOURCE: Adapted from McKee, N. Social Mobilization and Social Marketing in Developing Communities (1992)

As consensus in global nutrition has coalesced around the first 1,000 days window of opportunity, there has been an increased commitment to the global nutrition SBC agenda through increased publications and international forums on nutrition SBC. A literature review by SPRING (Lamstein et al. 2014) and the first conference focused on SBC for nutrition in 2014 resulted in more evidence showing that SBC interventions can contribute substantially to improved nutrition outcomes. USAID's *Multi-Sectoral*

Nutrition Strategy 2014–2025 acknowledges the importance of SBC for nutrition: "Improved social and behavior change (SBC) strategies and approaches are essential for increasing optimal nutrition practices, demand for services and commodities, and ultimately, increasing utilization of services."

Key Developments in SBC Theory and Practice

Theories and models can guide the design of evidence-based programs and are meant to be a starting point. Theories help ground SBC practitioners and help in forming a hypothesis of what is going on in a community and how to best use available resources to address that. No one theory will explain every behavioral setting or is suitable for all settings; and adequately addressing an issue may require more than one theory. Creative and tailored use of models and theories increases the success of interventions. (Glanz et al. 2005). Table 2 presents some of the theoretical models that have influenced the field of SBC.

Table 2. SBC Theoretical Models

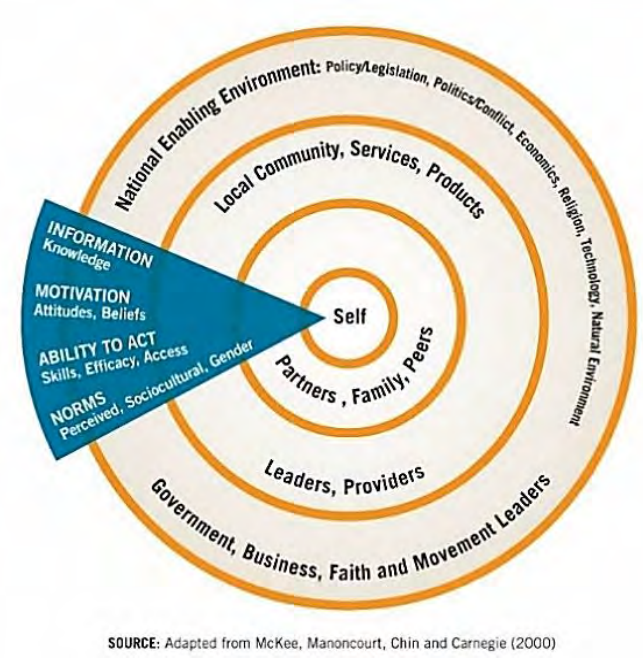
Theory	Emphasis	
Individual level		**More individual**
• Health Belief Model • Reasoned Action (Fishbein and Ajzen) • Stages of Change (Prochaska, DiClemente)	Planned behavior, rational decision-making processes (beliefs and subjective norms)	
• Fear Management (Witte)	Interaction between cognition and emotion	
Interpersonal level		
• Social Learning (Bandura)	Social comparison, learning from role models, self-efficacy	
Community level		
• Theory of Gender and Power • Diffusion of Innovations (Rogers)	Social influence, personal networks	
• Transformational Learning Theory (Mezirow, Freire)	Experience, reflection, and rational discourse	
• Ecological Models	Behavior as a function of individuals in their environment	**More social**

These theories reflect an evolution in thinking about human behavior that has been associated with re-orientations in public health practice. Thirty years ago, nutrition education focused primarily on information provision, simply telling people what to do. Now practitioners know that providing information, while important is not enough to change behavior. People make meaning of information and make decisions based on the context in which they live. Since people are influenced by the world in

which they live, simply addressing individual behaviors is usually not enough. So, the field of nutrition SBC has moved away from being a one-time, one-way communicative act to an iterative social process, basically a multi-level dialogue, that unfolds over time (C-Change 2011). Individuals act according to culturally influenced identities, hierarchies, and socially accepted norms. Recent evidence reinforces the notion that social support is often key to trying and sustaining behavioral changes (World Bank 2015). It is critical to acknowledge that even with information, motivation, and supportive social norms, individuals may not be able to adopt and maintain behaviors without the required skills, self-efficacy, and access to services and resources (USAID 2017).

The socio-ecological model in Figure 2 draws on various theories to view individual behavior as a product of these multiple and overlapping individual, social, and environmental influences, and captures efforts to both stimulate individual change as well as influence the social context in which the individual operates (C-Change 2011). This model represents the current gold standard for SBC practice. Several trends that continue to enrich the field are highlighted below.

Figure 2. Socio-ecological Model



SOURCE: Adapted from McKee, Manoncourt, Chin and Carnegie (2000)

The field of behavioral economics (BE) has helped the field of SBC mobilize the power of emotion and social norms to address health problems and stimulate enduring behavior change. BE draws on psychological research to distinguish two systems of thinking that drive human behavior—the automatic and deliberative systems (Kahneman 2011). Blending insights from psychology and economics BE has shown that individuals do not always behave in their own best interests, often choosing an option with the greatest immediate appeal at the cost of long-term health or happiness. BE New work on the science of habit (Neal et al. 2015) has contributed to approaches that disrupt unhealthy habitual practices and establish new habits, thus reinforcing sustainable change. These include changes in the environment, cues, and behavioral nudges that consciously or subconsciously trigger better choices (Thaler and Sunstein 2008). For example, providing multiple micronutrient supplements in small, affordable sachets and making them visible in local markets may make them more likely to be purchased (USAID 2017).

Another research trend points to the power of identity in behavior change. For example, a nutrition SBC effort could alter the social identify of a mother from one who supplements to one who exclusively breastfeeds, which carries with it complementary behaviors (e.g., a mother who exclusively breastfeeds may be more likely to take her child to well-baby visits, wash hands at appropriate times, etc.) (Meijer et al. 2017).

Audience-centered approaches focus on the perspective of the target audience and show promising results for effective SBC by involving audience members from conception through implementation of an SBC program and incorporating locally defined needs, ideas, and resources. Both design approaches and community dialogue approaches involve more listening and learning *before* introducing information, where the starting point is the person's or community's perspective, rather than the expert's information.

More participatory approaches to defining problems and solutions can provide better grounding for the design of interventions and tools and generate more sustainable results.

Human-centered design (HCD) applies principles from the private sector to solving problems in global health and development.[3] It places community members or individual "participants" at the center of the design and implementation process, engaging them with empathy in generating ideas, testing prototypes, and developing new solutions that are tailored to their needs. There are variations of this technique used in the field that use the "design" terminology. USAID's Center for Accelerating Innovation and Impact (CII) is partnering with Dalberg's Design Impact Group (DIG) to utilize human-centered design across the Bureau for Global Health's work. An example from that work generated strategies for providing family planning information and services to adolescents in Nigeria and India with tailored with private sector collaboration (http://www.engagehcd.com/dtc). A Feed the Future project in Nigeria commissioned a design firm, Picture Impact, to develop an illustrated "diary" for smallholder households that integrated health, nutrition, agriculture, savings, and livelihood messages. Picture Impact used HCD methods to deeply understand the people and details of their context. The resulting tool goes beyond communicating key messages to engage people in an active process of goal-setting and monitoring their own progress. (http://pictureimpact.co/think/project/1225/).

Community dialogue approaches apply principles of adult learning (Vella 2002; Boger 2010) and transformational learning theory (Mezirow 1991) to drive systems-level change while developing capacity. Examples include the "Whole System in the Room**"** method, which involves a 3-day workshop with diverse representatives from the community in a process of reflection on the past, grappling with tensions, and envisioning the future. "Stories-without-an-ending" (SWE), developed with a TOPS Small Grant by the Grandmother Project, promotes community-wide social change grounded in cultural realities through a participatory process of critical reflection and decision making about what behaviors to adopt. CARE's "Social Analysis and Action" method similarly draws people into reflection on their experiences and the meaning of proposed changes, making participants the architects of changes they choose.

Community dialogue approaches are notable for viewing culture and local knowledge as assets instead of as barriers to overcome. They depend on skillful facilitation and active participation of the full range of community members who truly listen to each other. They work because they allow people to voice their feelings and work through tensions related to change and give them the power to define problems and solutions so that when they agree to a course of action, their commitment is strong and the whole social system is engaged. While they may take more time and present some risk to program implementers, since the course of action may not be exactly what was planned from the top down, these approaches can increase the chance of sustainable results because of their solid grounding in the local community. While evidence sugges ts that community engagement can impact positively on health behaviors, most of what has been documented relates to increased knowledge and understanding of messages. More research is needed to link these approaches with clear behavioral outcomes (Bazzano et al. 2017).

[3] http://www.dalbergdesign.com/approach/; http://www.engagehcd.com/dtc; Jeanne Liedtka. 2017. "Evaluating the Impact of Design Thinking in Action." Academy of Management Proceedings VOL. 2017, NO. 1. Published Online: 30 Oct 2017 https://doi.org/10.5465/ambpp.2017.177

SBC's Systematic Approach

Developing an SBC program for nutrition should include a multidisciplinary team with nutrition, gender, and sectoral technical experts (e.g., WASH, agriculture, and education); SBC experts (communication and media/materials designers); in-country partners, including public, private, and community stakeholders; and monitoring and evaluation experts (USAID 2017). The following outlines a systematic approach for planning, implementing, monitoring, and evaluating a comprehensive SBC program (C-Change 2011).

Box 1. SBC Guiding Principles

1. Follow a systematic approach.
2. Use research to drive the program.
3. Consider the social context.
4. Keep the focus on the key audience(s).
5. Use theories and models to guide decisions.
6. Involve partners and communities throughout.
7. Set realistic objectives and consider cost effectiveness.
8. Use mutually reinforcing materials and activities at many levels.
9. Choose strategies that are motivational and action-oriented.
10. Ensure quality at every step.

Step 1. Understand the situation/context through formative research

Understanding the situation is the first step in any SBC effort. This requires: 1) analyzing the problem identified, including causes, effects and related issues; 2) defining the relevant population(s), both the people directly affected and others who influence them; and 3) studying the social and environmental context; and reviewing available research related to the problem. Because people are knowledgeable actors and experts in their own social context, program participants should be engaged actively in the formative research process to ensure that interventions are grounded in context-specific details that drive behavior.

Public health SBC programs use a wide range of research methodologies to explore household-level practices, preferences, needs, and barriers to behavior change, as well as cultural, geographic, social, economic, and other family and community factors. Methods include

Barrier Analysis (BA), a structured method to identify barriers to specific behaviors that is useful when quantification of findings is needed; focus group discussions (FGD) and individual interviews, for more open-ended exploration of how people think and talk about certain issues; Trials of Improved Practices (TIPS), which is good for getting experiential data on behavior changes that can be implemented in the short term; social network analysis and community mapping, which are useful for mapping influential relationships and environmental factors in a community; and various types of Participatory Action Research (PAR), such as Action Media and other forms of community dialogue, which elicit unique voices and perspectives through group discussion and debate and is helpful when aims include community empowerment and commitment for action. Triangulating methods brings best results. For example, BA helps implementers zero in on relevant behavioral determinants, but its close-ended questions limit insights needed to refine designs; the use of individual interviews and group dialogue methods allows identification of issues and values that can be incorporated into creative activities and tailored messages.

Step 2. Strategic program design

A strategic approach for a comprehensive SBC plan is developed in conjunction with a theory of change to indicate how activities will lead to outputs, outcomes, and, eventually, impact. The SBC strategy helps practitioners ensure that participants receive messages from different sources that complement and reinforce one another and are engaged in activities that support the program's SBC goals. The strategy also serves as a guide to which practitioners can refer throughout implementation to stay on track. Based on the results of the formative research, priority focus areas will be defined and an SBC strategy will identify and describe the target audiences, define behavioral determinants, articulate objectives, and select a mix of interventions and communication channels. Interpersonal SBC approaches include individual counseling; peer group meetings, such as Care Groups; and any kind of face-to-face interactions. Community mobilization could include activities such as town hall meetings, community dialogues, and community theater, which complement the more targeted or interpersonal communication methods. Mass media, whether print or broadcast, can bring extensive reach, but can never be a replacement for interpersonal approaches. Combining a mutually reinforcing mix of interpersonal, community mobilization, and mass media approaches that reflect focused priorities can maximize impact.

The success and sustainability of any intervention depends on local ownership, so the SBC strategy should be developed with stakeholders working across relevant sectors and levels. SBC interventions and plans for monitoring and implementing them should be designed in a way that acknowledges and carefully addresses differences among target audiences, and mobilizes local assets, so involving audiences in the design process can offer great benefits.

Step 3. Create tools, materials, and activities

In this step, the materials, tools and activities are created to implement the strategy. Formative research should guide the design of all program content, from printed communications like posters and flipcharts, training materials and counseling job aids, to mass media like radio and edutainment and community activities like video-making, cooking demonstrations, and farmers clubs. Concept testing and pretesting are undertaken to ensure that messages and materials are appropriate and relevant to their intended audiences and evoke appropriate responses.

Step 4: Implement and monitor

SBC teams develop an implementation matrix or work plan that turn plans into action. It helps ensure timeliness, cost-effectiveness, and quality in implementation. It should clearly link each activity to objectives, identify indicators to monitor activities, specify a time frame, and allocate budget and responsibilities.

Step 5: Evaluate and re-plan

It is important to learn from the experiences of the program and use this learning to guide the next round of work. However, research and evaluation do not occur only at the end of the SBC process. They are relevant throughout all the steps—for example, in the gathering of baseline information, the setting of measurable communication objectives, and in the monitoring of implementation. Ideally, an evaluation plan should be based on an explicit theory of change, and should include indicators of the inputs, processes, outputs, outcomes, and impacts identified. The information gathered through monitoring activities in step 4 should help implementers identify interventions or aspects of interventions that are not working as planned, to then make periodic or midcourse corrections (USAID 2017).

SBC involves complex issues related to human behavior that can be difficult to measure. But global evidence shows clearly that SBC *does* work when done well—that is, when it is grounded in a socio-

ecological model, using approaches that are tailored to fit the context and the audience, and following evidence-based principles and best practices. Guiding principles for effective SBC are presented in Box 1.

FINDINGS

Formative Research

Consistent with best practices to collect evidence upon which to base SBC designs, virtually all of the DFSAs reviewed have done some kind of formative research to inform the design of their program. While the methods, scope, and quality vary significantly (see Table 3), BA, FGDs, and individual interviews were the most commonly used methods of collecting primary data. Most of the programs wisely combined multiple methods to triangulate data. In one case reviewed, implementers reported not needing formative research beyond a basic community assessment of existing services.

DFSAs used BAs most frequently. It identifies determinants of selected individual behaviors through interviews with an equal number of "doers" and "non-doers"—members of the community currenting practicing and not practicing the selected behavior, respectively. The questionnaires and analytical methods used for BA are highly structured with pre-determined domains and yes/no questions and quantified results. The method is limited by its focus on individual behavior and self-reported data, so it is most valuable when combined with more open methods like focus groups, in-depth interviews, and community discussions. Some implementing partners report difficulty conducting BA, particularly the statistical aspects of data analysis. Those who administered it successfully had outside experts leading the process and invested in sufficient training for data collectors.

Selection of Interventions by Participants (SIPS), is a version of the well-known TIPS method (Trials of Improved Practices). Like BA, SIPS focuses on individual behaviors and behavioral determinants, but it also captures insights from participants on the actual experience of trying a new practice, rather than just reported experience with a current practice-- beyond what is captured through BA surveys. One DFSA in Zimbawe, the Amalima project, effectively used SIPS in conjunction with FGDs and IDIs.

Implementers did not often mention desk research as a part of their formative research, and so it may be undervalued. Implementers should always conduct a systematic desk review of existing literature on the project's socio-cultural context as well as public health research and data from sources like the demographic and health surveys. This helps focus the design of further research and could bring efficiencies by avoiding unnecessary inquires. The PAISANO project was able to begin implementation without doing formative research at the outset because they had robust data to draw upon from a predecessor project--the 2008 research done by Save the Children under PROMASA. While that was valuable, PAISANO did conduct formative research later as the project evolved and so produced a high-quality SBC strategy refined to meet the project's needs.

Community consultations and PAR-type methods were rarely used for formative research and represent a missed opportunity among DFSAs for a deeper understanding of the target community. One exception is ENSURE, which used Social Analysis and Action (SAA) as part of its initial gender analysis. While not observed, when interviewed, the staff emphasized the value of this participatory method. Such methods are valuable for gaining participants' active engagement in the process and for fostering buy-in, which is crucial to mobilizing and sustaining shared action. A guide from the Grandmother Project[4] offers implementing partners guidance and tools for conducting participatory community assessments and

[4] Aubel, J. and Rychtarik, A. 2015. "Focus on Families and Culture: A guide for conducting a participatory assessment on maternal and child nutrition." Mbour, Senegal: The Grandmother Project.

insights on the process for uncovering details about the values, social norms, cultural practices, and social networks in a community. Instead of following such guidance, it seems more common for DFSAs to hold community meetings called "consultations," which are less focused on listening and learning and more focused on informing stakeholders about the project's plans to cultivate "buy-in."

Participant observation is another valuable but under-utilized research method. It is the gold standard in anthropology, with valuable potential applications in FFP programs. Only one DFSA (PASAM-TAI) reported using observation methods.

Table 3. Research Methods used by DFSAs Reviewed

Research methods	# of programs (out of 11) reported using method
Desk Study	8
Barrier Analysis	7
Focus Group Discussions	7
Individual Interviews IDI, KII	6
TIPS/SIPS	1
Community Consultations/SAA	1
Observation	1
KAP (knowledge, attitudes, practice) studies	1
No research conducted	1

All programs conducted a gender analysis as required by FFP, although opportunities were missed to integrate the research and reporting of that exercise with the main formative research. In general, those gender studies used more participatory, in-depth methods which revealed helpful insights about values and norms. DFSAs could benefit from applying the same research methods in other areas of inquiry and better integrating the gender analysis with other formative research activities for MCHN and other project aims.

Application of results. While it was hard to judge the quality of formative research conducted,[5] the review looked for signs that data collected were applied usefully in the design of SBC. The strongest programs did a good job of analyzing the results from formative research and explicitly linking them to activities through carefully tailored tools and messages. For example, Amalima's TIPS experience found women were thrilled to discover the value of hind milk in satisfying babies who previously fussed after too-short breastfeeding sessions. Findings led the program to highlight the benefit of babies crying less and being satisfied longer. As a result of their gender analyses, virtually all programs developed activities to address identified needs related to household division of labor, support for pregnant women's nutrition,

[5] Reports available for review suggest a wide range of quality in formative research conducted. Some have sophisticated designs, some present only basic description of methods. Some show signs of best practices, including the use of mixed methods combining open-ended questions, observations, and group discussions with structured tools. Evidence of quality is found in some reports' rich socio-cultural details going beyond predictable barriers.

and sharing of resources. Many DFSA activities, such as Amalima's "Man among Men" campaign, do a good job of adapting methods of male engagement to fit male preferences. But strong research did not always translate into effective application of findings. In some cases, staff members could not provide examples of how research findings shaped the design of activities. Or, they gave rather superficial responses, as in this from an implementing partner interview:

> Q: What did you learn from the Barrier Analysis that helped you design the module?
> A: It was the handwashing.
> Q: What were the barriers?
> A: Some people don't like smell of soap. So, we have to convince people it's important, follow up through household visits, and meet with other influencers.

Here is another example of a weak application of formative research in a SBC strategy:

Barriers and priority results	Strategic Objective
The existence of food insecurity	The Project must implement strategies aimed at reducing food insecurity.

Many implementers cited the discovery that grandparents and fathers were key influencers for MCHN behaviors, therefore, those groups were included in home visits and received the same messages as those during mothers' care group meetings. While this is a valuable (if predictable) finding and an appropriate application to programming that follows widely accepted SBC best practice and FFP guidance in requests for applications (RFAs), a more probing analysis might allow identification of characteristics among different sub-groups of men that allows tailoring of approaches. For example, Amalima's focus group research resulted in three profiles of men who were motivated by sympathy and love, incentives, or status and respect. The male engagement activities were then designed to engage some men as role models, and with others, to focus on the concrete benefits the husband could gain from helping his wife. Another simple but great example of how projects contextualize and design activities to fit a local cultural preference is the use of songs throughout project activities in Malawi, Project designers understood the value of and context for songs and so integrated them into SBC activities. .

SBC Strategy

All but one program had some kind of SBC strategy, although the terms may vary (e.g., "BCC [behavior change communication] Plan," "Designing for Behavior Change [DBC] Framework"). The format, level of complexity, clarity, substance, and quality varies greatly. The way implementing partners present their strategic plan is not as important as the clarity with which they articulate its key elements and link those elements to the formative research findings, and how well the staff can operationalize it. Utilizing a systematic process for developing a strategy seems to be associated with quality.

Figure 3 presents a framework of the process followed by Amalima—an exemplary DFSA. It clarifies for the implementing team how a logical process flows from initial research, to more refined research, to the application of findings to develop a strategy, and then to implementation. It is a systematic, strategic process that takes time.

Figure 3. Amalima's SBC Formative Research and Strategy Development Process

There was a wide range of quality in the SBC strategies. While a few were rather superficial and neglect key elements, many reflect fidelity to the systematic process and do an excellent job of articulating how activities and messages apply the evidence and best SBC practices. These strong strategies demonstrate a conceptual grasp of SBC principles and include frameworks to guide tailored interventions at different levels. The best strategies have monitoring and evaluation (M&E) plans, like the exemplary Shouhardo III's SBC strategy, which describes a participatory system for M&E and SBC indicators. It is grounded in a well-articulated concept of SBC and the role of communication in behavior change, based on the following principles:

1. Action is what counts - not beliefs or knowledge.
2. Messaging is not sufficient for people to change their behavior
3. People take action when it benefits them; barriers keep people from acting
4. All activities should maximize the most important benefits and minimize the most significant barriers
5. Know exactly who the project participants are and look at everything from their point of view
6. The project will use participatory monitoring as a way to ensure the SBC activities and communication are effective.

The conceptual framework from Shouhardo's SBC strategy (Figure 4) is just one example of how elements of an SBC strategy can be effectively conceptualized:

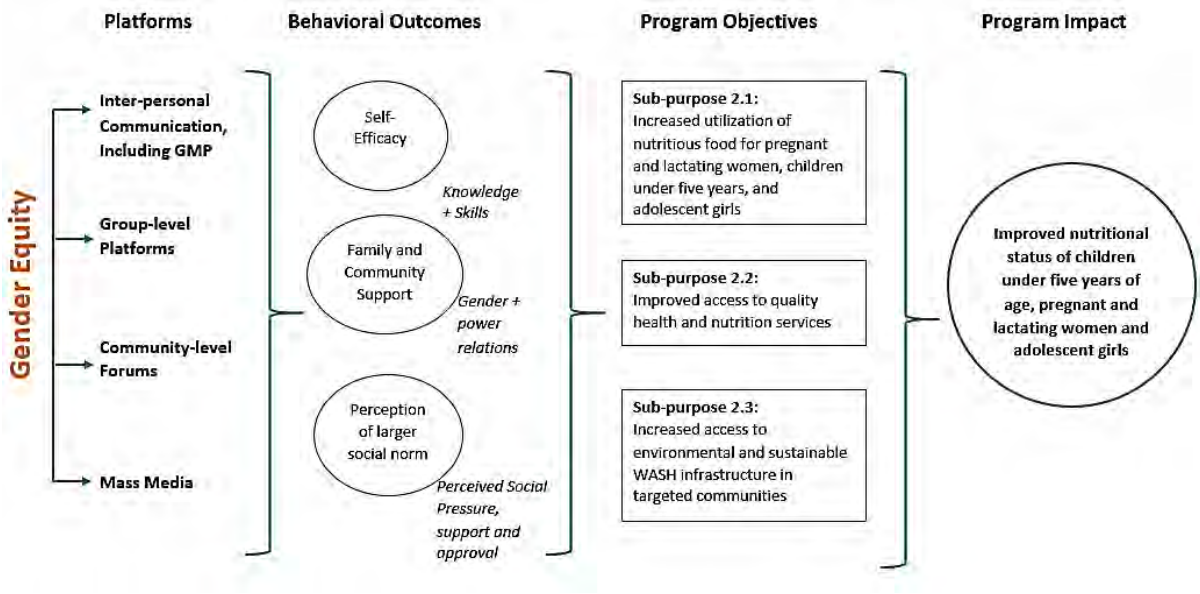


Figure 4. Shouhardo's SBC Strategy

Several programs explicitly incorporate the socio-ecological model, including PAISANO, Shouhardo III, and Njira. In Uganda, Northern Karamoja Growth, Health and Governance (GHG) program's SBC strategy includes an excellent application of the model, shown in Figure 5, indicating how a mix of methods target individual and social change at different levels.

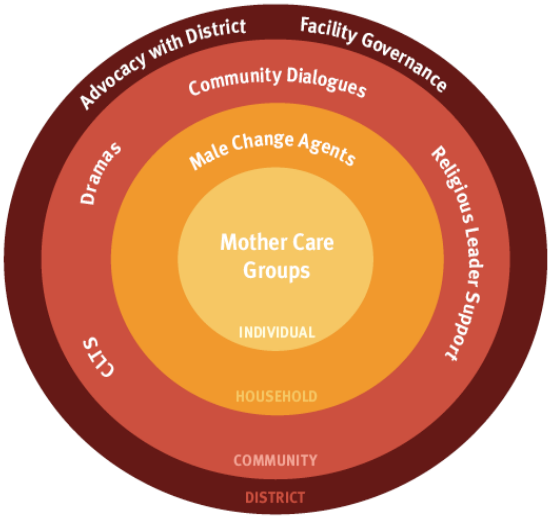


Figure 5. GHG SBC Interventions

The review found that even a well-designed SBC strategy does not necessarily translate into effective implementation by staff. For example, one team, in discussing some well-conceived SBC activities, said they had never seen the strategy and could not talk about how it applied findings from formative research, even though the program had top-notch global experts leading the SBC strategy development. Conversely, ENSURE's strategy was quite simple and not particularly well written, but the team members had clearly been involved with its development and could talk about its application. ENSURE was exemplary in the quality of its implementation.

The review looked to see whether and how each program's SBC strategy handled key elements identified in the best practices section above. Most program strategies focus on individual-level change, although growing attention within FFP and among implementing partners to social change and norms has led some to design strategies that engage influential groups and use community-based methods. An example from a DFSA SBC strategy that focuses on mobilizing local cultural assets for social change (instead of focusing on messaging for individual behavior change) comes from Shouhardo III. They identified grandmothers as an influential group, so organized grandmother peer groups with the aim: "first to establish rapport and communication with grandmother groups; second, to elicit dialogue and collective

problem solving by them; and third, to empower grandmother leaders to continue to elicit community dialogue on priority MCH topics."

All projects identified similar MCHN behaviors to promote, related to the first 1,000 days. Each had objectives related to nutrition for pregnant and lactating women (PLW), exclusive breastfeeding (EBF), early initiation of BF, infant and young child feeding (IYCF), as well as some WASH practices, such as handwashing with soap at critical times, safe water, and feces disposal. Also, every project included some kind of gender objectives involving male engagement. Specific behavior change objectives varied, however, as projects wisely prioritized their aims based on their situation and formative research results. For example, while virtually all projects aimed to improve attendance of pregnant women at antenatal care (ANC) visits, only some included family planning objectives or specific aims related to adolescent women/girls such as delayed marriage. Most programs had about 8–10 behavior objectives, some a bit more or less. While the review cannot judge the effectiveness of achieving objectives, programs seem to do better when they keep their aims low enough to allow sufficient depth of focus and layering of communication channels.

Many programs were weak on articulating communication objectives while others were quite specific about aims, such as to "increase perceptions that it is appropriate for fathers to help with child care" or "decrease grandmothers' approval of giving infants water." Programs generally focus on the aim to increase knowledge and identify "lack of knowledge" or "mistaken perceptions" as the main barrier, which in turn leads to activities focused on delivering messages to increase knowledge, as in this example:

Barriers and priority results	Strategic Objective
Lack of knowledge of the nutritional needs of breastfeeding women	Increase the knowledge of the nutritional needs of breastfeeding women

When communication and behavior change objectives relate to things like self-efficacy, or the perceptions of benefits, it points to the need for approaches that are more experiential and engage emotion.

Enabling factors—those that help facilitate positive behavior changes—are given much less attention in DFSA SBC strategies. The most commonly mentioned are factors like valuing healthy children and families. The stronger programs include strategies to mobilize these motivating factors, but it is rare to see a robust articulation of traditional norms and roles as community assets to work within behavior change strategies.

Elements that were missing from most SBC strategies reviewed and which could have strengthened them include profiles of segmented target audiences, advocacy components, and specific approaches to engage adolescent females. It is notable that despite widely recognized distinct needs faced by adolescent PLW, only one of the Care Group programs reviewed segmented adolescents to allow tailored messaging and support. The exception was the Shouhardo III, which mentions adolescent girls in one of its key purposes and included a focus on adolescents in its formative research and SBC strategy, which targeted them through tailored quarterly courtyard sessions. The project reported results from efforts to raise awareness through modules on adolescent nutrition, menstruation management, and early marriage.

A key factor that seemed to help ensure SBC strategies are used effectively in program implementation was having the local team and partners actively involved with developing the strategy and providing a good training on it. Some programs held dissemination or validation workshops on their SBC strategies, which is an important step to ensure that government partners and other stakeholders are aware of and supportive of the plan. But without intensive training to become well oriented to the program's specific

strategy, as well as training on the specific skills needed to implement, such as group facilitation, it is not surprising when an SBC strategy is not actively used to guide implementation.

SBC Approaches Used (and Overlooked)

This review documented an impressive array of approaches being used by the DFSA programs. Table 4 presents all of the methods or approaches used and the programs reviewed that employed them. Most of these approaches are using IPC as the channel of communication. Face to face interpersonal communication can be either one-on-one, as in counseling, or with groups, as in men's clubs or care groups. Community mobilization and media approaches were used less frequently and always in combination with some IPC approach. A few projects used radio, the only mass media method used, and a few used community video, a type of "edutainment." Both were used with IPC as they were linked with discussion groups. Farmer field schools and cooking demonstrations are not listed but are commonly used in DFSAs and present opportunities for SBC activities that are not usually captured in their SBC strategies and reports.

Table 4. SBC methods and approaches used by DFSAs reviewed

IPC Methods	DFSA using approach
Care Groups (or similar)	100% of projects reviewed
Other Peer Groups	
Fathers/men's clubs	Shouhardo III, PAISANO, Astory, Njira, PASAM-TAI, GHG, ENSURE, Amalima
Grandmother/Grandparents Groups	Shouhardo III, PAISANO, UBALE
Village Savings and Loan/Savings and Internal Lending Committee	VIM, PAISANO, Njira, PASAM-TAI, Amalima
Youth/Adolescents	VIM, GHG, UBALE, Amalima
Individual counseling / Household visits	100% of projects, largely through Care Groups
Village Agriculture Coordinator	Amalima (others have farmer field schools)
School of Nutrition (Guatemala)	PAISANO
Community Complementary Feeding and Learning Sessions (CCFLS) (Malawi)	UBALE (others have feeding programs and cooking activities)
Community Mobilization Methods	
Edutainment (community drama)	Shouhardo III, Njira, UBALE, PASAM-TAI, Swaki, GHG, Amalima,
Community dialogues (including SAA)	Shouhardo III, PAISANO, Astory, Njira, Swaki, ENSURE
Meetings with leaders	100% of projects, in varying forms
Couples activities	Njira, PASAM-TAI,
Intergenerational mentoring	Swaki
Radio	Shouhardo III, VIM, PAISANO, GHG, PASAM-TAI, Swaki,
Community video/listening clubs	GHG, VIM, UBALE, Swaki, PASAM-TAI,
Community-Led Total Sanitation	VIM, GHG, PASAM-TAI, Swaki, ENSURE, Astory, Njira, UBALE, Amalima
Advocacy[6]	Shouhardo III, PAISANO, GHG, ENSURE, VIM

[6] Advocacy could mean: policy advocacy with district/national government for access to services and support, advocacy with community and religious leaders for support of new practices and norms, or advocacy with health facility leadership. for improved services. Advocacy activities are most certainly underrepresented here, as most projects do some kind of advocacy without it being an explicit part of their SBC strategy.

As shown in Figure 1, advocacy is one of the three main approaches for SBC. But since most DFSAs focus on individual level behavior change, this is an under-utilized approach, even though it is mentioned in RFAs (for example, the FY13 Zimbabwe RFA calls for: "Improving adoption of key…practices through effective use of SBCC, *including local advocacy*….") Advocacy can help address the enabling environment for SBC and promote more sustainable changes. Most projects are probably doing some degree of advocacy with their government partners to promote participation and ownership of the activities or to promote change in policies or service systems. However, Shouhardo III is a rare example where advocacy is incorporated explicitly in a SBC strategy along with a defined approach, tools, and activities for its implementation, in this case focused on building capacity for farmer field schools to advocate for government services. GHG's strategy includes a more typical, general statement of advocacy aims in its strategy: "These will be supplemented by advocacy efforts with the local government and implementing partners to promote healthy behaviors" but does not include any articulation of how those efforts will be undertaken.

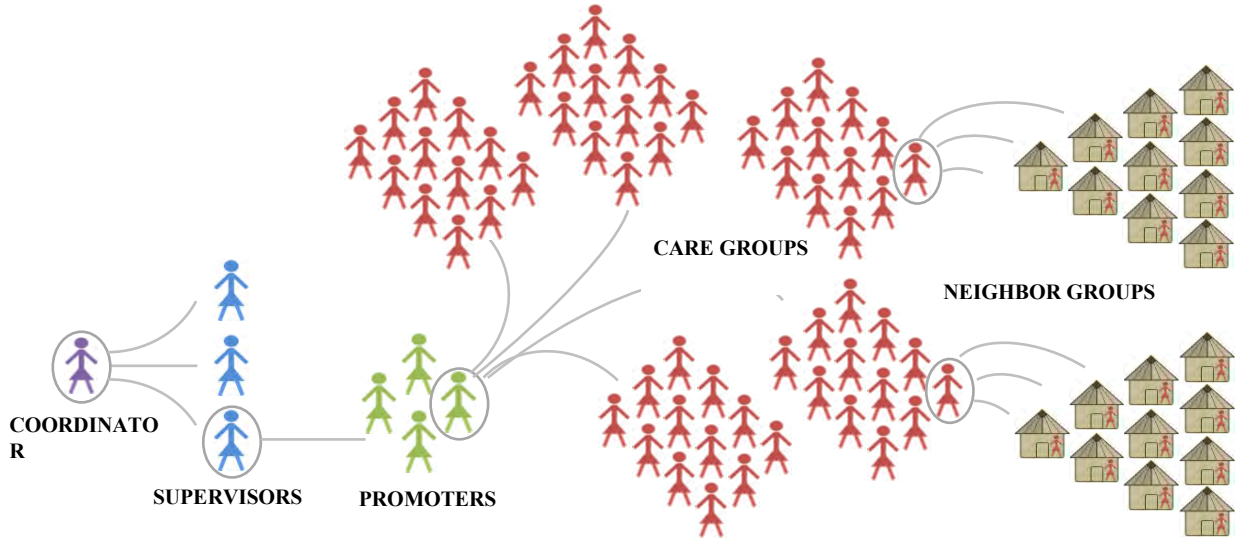
Care Group Model. The Care Group model is being used by almost all of the DFSAs reviewed (PAISANO and Shouhardo III operate similar activities based on mother-to-mother education and support), so the approach requires more detailed attention. DFSAs' implementation of care groups generally follows the global guidance found in technical reference and training materials offered to FFP partners through the TOPS program.[7] These resources have been introduced to partners through TOPS training and are available on the Core Group web site, but it is not clear to what extent partners make use of these resources, since fidelity to some details in the guidance is notably missing, particularly in regard to interactive facilitation.

Our review reveals that virtually all partners use the basic structure of Care Groups, as depicted in Figure 6, through which a group of 10–15 volunteers meet regularly with a leader for training on a series of topics, then pass on what they learn to 10–15 neighbors and support behavior change through household visits.

Care Group nomenclature and details of implementation vary by country to fit the local situation. For example, Njira has lead mothers meet with neighbor mothers as a group, and they only visit individual households for priority cases. While Care Groups have traditionally been implemented by and for women, men serve as promoters (the leaders who train neighborhood mothers) in some programs visited. One important feature of Care Groups is their integration with government systems, which varies by country. In Malawi, the model has been formally adopted by the Ministry of Health (MOH), which eases implementation and training systems and has clear implications for sustainability. In other countries Care Groups represent a new concept, and programs like Amalima report a longer and more difficult investment in getting implementation up and running, although they work through the government's system of village health workers as much as possible.

[7] The Care Group guide is: http://caregroupinfo.org/wp-content/uploads/2015/08/Care-Groups-A-Reference-Guide-for-Practitioners-7-11-16.pdf and the training manual is: https://www.fsnnetwork.org/care-groups-training-manual-program-design-and-implementation.

Figure 6. The Structure of a Care Group Program



Source: The Technical and Operational Performance Support Program. 2016. Care Groups: A Reference Guide for Practitioners. Washington, DC: The Technical and Operational Performance Support Program.

According to many implementers and government partners, the benefit of the Care Group approach is the wide coverage possible—the multiplying effect of the cascade model. It is a source of pride that Care Groups "get the message out" to reach every participant household. However, the commonly noted downside is the deterioration of quality, which is a hallmark of the cascade approach. Many project leaders note that they provide guidance on interactive facilitation approaches in training and materials, but due to weak skills of frontline workers facilitators still use directive techniques to deliver module content. A lack of analytical and critical thinking skills among uneducated lead mothers was cited by PAISANO as a factor in their difficulty to identify barriers and prioritize and negotiate possible solutions with mothers. It was noted that those with more education do better with facilitation, but that literacy requirements for Care Group leadership may result in leader mothers who are not motivated or fear public speaking, and disqualifying some mothers with passion and potential. Some implementers said that even after years of training and support, some lead mothers still struggle with counseling and facilitation.

Supporters of the Care Group model highlight it as a community mobilization approach, although implementing staff do not often speak of it in this way. Observations in the field affirm the passion of some participants to live as role models and engage their neighbors in a social change process. That galvanizing power seems to be unleashed when DFSAs have developed the Care Group model beyond its original concept of just working with mothers by engaging other groups who influence maternal and child health and nutrition such as fathers, grandparents, and youth; and by linking MCHN activities with those in other project domains (i.e., agriculture, livelihoods, and resilience). Care Groups function in DFSAs as a core element or hub of a network of interrelated community-wide activities including gender initiatives, village savings and loan associations, community theater, and grandparent engagement, demonstrating very effectively the "layering" and integration that FFP seeks from implementers. This application of the Care Group model positions PLW as the center of a socio-ecological model and there are signs that what we can call "Care Groups Plus+" will bring meaningful results.

Examples come from Uganda where the GHG evaluation showed that Care Groups combined with the male change agents *and* an income generation activity had the biggest impact. In Niger, all the DFSAs use the Care Group model and the midterm evaluation reports positive results from linking mothers' groups with other peer groups for father and adolescents, linking MCHN activities with literacy efforts, and fostering collaboration across project areas and even with surrounding communities.

DFSAs citing other benefits of Care Groups include VIM in Burkina, where they found that the model helped increase demand and use of health services from baseline to mid-term evaluation, and in Malawi where attitudes about colostrum greatly improved with BF education; and throughout the communities visited, signs of greater male engagement were clear, with men and women acknowledging shifting gender norms, expectations, and behaviors among the Care Group husbands who more actively support their wives.

Other Peer Group methods. Implementing partners have responded to the data on the importance of other groups on maternal and child health by organizing activities to engage those key influencers. All projects reviewed have some kind of men's groups to cultivate endorsement of gender equity, fathers' participation in children's health and support of strategies to improve maternal health and nutrition. One commendable feature observed is the way male engagement methods have been tailored to meet men's needs and preferences, rather than simply replicating the Care Group structure for men. Implementing partners reported strategies to engage men where they are—in work or social settings—talking informally and in limited doses about the same topics mothers' groups cover, but in ways that resonate for men. Given the importance of adolescent females in a 1,000 days approach to nutrition programming, it was surprising not to see more work targeting adolescents. Swaki offers an exceptional model for work with adolescent girl peer groups with their "Safe Space" program that includes literacy and intergenerational mentoring. GHG in Uganda is a rare program explicitly targeting youth in its strategy, working with youth-led community-based organizations on advocacy and drama activities.

Grandparents Groups. Responding to the growing acknowledgement of the important role played by grandparents on household health and nutrition behaviors, Save the Children is pioneering an important initiative for UBALE to engage senior members of the community. The project trains government partners to facilitate the grandparents groups, incorporating drama and discussions that complement topics addressed by Care Groups. UBALE's experience with this method could offer valuable lessons for other DFSAs.

Couples' Groups. A few programs go beyond male engagement and implement important work with couples. Recognizing that practices related to health and nutrition for PLW and young children are negotiated within complex household-level dynamics, and aiming to spur change in gender norms, such activities provide an opportunity for men and women to reflect together on shared values and aims as well as explore differences and tensions within a facilitated process. Njira holds couples' workshops and trains "model couples" who serve as community role models. Other projects that incorporate couple dynamics throughout implementation are ENSURE and PASAM-TAI with its "Smart Couples" initiative. Evidence of social change is noted through a sense of shared mission and leadership among the participating couples. New behaviors are being reported, like husbands helping wives with household chores, and pride

expressed that, as one man said about accompanying his wife to ANC visits, "people can see that our household doesn't have problems." [8]

Community Mobilization Methods. The other significant type of approach requiring special attention is Community Mobilization, which is important for its role in fostering change at the social level by engaging members of a community in a dialogue to participate in decisions that affect their lives. There are many kinds of activities that could be considered in this category, but the aim is to engage on a social system-wide level that distinguishes community mobilization from individual or peer group approaches, while still complementing them. DFSAs are making efforts to enhance programming by incorporating these methods, but more could be done in terms of scale and quality.

Most DFSAs seem to hold community meetings in the early stage of a project to "sensitize" the community members, especially leaders, with the aim of generating support. Then, community meetings are held periodically throughout the project with the aim of broadening exposure to key messages. Some examples of DFSAs' community mobilization efforts include UBALE's work with the CLANs (Community Leaders Action for Nutrition), Njira's Couples Workshops and Community Dialogues, and Paisano's "Nutrition Schools." These approaches exemplify best practices with their participatory methods such as Visualization in Participatory Programs (VIPP) and dialogues that elicit personal testimonies to grapple with barriers to changing nutrition behaviors. An example of good written guidance for facilitation of a community dialogue process comes from UBALE's Gender Champion orientation package, which lays out a method that can apply to any SBC activity:

> METHODOLOGY: We create a safe space for men and women
>
> 1. To reflect on, share and analyze their experiences
> 2. To develop and support strategies and skills for making changes
> 3. To experience the different approaches within the different modules before facilitating them themselves.

Another program example stood out for using community dialogue explicitly and effectively to facilitate a deeper process of reflection and to catalyze collective action to address the social and cultural norms affecting health and nutrition practices. ENSURE's Social Action and Analysis (SAA) approach, developed by CARE, was used initially to implement the project's gender strategy, but became integrated as an ongoing part of broader program objectives. SAA engages the whole community, including religious leaders, chiefs, and elders, to grapple with community norms. While it was not directly observed, staff members' description conveyed a strong understanding of SAA and ability to use the method effectively. As one staff member put it, "We promote a mindset of discussion, opening people up to behavior change rather than *telling* them what to do. It's a mindset change." It would be helpful for FFP to study SAA and other community dialogue methods to document how well they work in practice.

All DFSAs implementing Community Mobilization activities express their value in raising awareness and discussion within communities, but it is hard to know how well any of these methods are being implemented, and the extent of changes in household discourse and behavior without systematic research and evaluation. The key to success is skilled facilitation, and ascertaining quality requires observation**.**

[8] This comment arose in an informal interview between the reviewer and a community participant. It illustrates the kind of socio-cultural insight that could be gleaned from open-ended research techniques. If this was a theme emerging from formative research—that men in this social setting value domestic harmony—then the SBC approach could build a "supportive men have no problems at home" messaging strategy.

Limited observations in the field indicated this is likely a significant weakness. For example, at one community dialogue observed, representatives from all relevant groups were gathered in a promising situation. The facilitator began by announcing the topic and problem to discuss. There was no warm-up, no open questions to get people talking about the topic. The facilitator "engaged" participants by asking "How will we solve it? How can we convince people to do X?" There was no drawing out of their own experiences, no visioning, no probing questions for specifics on how or why. Participants looked bored, reflecting the lack of real dialogue. The lasting value of such interactions is an important question.

Community Video. Community video activities are a powerful form of edutainment as they engage both those who create the videos and their audience. Programs typically facilitate community viewing followed by discussions with the broader community and elders and community leaders, to process messages interactively. Examples are the GHG project in Uganda that used elements of human-centered design in the development of eight community videos, one for each of their promoted behaviors, and involved the community with design decisions and production. PASSAM-TAI screened WASH videos in partnership with a local digital cinema organization and facilitated debates among viewers about the content, showing the potential of video for community mobilization.

Mass Media. DFSAs use some mass media. Given the remote, resource-poor settings of these projects, it is not surprising the review found none used TV or social media. Several DFSAs incorporated radio into their programs (Bangladesh, Burkina, Guatemala, Niger, Uganda). In Uganda, GHG partnered with a local radio station to bring in volunteers for discussions, and then facilitated listening groups in the communities to stimulate discussion. As with community video, the value from radio broadcasts comes when community audiences are engaged actively in discussion in response to the topics aired.

Community Drama played an important role in the Bangladesh and Malawi programs, and was also used in Burkina, Niger, Uganda, Zimbabwe. In Malawi, UBALE used the Theatre for Development approach on which staff and community members were trained. Theater for Development is used to engage youth and is showing great results. For each production, the youth must investigate a topic that is currently being addressed in the community's Care Group. Their research engages them with local experts and gets them thinking about barriers to behavior change as they decide how to develop a story. When they perform, the whole community learns in a powerful, entertaining way. Staff and community members alike said Theater for Development has made a big difference in gaining traction for WASH and gender issues. In Zimbabwe, food distribution events are preceded by edutainment with community drama performances, song, and dance. In other countries, community drama is used with groups such as village savings and loan. And

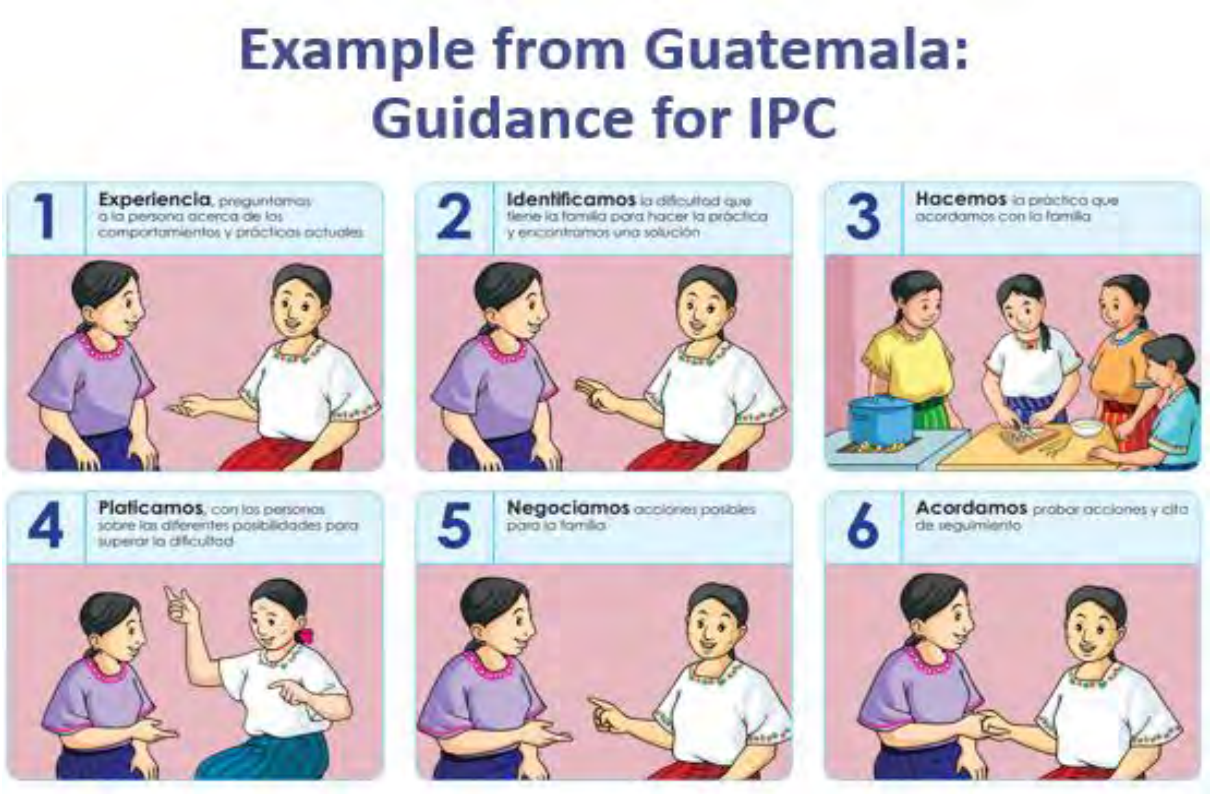
Materials and Tools

Printed materials play an important supporting role in SBC activities. Every program uses of flip charts, counseling cards, and posters for education and counseling. While this review did not conduct a systematic analysis of their content or development process, a few general comments can be noted. There is a wide variation across programs in the type and quality of materials. Some programs with sub partners who have strong expertise in this area have produced very professional designs based on thorough field testing (for example Manoff for Amalima). But in general, printed materials for many DFSAs may suffer from some common weaknesses found generally in public health programs. In addition to not being field tested with target audiences, only stakeholders, so lacking tailored adaptation to local sensibilities, they tend to be too complex, cumbersome to use, with too much information.

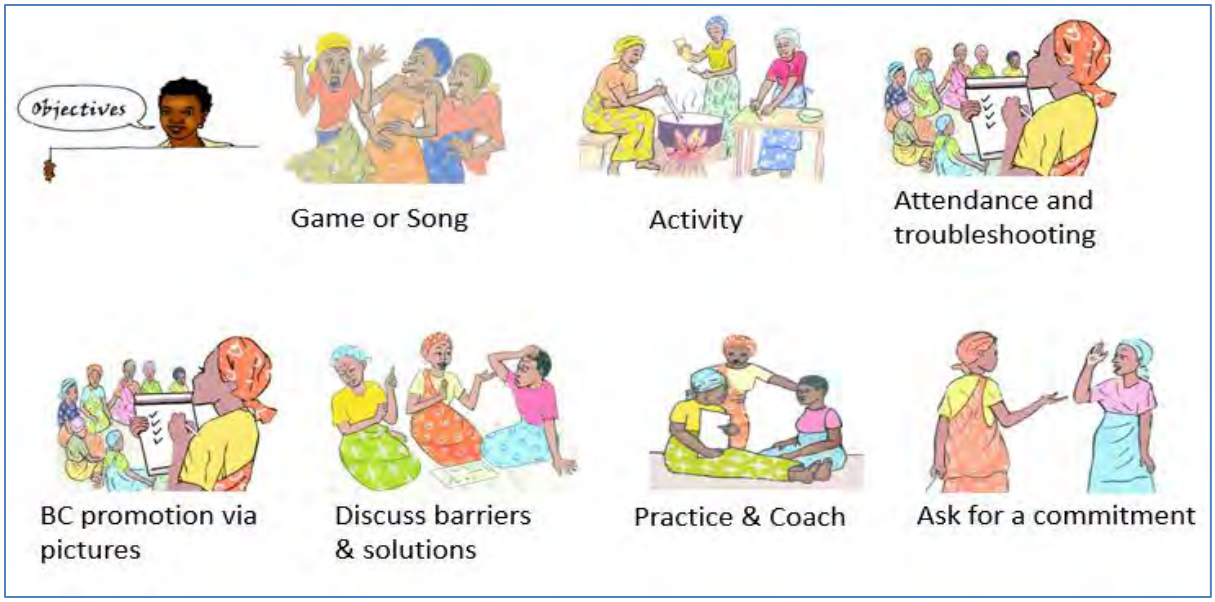
Quality of Interpersonal Communications

Since almost all the methods used by DFSAs depend on interpersonal communication, including Care Groups and all the related peer group activities, it calls for careful assessment of their quality. The review found that most programs have tools and guidance reflecting global best practices on how to facilitate group meetings and conduct counseling. For example, a PAISANO tool reminds a Care Group mother of the steps in home visit interactions:

1. Asking about her experiences
2. Discussing challenges and possible solutions
3. Doing an activity to practice skills
4. Brainstorm how to overcome barriers
5. Negotiate feasible actions
6. Agree on an action plan and next steps.



The global Care Group guidance (referenced in footnote 5) used by many programs provides the cues for facilitating care group sessions. The guidance is well designed to promote interaction. If sessions are not dynamic and engaging for participants, we know from principles of adult learning that the information won't be meaningful, and new behaviors won't stick.



Only through field visits was there an opportunity to observe how well programs followed this guidance and demonstrated IPC skills. Based on observations of Care Group sessions, household visits, and community meetings in 15 communities with four projects in two countries (detailed in Annex 1), this is an area for improvement. Key findings on the quality of interpersonal communication skills are:

- Most programs conduct sessions with a focus on delivering messages rather than engaging people in a process of learning to solve their own problems. An example indicating the orientation of implementing partners to messages instead of an interpersonal communication process comes from an interview with an implementing partner who was asked how the program supports the facilitation process for Care Groups:

  Q: "Do you have guidelines for running those meetings?"
  A: "Yes, the main thing is the key messages."

- When participants raise issues, there is a lack of probing questions by the facilitator and missed opportunities to support problem solving.
- Quality of counseling tends to deteriorate by the community level, even when expertise is evident at the train the trainer level.
- Program staff and stakeholders talk most about the content, emphasizing the *what* rather than the *how* of group facilitation.
- One crucial skill for counseling and group facilitation was almost completely absent: "teach back" to verify learning. In only one case observed did the Care Group facilitator perform the practice-and-coach step. The ENSURE project trained and supported participants to do this as part of their Dialogue Counseling Process through training simulation exercises and continual coaching. Notably this program was exceptional for *not* using information-heavy flipcharts in Care Group meetings. The effective facilitation using only a simple cue sheet indicates the value of focusing on the dialogue *process* rather than the content of Care Group meetings.
- In Zimbabwe, both programs demonstrated stronger IPC skills with more interactive care group sessions than observed (and reported) elsewhere.

SBC Capacity Development Systems

Since quality of implementation is so important, we focused on what DFSAs are doing for capacity development. This includes both initial training and systems for training and ongoing coaching. No observations of training events were included in this review, which would be the only way to ascertain the degree to which partners are using active, skills-based training methods based on adult learning principles. Partners consistently report that they use participatory methods and some mention adult learning principles. Some projects report using the Make Me a Change Agent tools and report good results with practitioners' facilitation skills. For example, ENSURE staff described the value of Make Me a Change Agent's very active group exercises that helped them as trainees realize that SBC is not just about knowledge.

Many programs use the Care Group Quality Improvement Verification Checklist for monitoring the quality of group facilitation. But it is not clear how systematically it's used, whether teams value it, and most importantly, how is it being applied. The checklist should be used for coaching as intended, not just monitoring.

In addition to project activities, programs are also developing SBC capacity through USAID/FFP support (for example the Zimbabwe mission's Learning Sessions), and cross learning opportunities with other DFSAs in country (for example the two Malawi projects collaborated on gender work) and other USAID partners (for example, Guatemala appreciated support from HC3). Some mentioned independent engaging consultants to deliver valuable trainings on Make Me a Change Agent and Essential Nutrition Actions. The issues of capacity relate directly to sustainability. As local partners gain skills and confidence to implement independently, project inputs can be gradually withdrawn for transition to post-project sustainability.

Sustainability

DFSAs are responding in varying degrees to FFP's call for sustainability planning, based on the sustainability study done by Tufts (Rogers and Coates 2016). To assess potential sustainability of SBC activities and outcomes, we look for signs of deep engagement in planning and implementation by host governments and community members, investments in capacity development for SBC implementation, and SBC indicators. This review did not undertake a systematic review of DFSAs' sustainability work, and could not evaluate actual behavior change, but a few indications of potential are noted.

Some projects developed specific exit plans, notably Swaki, with a full, stand-alone exit strategy, and Amalima, with a sustainability matrix that keeps staff focused on monitoring key progress indicators. However, many projects continue autonomous planning processes and later lobby governments to take up activities; do not define actions for transition of activities; and lack indicators for sustainability of social and behavior change. Often sustainability is more hoped for than planned for, as one implementer put it when asked about their sustainability plan: "I hope to come back in 2022 and see all leader mothers still working and helping their neighbors."

All DFSAs are cultivating local leadership for SBC activities to some extent, and many make efforts to connect them to the formal system for longer-term roles. For example, in Bangladesh, Shouhardo III is fostering community leadership by looking beyond obvious personalities to cultivate early adopters as peer leaders and connect the "natural leaders" to formal structures for sustainability. Beyond this, they have plans to phase out the incentives for volunteers and transition to a model of sustainable natural leadership.

Most DFSAs implement their Care Group activities in collaboration with their government health system, but the extent of integration varies greatly, as noted earlier. In Malawi and Uganda, the Care Group model

has been fully adopted by their MOHs, with training and implementation operating through the district health and nutrition systems, mobilizing and developing the existing cadre of workers. which enhances sustainability potential. But in places where DFSAs are newly introducing Care Groups, implementing partners are investing in building institutional commitment and a harmonized structure through which current and future implementers can carry on the work. Projects like ENSURE consider this advocacy a key strategy for sustainability in the absence of government funding.

Recognizing the potential distortion of motivation for long-term participation in Care Group activities introduced by conditional food rations, VIM planned to delay launching food distribution and begin health and nutrition education without that linkage in the year of the project , so that communities would come to value the education and promotion of behavior change as the main project elements (rather than being motivated primarily from free food) and be more likely to continue after food distribution ends. Similarly, Amalima follows a no free inputs policy and has de-linked Care Group participation from food aid. Notably, it was in this program that one participant surprised her peers and the observing implementing partner's staff by saying she was not even registered in the program for food rations, and that she came because she "liked to learn these things." This kind of locally owned motivation is more sustainable than that dependent on receiving a food ration.

DISCUSSION

Common Strengths

There is much about the DFSAs' SBC work that is commendable and working well. While there is a lot of variation in the degree to which these strengths are represented in various projects, in general, program designs have benefited from lessons learned in previous programming and research findings pointing to best practices for SBC.

- Formative research is being conducted and applied (with uneven quality, but it is a big advance that programs are universally committed to this best practice).
- SBC strategies reflect best practices and include proven effective strategies along with more innovative approaches.
- Programs integrate approaches, with well-designed project structures that implement layers of mutually reinforcing activities. Examples of piggy-backed activities include 1) the young child feeding sessions where family members are given education, counseling, and peer support for sustained nutrition improvements; 2) male champions engaging their peers at farmers' group meetings; and 3) model couples give presentations at Village Savings and Loan meetings.
- Through community-wide learning, positive role models are spurring shifts in attitudes and norms around things like male participation in child care and grandparents' support for maternal nutrition.
- Programs are working through existing community groups and developing local leaders and capacity.
- Implementing partners are benefiting from good technical support from their headquarters, and guidance through FFP. They enjoy apparently universal support from their host country governments, and to varying degrees, strong commitment to collaborate.

Common Weaknesses

The quality of SBC implementation varies widely, and often does not live up to designs. For many programs, strong research and SBC plans are handled by experts removed from direct implementation, so the vision presented in documents does not always translate to the staff and field workers who run activities. The "capacity gap" is wider in some programs than others, but if FFP addresses it, more optimal results could emerge from resources invested.

Interpersonal communication skills are the most basic ingredient to the success of SBC activities and represent the most notable weakness of DFSAs. While observations for this review were limited to four programs, the findings echo common observations throughout FFP and other public health programs globally. Despite clear technical guidance emphasizing participatory, audience-centered interactions, it appears that the majority of implementing staff lack a grounding in principles of adult learning and are therefore unable to model effective facilitation to frontline workers. The focus on disseminating messages remains powerful, and unfortunate, since, as noted in the SBC Best Practices section, evidence shows that information is not enough to change behavior. It is understandable that local staff replicate the directive style of communication they learned growing up and that has been reinforced by the information-driven approaches that have long dominated public health practice. If this cycle is to be broken, program implementers need to be given not just more training in SBC and adult learning principles, but support after training with mentoring and coaching that is built on repeated practice with feedback.

The other common weakness relates to the tendency to conceptualize SBC as about message dissemination for individual change. While implementing partners demonstrate commitment to the idea of social change through broader approaches than just individual behavior change communication, there remain missed opportunities to engage at the level of social systems and culture for deeper community-driven change. If staff and frontline workers improved their understanding of principles of participatory community engagement, transformational learning, and the skills to facilitate group meetings using dialogical methods, social norms and behavior could evolve in a deeper and more sustainable way.

Further discussion of key findings follows.

Formative Research

Barrier Analysis has proven beneficial to implementers seeking to identify determinants to targeted behaviors. But its highly structured methodology means it should be used only in combination with other methods that can uncover unexpected but powerful socio-cultural details that can help shape the design of activities and messages. For example, common DFSA BA questions to identify perceived social norms read: "Do you think most of your friends do ___?" and "Do you think most of the ___people around here do ___?" Richer insights could arise from a question like: "What kind of people would do __?" Another example, on perceived efficacy, a BA asks: "In your opinion, do you think that sleeping under mosquito net decreases the risk of you contracting malaria?" A more open way to elicit ideas about efficacy would generate more valuable data than the predictable "yes" response , for example asking: "What is the best way to prevent malaria?" would allow us to learn what portion of people independently offer the correct answer "insecticide-treated nets," and also learn what other ways people try to prevent malaria..

Some DFSAs reported implementation problems that could likely have been avoided if they had used more audience-centered consultative methods for formative research. For example, VIM started working with grandmothers but stopped when they found grandmothers "kept giving mothers the wrong messages." And PASAM-TAI reported that Men's Learning Groups did not initially take hold because men lacked interest in the topics they did not perceive as a priority for them. A mix of methods should be selected to address research questions beyond just "what are the barriers?" Unstructured in-depth interviews, participant observation, FGDs, TIPS, and dialogical and participatory action research methods can reveal nuances related to *how* people do things as well as why, and capture contextual details that help implementers figure out how to mobilize community values and assets to catalyze change. And, as noted, consultative, audience-centered methods help in both the formative research and implementation stages, bringing more "bang for the buck."

SBC Strategies

The power of RFA language to guide programming is evident when looking at the RFAs from 2012–13 to which programs reviewed here responded. Those RFAs requested applicants to "describe their approach to achieving high coverage," and consider "targeting influencing groups e.g. grandparents and spouses." RFAs encouraged implementation of Care Groups and Farmer Field Schools and included extensive gender requirements. The results are seen in a generation of programs implementing Care Groups, Farmer Field Schools, and gender activities, and focused on maximizing coverage.

RFAs in more recent years have included the call for a SBC strategy, responding to an earlier TOPS working group recommendation. An example from the FY13 Zimbabwe RFA required an SBC strategy in the application that described "how project staff will identify priority groups, influencing groups, priority behaviors and desired changes, behavioral determinants (barriers and enablers)" and key messages and activities that are "tailored to communities where project implementers will work."

However, the most recent 2018 RFA for Burkina Faso and Niger does not explicitly request a SBC strategy though it strengthens focus on social dynamics and sustainability of change, \ asking for: "Description of the approach and proposed interventions for the promotion of desired social and behavior change, and practices; and for strengthening of local systems, and, as appropriate, regional and national systems as well." And "Furthermore, the end goal should be a sustainable intervention - self-sustaining and reinforcing - such that the desired change creates a positive feedback loop. A strong component of this will be social and behavioral change strategies geared specifically to the various participant types."

Given FFP's strong emphasis on things like sustainability and gender for which SBC is crucial, future RFAs should include a carefully articulated call for SBC strategies, SBC staff, as well as plans for capacity development and monitoring for SBC implementation. One chief of party interviewed suggested that "USAID should require that SBC should be part of the design and be set up before implementation begins," which is an indication that implementers do not view it as a requirement to have an SBC strategy.

Care Groups

The Care Group model has some advantages that help explain its ubiquity, along with some disadvantages as an SBC approach. Care Groups are judged as a great way to achieve wide coverage, but reach does not necessarily translate into behavior change. Just because a message has been delivered does not mean that people have listened to, understood, or valued the message. We have to break from the assumption that information will change behavior. But since information is an important part of the change process—it allows people to make informed choices—it is important for implementers to ensure that 1) the information responds to peoples' felt needs and interests and 2) people engage with the information actively so they can learn, remember, and apply it to their lives. This is why the lack of probing opening questions and skipping the teach back step in observed Care Group meetings is of concern.

Another potential disadvantage is the highly structured nature of Care Group modules' content, which can create inflexibility. Most implementers say that practitioners are free to adjust topics, and this review did find examples where the program repeated modules that seemed not to have stuck or rearranged the sequence of delivery. But in general, the promoters and lead mothers are expected to stick to the scheduled topics and only provide tailored guidance during home visits. Without intensive, systematic observations it is impossible to know how well such tailoring is being done, although systematic interviewing with mothers after home visits would generate helpful insights.

Another drawback of Care Groups is the inclusion of adolescent PLW along with older women so that crucial opportunities are missed to address unique needs of adolescents. Given the low status of adolescent females and their household demands, they more often miss receiving Care Group leader home visits, so holding separate Care Group meetings for adolescents could make a positive difference.

These drawbacks of the Care Group model can be mitigated by 1) improving the quality of interpersonal communication skills to ensure that counseling is done well, and that groups learn in a more participatory way, and 2) continuing to invest in complementary activities that bring synergistic impact from the Care Group experience—as has been noted as a great strength of DFSA programs. Care Groups hold potential to be a shining star in a country's health system, but only if done well. FFP can play a role to develop systems for accountability to measure and improve quality implementation.

Capacity

It is important that all staff members have a strong conceptual grounding in SBC generally and are conversant with their own project's SBC strategy. Understanding the concepts and strategic aims seems to

be a weak link in DFSAs but is necessary for staff to support capacity development of frontline workers and advocate for greater investment of resources from local partners. Many involved with DFSA programs admit the loss of quality through cascade training systems. But more can be done to fuel the cascade by ensuring implementing partners have strong training in adult learning principles and process, interpersonal communication expertise, as well as the coaching skillset for quality improvement.

There seems to be no requirement in RFAs for actual demonstration of SBC capacity. Given the variation among implementing partners in the capacity that they bring, it would help for FFP to have applicants include either a concrete demonstration of their capacity or a plan for conducting SBC capacity assessments and training to fill gaps before implementation begins.

Several DFSAs have field officers living in the communities they serve, so their proximity allows for much more intensive on-the-job coaching and modeling of the techniques of interpersonal communication that are more art than science. Any opportunities to expand this staffing structure would help systems for ongoing capacity development—providing that the field staff have the right skills to be mentors.

Other considerations for capacity development include the value of a low-dose/high frequency approach to in-service training, in which specific weaknesses can be addressed in limited, practical sessions targeting only what is needed at a particular time. Another practice not noticed during this review but which could incentivize quality improvement is a system of recognition for specific skills. For example, at periodic team meetings projects could award a "Great Communicator" award for strongest group facilitation or give a "Big Ears" award for the counselor demonstrating best listening skills.

Sustainability

FFP has made it clear to implementing partners that sustainability is a crucial element that must be planned for in every program. As stated in the 2018 Niger/Burkina RFA, partners are responsible to develop "thorough and realistic sustainability and exit strategies that will result in lasting change [that are integrated] with the technical approach [and] incorporated into the activity design at every level." They should specify outcomes to be sustained and strategies to achieve them, including provisions for how "host country partners, the private sector, local government, and participants [will] take ownership of their development processes to sustain the critical services and programmatic outcomes."

Two major factors associated with sustainability identified in the 2016 Tufts study are particularly relevant to SBC—capacity and motivation. One type of approach that can be used for both formative research and implementation that is strongly associated with building local capacity as well as motivation and accountability involves the participatory, community-driven, dialogical methods discussed earlier. The more active people are with developing something, the more they learn and the greater is their stake in its maintenance. One study demonstrating the sustainability of SBC efforts (McMichael and Robinson 2016) found new norms and behaviors sustained 2.5 years after the intervention and attributed success to the intervention's focus on social norms and emotional drivers, habit formation, and collective action and civic pride. It would be helpful to have systematically collected data on SBC outcomes among the DFSAs that best implement participatory, dialogical approaches that aim beyond individual behavior change, and to measure impact several years after implementation has finished.

RECOMMENDATIONS

Two key take-aways from this review are:

1. While there is much similarity of approaches across programs, and, generally, many strengths found in program designs, the quality of implementation varies greatly. At this stage in the evolution of FFP's programming it may be more helpful to increase focus on implementation quality and capacity.

2. Analysis in this limited review has focused on how these programs stand against SBC best practices, but more systematic study would be necessary to determine what approaches are delivering better outcomes.

Recommendations arising from this review may have to a certain extent already been addressed as part of FFP's "Refine and Implement" initiative, designed to support more context-responsive programming by focusing the first year on formative research, community assessments, and refinement of DFSAs' theories of change in collaboration with FFP. Suggestions for FFP to consider in future programming fall into several categories, as follows:

Reframing SBC in FFP programs

Focus more on quality of implementation. Shift the balance of thinking from the "what" and "how much" to the "how." For example, if a sound rationale has been demonstrated for using an approach (e.g., Care Groups), try to ensure it is implemented as well as possible. FFP should lead the way in abandoning the language of maximum dissemination of messages, and instead adopt the language of dialogue and transformational adult learning. Ensure the key technical content is sound, then push for quality of group facilitation.

Prioritize the areas of change that are likely to be the most impactful. FFP should help implementing partners prioritize from the application stage, so no one tries to do too much. Sacrificing quality for quantity does not promote sustainable change. Less is more.

Think more about demand than supply. Define local people as active change agents rather than "beneficiaries." A more client/community-centered approach starts with deep listening to local needs and desires, then facilitates a process of nudging demand toward practices that global evidence shows will help but which people won't adopt sustainably based on just receiving information. Authentic engagement of community as partners to drive change is a reversal of the tendency to begin with project inputs/information/food/ activities and trying to sell it to the locals.

Think of culture as an asset, not an obstacle. Project implementers often use the term "culture" in a narrow and negative way, as the barrier to behavior change their public health perspective is pushing. FFP leadership can help implementers re-conceptualize culture as a complex process of creating meaning that maintains society. Culture plays a stabilizing role in society but can also be the fuel for positive change.

RFAs, Applications and Guidance

The guidance and program direction FFP provides in technical reference and other documents can help improve SBC in DFSA programming. A general suggestion is for FFP and implementers alike to better **ensure adherence to best practices regarding the SBC process**, while allowing freedom to prioritize objectives and tailor designs for messages, tools, and activities to fit each situation. Some specific areas for attention follow.

Applications should articulate a sound rationale for approaches proposed. There is need for greater rigor in demonstrating *why* activities are appropriate. Programs should avoid using approaches that may be popular but not justified in a situation, and at the same time avoid wasting resources by striving for innovation when a proven method is suitable. **Applications should articulate how implementation will be carried out** to avoid proposing something that's not practical or affordable. If an implementer cannot explain how something will be done, it may be best to eliminate that activity.

The most recent guidance and RFAs may be adequate in many ways. For example, language in the 2018 RFA for Niger and Burkina calls for "…details of *why* each intervention was prioritized and selected" and even the FY13 RFA for Zimbabwe contained good language that emphasized the need for quality over quantity in programming as well as the need to explain implementation plans:

> "Quality of programming is paramount to achievement of results**.** Applicants should propose coverage that allows good quality programming to be implemented and explain reasoning and assumptions in the proposal narrative."

If there are gaps between guidance and execution, it calls for more attention from FFP to ensure that both applicants and reviewers understand the expectations described in RFAs, and closer oversight to ensure application of that guidance during the first year under the "Refine and Implement" approach, which expects active engagement by FFP while assessments and formative research are being conducted and theories of change are being revised.

Formative research should include sufficient desk study and primary data collection using a mix of qualitative methods and following a comprehensive research protocol. **Encourage efficiencies** and early applications of learning by designing formative research methods that piggyback on baseline or other studies and **integrate the gender analysis with SBC formative** research. As part of this, **partners should study and profile all sub-groups targeted so that segmented activities can be tailored** to respond to specific details of a group's needs, values, and life context. Ensure that the choice of **research methods is justified** based on research questions. **Encourage maximum active involvement** in the research from local implementing partner staff, community members, and government partners. Ensure that implementers have **sufficient time** and demonstrate **adequate capacity** to conduct the research effectively.

SBC strategies should be explicitly grounded in formative research and identify key elements of the plan, including the target audiences, behavior change objectives, barriers and enabling factors, the key content, and activities or channel mix. Ensure that local staff, government partners, and community members are actively involved in the design of the strategy. **Allow sufficient time and resources during the start-up period for all the staff and government partners to be trained on the strategy** and ensure they know how to operationalize it.

Capacity development

Implementers should demonstrate their capacity in adult learning and SBC best practices from the outset. In the absence of such capacity, implementing partners should conduct an SBC capacity assessment to ascertain needs, and then develop an appropriate plan for training. The FY18 Niger and Burkina Faso RFAs wisely suggest that the staffing plan should present staff with substantive experience and skills including "stakeholder engagement, community level governance and planning, social and behavior change, and facilitation."

Invest more in SBC capacity development for project staff and government partners who train or support community-level workers and volunteers. Explore opportunities for broad-scale application of

training in adult learning principles and SBC methods at the outset, then **invest more in ongoing coaching systems** to ensure quality is developed and maintained from staff through to community volunteers. Any formal training (in SBC techniques, infant and young child feeding counseling, Care Group facilitation, etc.) must be followed up with intensive interactive, supervised practice in community settings. This review could not ascertain how many DFSAs provide this kind of support, but it could be worthwhile to **consider expanding TOPS-type technical assistance** to ensure implementers can deliver adequate training of trainers for adult learning as well as ongoing quality improvement coaching. **Mobilizing high capacity peers within the DFSA/USAID network** could be part of this effort.

SBC best practices

Promote use of more consultative methods for both the research and implementation processes. Incorporating local actors more actively, early on in a project. Using more participatory methods based on dialogue, deep listening, and community engagement will foster more authentic ownership and increase the chances of success and sustainability, even if it takes longer. These client- and community-centered methods have the dual benefits of 1) generating deeper understanding of the factors shaping peoples' behaviors and 2) engendering within community members a stake in the efforts, since their voices have been raised and heard and they have been involved with defining the problems and proposing solutions.

Use SBC approaches focused on all three levels. Strategies should address the individual/household level to support individual behavior changes; community mobilization for wider participation, collective action, and ownership; and advocacy to mobilize resources and political/social commitment for more structural change which could have broader and more sustainable impact.

Promote the use of particularly promising approaches:

- **Grandparents Groups.** There is consensus on the need to engage more actively grandparents as key influencers in households and communities. FFP may encourage systematic study of the experience exemplified by UBALE in Malawi as well as that of the Grandmother Project and promote successful efforts in future programming. Careful attention will be needed to how such groups are facilitated so that it is not viewed as an activity simply to convert the elders to the correct ways, but that the voices and experience of elders are drawn out to work through the sometimes-difficult tensions between old and new ways.
- **Couples dialogues**. Njira's program in Malawi and similar activities across FFP's portfolio should be studied to document best practices and impact of gender programs that highlight dynamics between women and men and the role of couples' initiatives in social change. Participatory methods should be used to develop leadership and capacity to facilitate couples dialogue and role modeling processes at community level.
- **Agriculture SBC Agents.** Amalima's Village Agriculture Coordinator is a behavior change agent explicitly invested to work as a peer educator who goes beyond demonstrating recommended practices and helps farmers work through barriers to adopting new practices. It is a pioneering role—the first of its kind in agriculture in Zimbabwe, and perhaps unique across DFSAs. It is a model for FFP to study and develop as a way to bring more SBC best practices into the process of supporting new agricultural techniques.
- **Edutainment**: As demonstrated by several projects, methods like community drama and community video are very effective ways to broaden and deepen learning as well as movement for social change. Edutainment can be a low-cost, high-impact approach that easily integrates with and boosts impact of other SBC activities. The key for success with these activities is to provide good technical guidance. Participants need training and ongoing support to ensure that creative activities are grounded in sound technical information and do not promote harmful practices, and that skilled

facilitation of community discussions will maximize the SBC value of community-wide entertainment.

Promote nutrition-specific interventions that focus on a lifecycle approach, with tailored interventions that address the distinct needs of adolescents and other sub-groups. For example, facilitate separate Care Groups for adolescent PLW and allow flexibility of lesson content to fit the needs of the group at a given time. While no one asked during the field visits about separating younger from older Care Group participants recommended doing so, one young woman's comments pointed to the value of segmentation. She said she never participated in group meetings because she thought it was for older people, and if her parents' generation participated, she did not think she should be there.

Ensure sound development of SBC printed materials and tools based on formative research and field testing with participants as well as users. Ensure content is simple and formats are user friendly and that users are given training and support to use materials effectively.

M&E and learning for SBC in FFP programming

Require meaningful SBC indicators. During the Refine stage, FFP can support partners to draw on the FFP M&E guidance strategically and remove any indicators that do not add concrete value to the project. While it is necessary to collect some process indicators, like the number of home visits made, and output indicators, like the number of community volunteers trained in infant and young child feeding counseling, it is important not to undermine fundamental behavior change aims and waste resources with an over-emphasis on counting how many messages were delivered. Outcome indicators on health and nutrition provide necessary evidence of SBC success in bringing about change in the targeted practices, but FFP and its partners also need to understand intermediate outcomes like changes in participants' self-efficacy, their intention to adopt a new behavior, or their perceptions of social status associated with the new behavior. DFSAs could also collect indicators of social change such as increasing community actions or advocacy, acceptability of discussing sensitive topics, or shifts in power relations in the community.

Commission a qualitative study of SBC impact among projects. Consider using participant observation as part of the mix of methodologies. Study the sustainability of both activities and behavior changes by going back after several years. Conduct a **systematic study of Care Group effectiveness in DFSA contexts**. The published studies are mostly limited to the early Care Group experience in post-war Mozambique, which may not be relevant to current DFSA situations. Data that directly link participation in Care Groups with health and nutrition outcomes would be helpful to justify future programming and advocate with government partners. **Also, study other promising methods that have not been well documented**.

Sustainability

Sustainability is a complex issue FFP continues to grapple with. The results from the Tufts/FANTA sustainability study, along with findings from this review, point to a few recommendations regarding SBC-related sustainability:

Invest in SBC capacity building and mentoring to improve accountability for project activities and sustainability. Since this can be resource intensive, pursuing implementation plans less ambitious in scope may be another way to boost quality that leads to sustainability. Less is more.

Promote more social enterprise and local institutions from the private sector as well strengthening partnerships with civil and public sectors. Lessons from behavioral science and SBC sub-fields like social marketing and human-centered design point to the importance of tapping humanity's entrepreneurial instincts at every opportunity to increase the chance of sustainability. Related to this is the importance to

recognize the **detrimental effects of hand-outs**. In addition to fostering dependency rather than the independence needed for sustainability, free inputs can send a message that the participants are not valuable, which works against sustainable behavior change aims.

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Annex 1. DFSA SBC Review Field Visit Itinerary

Activities on the trip to Malawi and Zimbabwe to review four DFSAs included meetings with FFP staff at USAID missions in Lilongwe and in Harare; meetings with implementing partner staff in project offices; and visiting communities with project staff to observe SBC activities and talk with volunteers and participants. In each setting there was time for questions and answers (Q & A), discussions with community leaders, volunteers implementing activities, and community members. Opportunities to observe actual sessions were limited. Direct observation of actual project interpersonal communications sessions consisted of: one care group meeting for each of the projects, home visit counseling sessions for two projects (one in each country), and one community dialogue. These form the basis of findings on the quality of facilitation, along with several role-plays in some sites that were done at the reviewer's request to demonstrate how such sessions would typically go. Relatively formal discussions with project staff were held in project offices, with teams presenting information about the programs followed by Q & A. In addition, throughout travels, countless hours of informal conversation with field officers and other staff occurred. Each day's activities are listed in the itinerary below:

MALAWI

Day 1 UBALE

- Blantyre: Met project staff (MCHN team) at UBALE (CRS) project office. Met project staff at Save the Children office (SBC and MCHN team).
- Blantyre Rural Field visit to village in Traditional Authority Machinjiri:
  - Observed Care Group meeting with promoter and lead mothers. Focus on dietary diversity and hygiene. Q & A after.
  - Observed youth drama performance [Theatre for Development (TFD)]. Skit focused on gender issues and dietary diversity.
  - Visited demonstration gardens (orange-fleshed sweet potato) with Care Group members
  - Walked around village, observed improved stoves being used, latrines and tippy-taps. Q & A discussion throughout.

Day 2 UBALE

- Met at CARE Malawi Office in Nsanje with Project Manager and MCHN team.
- Visit to Community:
  - Meeting with community leaders and CG members. Heard their presentations followed by Q & A.
  - Observed drama performance (TFD) on gender and nutrition themes
  - Nutrition demonstration: members of CG/GPG presented recipes using a wide range of locally available foods and juices they made. Q & A.
  - Demonstrations of tippy taps.
  - Observed CCFLS: Third day of complementary feeding program. Talked informally with individual mothers and community volunteers.
  - Home visitation with a breastfeeding mother, private interview.
- Dinner meeting with DCOP. Broad discussion on program.

Day 3: UBALE

- Field visits to Chikwawa. Meeting at CADECOM Office Nchalo. Met with project manager and MCHN team (5 field officers).
- Community #1: Met with community leaders and Care Group. Met with 15 care group members and CG promoter. Did not hold an actual session, but upon request, they did a role play to demonstrate how they would do home visits.
- Community #2. Met with Grandparent Group and community leaders for Q & A.

Day 4: Lilongwe

- Meetings at USAID and Malawi MOH (Director of Nutrition and assistant)

Day 5: Njira

- Field visits in Machinga District. Project Office: met Machinga Project Manager and 6 members of team at project office. Staff gave presentation, overview of the project.
- Community Visit #1:
  - Care Group mothers presented foods, seasonal calendar, food preservation rack.
  - Observed CCFLS
  - Observed Growth Monitoring
- Community visit #2
  - Walked around village, saw backyard garden and permaculture plots.
  - Met with community leaders and CG members in "Ubwino Center," also SLIC group, and fathers group. Q & A.
  - Visit to FDP to observe food distribution process, led by Care Group members.

Day 6: Njira

- Site visits in Balaka District. Meeting in Balaka office with the project staff for this district.
- Community #1:
  - Met with "model couples" and "male champions." Observed them doing a role play (upon request) to exemplify how they conduct home visit interactions. Q & A.
  - Observed Care Group meeting. Topic: family planning. Q & A afterwards.
  - Household visit. Observed Care Group Leader visiting a couple and their 2 children.
- Community #2:
  - Observed large community wide meeting. "Community Dialogue" with ~ 80 people, and 2 facilitators. Topic: male involvement in women's health.

Day 7: Njira

- Meeting with COP and DCOP. Discussion and debrief on visits.
- Afternoon: Drive back to Lilongwe.

ZIMBABWE

Day 1: Harare

- Meetings at USAID with Director Humanitarian Assistance and Resilience, Head of nutrition, and AOR for 2 projects.

Day 2: Amalima: Bulawayo

- Meeting with full project staff. Presented comprehensive overview of project.

Day 3: Amalima site visits in Mangwe

- Community #1: met with village agriculture coordinator) who gave presentation. Had Q & A with him and discussion with community group members.
- Community # 2: met with Village Savings & Loan group
- Community #3: Observed Care Group meeting. Topic: food groups, care for pregnant women. Discussion Q & A

Day 4: Amalima site visits in Gwanda

- Observed lead mother conduct home visit including mother and her in-laws.
- Afterwards, Q & A. Walking around homestead.
- Visited Food Distribution Point
  - Observed community drama activity
  - Met with Male Campions for Q & A
  - Care Group presentation of foods/cooking demonstration
  - Observed food distribution

Day 5: ENSURE site visits in Chivi District, Masvingo

- Courtesy call at DA's office.
- Chivi Community Visit
  - Gathered with community leaders and Care Group participants for discussion.
  - Observed full Care Group meeting using DCP, including role play of home visit.
  - Q & A with CG.
  - Q & A with Men's Fora group. They present nutritious dishes made with local foods, then serve everyone lunch they've prepared. CF for young children.
- CARE office: discussion Q & A with staff and review of project materials.

Day 6: ENSURE Mutare Office

- Meetings at ENSURE office with staff. In-depth orientation to project from team members. Interviews with staff as full group, and individually.

SBC Methods Used by DFSAs

Program	Radio	Print materials	Community drama "Edutainment"	Community Mobilization	CLTS	Care Groups	Other peer groups	Individual counseling	Other
Bangladesh – Shouhardo III	Y	Y	Y	Y	N	Y	Y	Y	GMP with nutrition counseling
Burkina Faso - VIM	Y	Y	N	Y	Y	Y	Y	Y	TV, radio
Guatemala - PAISANO	Y	Y	N	Y	N	N	Y	Y	Cooking demos
Madagascar - Astory	N	Y	N	Y	Y	Y	Y	Y	Farmer field schools
Malawi – Njira	N	Y	N	Y	Y	Y	Y	Y	Songs, farmer field days
Malawi - UBALE	N	Y	Y	Y	Y	Y	Y	Y	Community Complementary Feeding Learning Sessions (CCFLS)
Niger – PASSAM-TAI	Y	Y	Y	Y	Y	Y	Y	Y	Community competitions, traveling caravans, cooking demos
Niger - Swaki	Y	Y	Y	Y	Y	Y	Y	Y	Cooking demos
Uganda - GHG	Y	Y	Y	Y	Y	Y	Y	Y	video
Zimbabwe – ENSURE	N	Y	N	Y	Y	Y	Y	Y	
Zimbabwe - Amalima	N	Y	N	N	Y	Y	Y	Y	Village Agri Coordinator (VAC)

Annex 2. Information Resources

SBC CONCEPTS, MODELS, STRATEGY DESIGN AND TOOLS FOR IMPLEMENTATION

Alive & Thrive. Interpersonal communication and community mobilization: Featured tools. http://aliveandthrive.org/resources-main-page/tools-library/interpersonal-communication-and-communitymobilization-featured-tools/

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Prevention of Maternal and Child Deaths Initiative: Accelerator Behaviors. https://acceleratorbehaviors.org/index.

Reos Partners also provides HCD tools: https://reospartners.com/methods/

USAID's Center for Accelerating Innovation and Impact (CII) for developments of HCD applications in international development. http://www.engagehcd.com/

TRAINING CURRICULA AND RESOURCES

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GUIDES FOR DESIGNING, CONDUCTING, AND ANALYZING RESULTS OF FORMATIVE AND CONSULTATIVE RESEARCH

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Resources on Action Research methodologies can be found here: http://www.aral.com.au/resources/index.html

EVIDENCE OF EFFECTIVE, AT-SCALE NUTRITION SBC

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