

***Review of CSXVI Detailed Implementation Plans
to Assess PVO Behavior Change
Strengths and Needs***

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INTRODUCTION

The BHR/PVC has made 16 selections for the 2001 Child Survival XVI projects. The selected PVOs (Private Voluntary Organizations) have submitted Detailed Implementation Plans (DIP), which recently completed an overall technical review. Under a proposed Memorandum of Understanding (MOU), the CHANGE Project has undertaken to do a comprehensive assessment of current behavior change capabilities among the implementing Child Survival projects. The purpose of the assessment is to identify strengths and weaknesses in conceptual and operational capabilities, and to “articulate perceived needs, gaps and opportunities for building capacity and strengthening programs.” CHANGE has outlined a four-step process that includes 1) an electronic and/or telephone survey and face-to-face interviews, 2) consultative meetings with CORE members, 3) a review of the behavior change components of the CSXVI DIPs and 4) a written report synthesizing the findings from all of these steps.

This document constitutes 3), review of the behavior change components of the CSXVI Detailed Implementation Plans. The methodology used for this analysis can be found in the annexes.

SECTION I: BEHAVIOR CHANGE PROGRAMMING CAPABILITIES

This section will examine the degree to which the project DIPs successfully develop and apply the three essential guidelines for managing behavior change: formative research to develop databased planning, identification of key behavior determinants, and multi-level interventions addressing key determinants.

A. Demonstrated Capability for Conducting, Analyzing and Applying Formative Research

Established behavior change program standards require pre-project research that contributes to databased planning of activities. Decision-making is based on careful consideration of priority **audience segments** for intervention; **behavioral goal setting**; identification of internal and environmental factors influencing that behavior for that specific audience segment and, finally, identifying appropriate activities to address those factors and bring about needed changes in behavior, eventually affecting health outcome. This “data-based planning” requires that epidemiological, environmental and social data are available, either through project specific research and/or secondary sources (such as national health information systems, existing KAP and qualitative data, operational studies of health and other systems).¹

The child survival grant process requires that applicants demonstrate knowledge of relevant epidemiology and audience behavior, and demonstrate the application of these data to the planning process. The meta review therefore looked to distinguish levels of

¹ Please consult the USAID /BHR/PVO Technical Reference Materials for the most relevant behavioral models.

sophistication in collecting different types of relevant data and applying these data to program planning and intervention.

“...Conduct assessments, review existing data, consult available literature to determine health risk, identify behavioral factors, assess environmental conditions and test feasibility of proposed behaviors and interventions.”

Compilation from Child Survival BASICS Quarterly Technical Newsletter, 1996, and USAID/BHR/PVC Technical Reference Materials Dec.2000.

1. Methods

As stipulated by the USAID PVO Child Survival Grant Process, all of the project behavior change components conducted formative research of some type and to some degree. The most basic was the KPC survey (a requirement for PVO CS grantees), sometimes expanded to a KABP survey. Complementing this, over half conducted what they termed “Focus Group Discussions,” although in some cases the structure and results resembled more of a Question/Answer session. In at least two DIPs, no qualitative research was conducted to support or justify future desired behavioral outcomes. Plans do exist for qualitative studies once the project is on line, however. Facilities Assessments were the next most frequent type of research, wherein the number and condition of all relevant health institutions were listed. The facilities assessments lent understanding to the limitations of services and lack of use. Lessons Learned Workshops, Key Informant Interviews, Organizational Assessments, Worker Performance Assessments, Appreciative Inquiry, Verbal Autopsies, Social Autopsies, secondary data review and Stakeholder Assessments made up the variety of other types of formative research. Historical and anecdotal evidence was in abundance in some of the faith-based organizational DIPs. One in particular claimed that the staff has “intimate knowledge and understanding” of local beliefs and practices because they are all locals. While this acknowledged the NEED for data to plan, studies have shown that this is not a valid assumption as people filter their own cultural environments. It is hoped that conclusions made based on this data has been or will be verified via other, more scientific means.

Noticeably lacking were any reports on market studies or product planning, even though there are three net sales projects, one iodized salt sales project, two ORS sales projects, one birthing kits sales project, and one wells with fee-for-maintenance project. One project DIP includes a marketing plan outline in its annexes², however, this does not allow for examining current market forces and phenomena.

Roughly half of the projects intend to use the Hearth Nutrition Model as a project activity for malnutrition interventions. While it can be undertaken as an activity directed towards achievement of project goals, it was originally designed as a formative research tool for gathering information on locally appropriate foods and feeding methods, to be studied and scaled up as possible. There is some concern about whether PVOs fully grasp the scientific nature of working the Hearth Model, and they may overestimate what kind of results it will produce.

² PSI/Rwanda.

On-going research and qualitative studies are planned in approximately one third of the DIPS. Some of these include Operations Research, more FGDs, TIPS, and Action Research. Unfortunately, these planned endeavors do not always reappear in the work plan or the budget. Those organizations that undertook a larger variety and volume of formative research activities were able to better correlate the detail and alignment of the project interventions to desired outcomes.

2. Depth of Research

The projects seemed more at ease managing empirical and databased assessments, such as facilities inventories and worker performance reviews. The health risk assessments are sound, and bio-medical discussion is rich in many of the DIPS. This is a manifestation of the predominant professional strength of most project staff configurations. In terms of depth, the bulk of the focus group discussion (FGD) findings provided only a superficial look at the opinions, attitudes and motivations of the target groups. As earlier mentioned, the reports from some FGDs give the impression that the sessions were question and answer, serving only to reinforce what may already have been deduced from the KPC. The FGD findings suggest there were lost opportunities for really probing the causal relationships between beliefs and practices. Most stopped at documenting rather than investigating. Two examples can illustrate this point:

FGDs conducted regarding the promotion and sale of mosquito nets asked people why they did not have a mosquito net. The response was that the price was too high. No further probing appeared to take place. Possible questions that could have explored the subject further, such as, “in comparison to what?” or “what could you buy with that same amount of money?” – would open new avenues for investing value in malaria prevention.

Some mothers indicated in FGDs that they do not like the taste of Iron Folate, and this is why they don't take it. No probing was done to ascertain what that bad taste is, nor to inquire if there are other foods or items that they eat despite its taste because they know its benefits (chalk blocks in West Africa, for instance).

Only a little formative research provided insights into health care providers' performance ideals and their attitudes about their work and clients. Worker assessments and performance ratings indicate competency levels, but these do not reveal the motivational triggers of the personnel. Notwithstanding the litany of low/no salary, deficient physical environments and lack of supplies to work with, seeking out the opinion of the health care providers about their current working situations and their suggestions (within reason) for improvement, they can help projects more accurately focus training and expectations and address environmental factors affecting key behaviors.

While virtually all of the DIPS stated their intent to use a wide variety of communication channels, less than a quarter of the project DIPS reported on having explored media access and channel preferences of their audiences. One or two provided data on radio or

TV access, whereas most DIPs indicated a low to moderate literacy rate among women, and subsequently chose print channels that corresponded to this. Many of the indigenous cultures at the center of these projects engage in song, dance and drama as a traditional means of communication, and so the projects design this feature into their activities. However, it would appear that these communication means do not merit any analysis in terms of acceptable messages, forms of expression, or production costs and procedures, as would occur when exploring modern media options. Only one organization³ detailed how they would develop traditional media, and the need to have some instructional guidelines so that it becomes more than just entertainment.

A number of the projects are fortunate to have access to professional or academic institutions that can or did assist in conducting formative research, or continuing research activities in the area of communication and/or behavior science. In this way, ethnographic and behavioral studies can be undertaken at a pace and to a level of investigation for which most projects have little time and resources. Peru and Bolivia will access assistance from University communications departments, as well as an independent communications institute. In the past, graduate level students have worked on some Child Survival projects, undertaking in-depth study on an aspect for which project staff had neither time nor expertise to investigate. This will continue in some projects.

3. Developing Target Group Behavioral Profiles

The BASICS Behavior Change Matrix⁴ was elaborated in at least a few of the DIPs⁵ with some modifications. This is a graphic illustration of the current behavior, the surrounding factors and persons that support or reinforce these current behaviors, and the necessary other factors or persons' interplay to achieve the new, desired behavior. These different attempts to profile selected target groups will greatly assist the respective projects in gaining a full dimensional picture of the context in which the target group is functioning. For the remainder of the DIPs, most provided anecdotal or narrative descriptions (based on interpretations of the KPC) of the target group behaviors, but there was not a systematic organization of information that could provide a profile of each group, to then identify potential correlations and contradictions in the ensuing strategies.

4. Application of the Formative Research

The application of the formative research in developing project direction and strategy appears to be more reinforcing of existing hypotheses than truly formative or directional, at least in terms of behavior change planning. However, this may be largely due to the prescribed procedure for developing proposals and DIPs, rather than a skills deficit on the part of the PVO. The great benefit of most of the formative research is that it provides a snapshot of the global picture, and in determining the types and range of partners and generic target groups.

³ World Relief in Mozambique and Malawi.

⁴ Copy in the annexes.

⁵ CRS/Philippines, CARE/Peru.

Most PVOs acknowledge the importance of “knowing “ the target audience, and applying this to subsequent stages of planning. But the majority of PVOs skip the phase of audience research that explicitly identifies **priority** target audiences for maximum impact. So while extensive information is collected about “the audience,” it may not be about a priority audience. It appears that most of the target groups were chosen prior to conducting formative research activities. In a few examples, sub-groups (also known as secondary audiences were chosen following research that identified a particular set of persons who exerted significant influence on the primary target group. For example, ADRA/Haiti, World Relief/Malawi and Save the Children/Mozambique specifically identify men in their capacity as fathers after learning in formative research that they control health expenditures. World Relief/Mozambique identifies “grannies” as having significant influence and access to young mothers, and as such intends to develop a network for them.

Formative research that examined the external environment (policy, geographical, social, etc.) generally identified obstacles such as distance, lack of transportation, uninformed authorities and issues of gender bias. In some areas of political uncertainty (Peru, Tajikistan), projects were careful to take this into account. While many groups demonstrated knowledge of using “Positive Deviant Inquiry” to develop nutrition programs, none applied the concept to other technical areas; to look for existing solutions to external barriers by identifying and learning from individuals who had overcome barriers including external barriers. Likewise, there was no comparison of how these same external barriers influenced other non-health arenas such as getting produce to markets, attending ceremonies or other significant events, collecting taxes, etc. An exploration of this kind might identify possibilities for manipulating the environment, either to increase the probability of success, or to decrease the probability of failure.

A small number of project DIPs actually articulate the systematized link between the desired health outcome, the necessary behavior to perform in order to obtain that health benefit, the factors that influence performing or not performing the behavior and the activities that would be carried out to facilitate that behavior.⁶ In most cases, however, the systematic articulation is not so clearly defined. Just as the behavioral research findings are generalized (mothers do not breastfeed exclusively because they don’t have time), so are the lists of key messages (breast milk alone is best) and the accompanying activities (one-to-one counseling, mother’s groups, health education talks).

4. Conclusions

- On the whole, the process of collecting and applying of formative research to planning is well managed, and PVOs use the results to explain certain conditions and to justify key behavior strategies and interventions in their projects;
- The variety of formative research activities that was undertaken is impressive, and in some projects the interrelation of studies (ex. Malnutrition Surveys and Food Security Assessment) enhances an understanding of the problem;

⁶ Example in wording taken from World Relief/Malawi DIP, pp.88-.

- Findings and analysis in most FGDs are somewhat superficial, possibly reflecting a lack of depth in the research instruments, and/or inadequate skills on the part of the interviewers and analysts
- The value of on-going formative research is highlighted in some projects that plan for Action Research to develop mechanisms for working with traditional healers, or qualitative research for curriculum development⁷.

5. Recommendations

- Promote more thoughtful planning of the formative research agenda – what kind to undertake in order to learn what information and for what purpose, consistent with the project hypotheses;
- More careful development of research instruments (FGD guides), and in-depth training for probing and analysis;
- Refining analysis techniques that let planners hone in on priority audiences, behavioral determinants, appropriate activities and channels;
- Better application of the findings to identify ways to manipulate and mitigate the external environmental factors that increase or decrease probability of success;
- Project management should re-visit the FGD findings on a regular basis to continually mine the information within;
- Systematic planning and cross check of formative research findings against key behaviors and intended activities;
- Areas that need research attention: communication channels, market studies, health worker attitudes and opinions.

B. Demonstrated Capability for Identifying Key Behavior Determinants

“ The key behavior determinants describe current behaviors, both positive and negative. They also identify influencing factors – (credible) obstacles, cultural and social pressures and perceptions, and potential mitigating phenomena that will assist or obstruct adoption of new behaviors.” *Same sources.*

One critical factor in producing new behaviors that will change an epidemiological outcome is the accurate determination of old or harmful behaviors, their origins and influences (both internal and external), and the degree to which they may be modified. A ‘mis-diagnosis’ can send a project in a direction that will not produce a significant impact on the epidemiological status quo. Concurrently, the desired replacement behavior must be specified, and then the identification of a few factors or behavioral determinants that most strongly influence the performance or non-performance of that behavior among a particular audience. This is the importance of good formative research. There is an

⁷ Save the Children/Moz., and World Relief/Malawi, respectively.

established set of behavioral determinants to consider and “choose” from; some are internal factors like knowledge, attitudes, perceived risk and self-efficacy. Others are environmental or external factors like access to products and services, policies and institutional norms, cultural practices, etc.

1. Determining the relevant behaviors to modify.

A number of the faith-based organizations demonstrate a profound understanding of how to utilize current beliefs, practices, traditional hierarchies and influencers to great advantage for adoption of healthy behaviors. It is clearly stated that rather than trying to argue down or dismiss harmful traditional beliefs, the project approach is to examine the beliefs with the target groups and find ways to apply these existing beliefs to introduce or reinforce healthier practices, compare or replace faulty perceptions with healthy practices and beliefs.

The project DIPs of faith-based organizations (World Relief, World Vision, and ADRA) state unequivocally that they use the Christian concept of transformation (but not conversion) as a fundamental condition for success in behavior change. Through engagement in project activities, individuals and communities undergo “transformation” which enables them to make fundamental changes. The language to describe this process is vivid: “a matter of the heart”, “caught, not taught”, DREAMS listing. This spiritual ingredient is an open acknowledgement of the dependence on a higher power, and it is this aspect that distinguishes the process from other secular organizational approaches. Unfortunately, justification of this transformational approach often depends on anecdotal evidence, which may also make it difficult to replicate in a secular setting.

While not apparently compatible with a “scientific” or systematic causal model, such a transformational approach is quite compatible with the “empowerment” philosophies of many of the more secular PVOs. Though not stated by the faith-based PVOs themselves, the approach could be translated into behavioral terms (without the epiphany of spirituality). For example, “transformation” can be derived from the synergistic effect of increased self-efficacy, improved skills, and social supports including strong normative pressure. In turn, these support changes in intention to perform a behavior, changed attitudes and skills that bring about changes.

Three DIPs cited lessons learned from earlier or partner projects that emphasized the necessity of taking time to gain a thorough understanding and respect for people’s customs, myths, beliefs and practices, and of engaging the people themselves in adapting those areas as possible. This demonstrates the evolving state of behavior change practice.

Again, due in part to the ‘lightweight’ quality of the FGDs, and the lack of serious exploration of health worker attitudes, there may be some key pressure points in behavior identification that have been overlooked.

2. Determining other External Influences

This meta review looked for PVO programs that considered external as well as internal behavioral determinants in designing program plans. It was important to assess PVO consideration of external factors, to distinguish those that are taking a comprehensive behavior change approach from those more narrowly planning classical IEC programs. By definition, information, education and communication programs address internal factors such as knowledge, attitudes and skills, but rarely address external factors, such as access to products and services, availability of services and supplies, norms and policies.

Most of the DIPS did consider and subsequently identify external environmental factors and pressures from significant social influences that could impede successful implementation and subsequent positive behavioral outcomes, but that are subject to some form of manipulation through project activities. In one instance,⁸ the MOH-endorsed IMCI course is not up to the WHO standard, yet all partner organizations are required to use it. The DIP allows for the possibility of providing supplemental courses. In another case, an ITN project identified a series of challenges that are linked to the poor private sector perception of mosquito nets – both in terms of presence and value. The accompanying strategy to create demand and assure supply takes these factors into account.⁹ In other DIPS, the lack of analysis for just such environmental factors could hinder project development of appropriate strategies and matching activities. In some cases, there appears to be a disconnect between what the known influencing factors are, and plans to overcome or manipulate them. One striking example is from a Maternal Care project, wherein it is stated on several occasions that “...men show little active interest in the health of their wives, and grandmothers are opposed to pre-natal care.”¹⁰ These same players are the decision-makers in how family money is allocated, and whether or when a woman may seek professional health care. Yet there does not appear anywhere, a precise strategy that targets these influential persons apart from their collective membership in the community target group.

Some situations would have been easy enough to investigate, and propose some ideas. In one example for a growth promotion activity, mothers of small stature themselves may only see babies of low birth weight, and consider underweight babies normal. In another example, the external factor of household purchasing power has declined as stated in the DIP, yet the project intends to sell iodized salt (at a higher price)¹¹. The external factors in both of these situations could be susceptible to manipulation through project activities, but the DIPS did not examine the possibilities.

For PVOs who have identified that changing health worker behavior is key to improving certain health outcomes, overall they do not give a thorough exploration of a wide range of determinants that might be influencing health worker behaviors. So while the skills, attitudes and behaviors of health workers are considered barriers influencing individual and community behaviors, an exploration into the determinants of the behaviors of a priority “secondary audience” is rarely explored. For example, health worker attitudes

⁸ Save the Children/Bolivia.

⁹ PSI/Rwanda.

¹⁰ CARE/Peru.

¹¹ Aga Khan/Tajikistan.

may be identified as highly influential in mothers seeking immunization services. But little exploration then goes into what factors influence health worker attitudes and behaviors. The determinants that influence the behavior of health care providers, as indicated earlier, appear to be reduced in most DIPs to their working conditions and/or their professional knowledge and experience, leading to application of “standard” solutions, such as training, rather than involving health workers in developing more creative and targeted responses.

Some PVO plans are inconsistent. A number of DIPs provided evidence from their formative research that health personnel do know proper diagnosis and treatment for the range of illnesses, and yet do not consistently act on it. (underscoring that knowledge does not always influence their behavior.) One document acknowledged that health staff have good skills and ample supplies, yet clients would not come. “Low morale,” “disrespectful attitude” and “intellectual superiority” are some of the descriptions of the health personnel behavior, which would suggest attitude problems. These issues can and should be explored in greater depth, and appropriate strategies that attempt to address the underlying factors should be designed. Deeper motivations and more creative solutions can often be found in cases where the immediate and obvious causes cannot be altered (low salary, for example).

Policy influences on key child survival behaviors are barely considered. Policy makers at the decision-making level were individually and collectively interviewed by some project management, but the information provided did not appear to alter project strategy.

3. Designing New or Replacement Behavior Strategies: From Ideal to Feasible

Ideal behaviors are often not feasible for audiences to perform. Various techniques have been developed to work with communities (target audience segments) to develop behavioral recommendations that are both feasible and still efficacious. These methods by definition are always somewhat participatory, some more than others. Some identify existing practices as the starting point while others introduce ideal behaviors and invite modifications.

Two premises are acknowledged by some project DIPs: health improvement must be linked to the new behavior practice through monitoring; and projects should profit from the value of and need for social conformity in order to gain wider acceptance of new behaviors.

Most DIPs show a “rush to tactics,” or a “rush to “messages” with little attention to delineating a causal chain to explain the behavior change process. In outlining the desired behaviors, most DIPs jump to long lists of key messages. One DIP had 12 EPI messages, 7 CDD, 4 BF, and 8 STI/HIV/AIDS messages. Another had 33 intervention messages, and one had 20 messages.¹² Each of these messages has within it incremental message-steps that must be translated into action.¹³ Delineating each accompanying

¹² Africare, IRC, and Counterpart Int’l.

¹³ The PRITECH project once outlined 36 steps for a mother to accomplish in the process of making a solution of ORS, not counting administering and monitoring.

behavior and possible impediments is a critical exercise for project staff to perform. Hand-washing alone consists of about 35 component behaviors which present challenges or behavior change planners. Recognition of this level of intricacy was lacking in almost all of the Behavior Change strategy discussions. In addition, the benefits to the target group of performing the “new” behavior were not generally articulated (for example, the time that is involved in exclusive breastfeeding needs to have a beneficial trade-off attached to it that has meaning for the mother). Excluding these benefits is a missed opportunity for activating a vital mechanism to motivate behavioral adoption. In effect, many PVOs seem to underestimate the complexity of behavior change and the value (to the audience) of current practice), and don’t allow for the necessary ‘deconstruction’ and reconstruction of behavioral patterns in order to provide a satisfactory answer to the audience’s implicit question -“what’s in it for me?”

Those DIPs that intend to use the Hearth Model, and some others that have local Mothers’ Groups, plan to employ the concept of positive deviance cases, and the use of these cases for modeling behaviors. It is unclear whether they grasp the fundamentals of a positive deviant approach: that it must highlight a relevant positive behavior that is naturally occurring in the environment, and that is not initially an outcome of a project application. It appears that Positive Deviance Inquiry and Hearth Model are familiar buzzwords, but it is not clear that all groups proposing use of the technique have a solid conceptual or methodological grasp of the approach.

In addition, about a third of the projects’ behavior change strategies plan to exploit modeling behaviors, and the influence of social norms on attitudes and behaviors. These strategies make good use of local networks of influential leaders, and hold high behavioral standards for its collaborators. Goal setting for personal and collective behavior change is in itself highly motivational. The use of non-monetary incentives (soap, certificates, training, scarves) as positive behavioral support rewards the efforts. In some DIPs, the expected behavior changes determined for health care providers do not appear to address all of the issues that concern the target groups. One project documented mothers’ concerns about mistreatment, poor counseling, inadequate follow-up instructions¹⁴, but did not articulate new desired attitudes and behaviors that would be cultivated (in the training and supervision activities) or specify these issues in the projected training activities for health care providers at all levels.

Some interventions pose more challenge than others, for example, breastfeeding, and so specific research in some DIPs is proposed for examining obstacles and mitigating factors that will form the foundation upon which appropriate messages, spokespersons, and actions can be built.

4. Conclusions

There is overall recognition of the importance of individual, community, organizational and political factors positively and negatively influencing child survival health outcomes.

- There is a wide spectrum of understanding when it comes to applying behavior change strategies, which could be described as ranging from ‘mystery’ to ‘mastery’;

¹⁴ CRS/Bolivia.

- The planning step of identifying specific internal and external factors influencing child survival behaviors of interest may be the weakest link;
- The identification of key behavioral determinants is not always followed by an activity plan to address those determinants and to “lose or use” (negative or positive) specific behavior practices;
- The majority of the target group profiles do not have much dimension to them, beyond the basic demographic indicators of sex, age, educational and marital status, and income;
- The concept of incremental stages of behavior change, a causal model of behavior change and the delineation of steps to change is not in great evidence. Rather, there is often a “rush to tactics and messages.”

5. Recommendations

- More thorough examination of behaviors and what it will take for a particular audience to adopt the new behaviors (existing practices, perceived benefits of the current and proposed behaviors; exploration of the determinants of secondary audiences;
- More forthright and explicit identification of the conditions for success and potential barriers as a way to pull together all the formative research;
- More in-depth profiling of the target groups that organizes in a systematic way the basic demographic indicators, specific health beliefs, health-seeking behavior, lifestyle influences on decision making, and media or communication habits (see annexes for an example);
- More investigation of the motivations and influences that guide key policy and decision makers would greatly aid in advocacy efforts where needed;
- A step-by-step or checklist approach to detailing the increments of behavioral change involved in adopting an action proposed by a key message;
- List out the tangible benefits to be gained by engaging in new behaviors and the costs associated with the new behavior (in terms that have relevance and value for the target group), combined with a thoughtful comparison of these costs and benefits relative to the audiences’ current practice;
- Disseminate examples from those DIPs with good behavioral assessment, mitigation of uncontrollable factors, and alignment with strategies for improved health outcome.

C. Demonstrated Capability for Designing Multi-Level Interventions

“Plan multi-level interventions that are appropriate to both the target group’s stage in the behavior change process and the determinants of its behavior. Interventions are implemented at the policy level, service delivery, level, community, household and individual level.” *Ibid.*

Good multi-level intervention planning falls out of good formative research and the accurate determination of behavioral factors. Project interventions or activities must correspond directly to the particular set of behavioral determinants influencing target behaviors for a particular audience segment. Planners must identify “the right tool for the

job;” in other words, an activity that is appropriate for the behavior change objectives, and determinants of that behavior. If vaccine supply and health worker attitudes are identified as the factors most influential in effecting health behaviors, then an appropriate supply and monitoring activity and health worker training and supervision would be appropriate activities. Mothers support groups or mass media promotion would not.

1. Appropriate match between audience, behaviors, determinants and planned activities

This area for the most part, was interpreted by project planners to mean a delineation of interventions according to structural and organizational levels – as indicated in the latter half of the above definition. The great overall strength of the DIPs appears to be in the careful planning for training and supervision at various levels in a cascade fashion. Apart from the policy level (for which very few advocacy interventions were actually planned, though cited often), there are thorough training tables and work plans to accommodate the service delivery level, the community, household and individual level. In most cases, the interventions are appropriately “packaged” for the level at which they are operating. Those organizations with a more mature project environment, or a more advanced understanding of this capability¹⁵, field a collection of activities around one intervention that catch the different stakeholders at various points in their understanding and their level of responsibility. The most obvious manifestation of staging a multi-level intervention that moves beneficiaries along a progression of behavioral evolution, is in the formation, mentoring and ‘graduation’ of village health committees and Care Groups, which numerous projects intend to do. In one solid example, a project DIP outlines its BCC (among others) capacity building objectives by structural level, and then later in the sustainability discussion, defines stages at which the referenced capacity should be enjoined, and how that will look.¹⁶

In a good demonstration of devolving responsibility, a more mature intervention intends to turn over the ORT corners to Care Groups for management, thus allowing a greater level of decision-making and control. In those project areas that are less mature, the standard approach is a set of parallel but complementary training and behavior enforcing activities that should move the respective target groups along a linear track towards the desired outcomes. For example, one project will introduce CDD/ARI in an environment that has had little exposure to Child Survival concepts.¹⁷ Interventions include working with MOH and UNICEF to secure supplies of ORS for village pharmacies; training MOH staff in standard case management for CDD; training village-level health workers in recognition of danger signs and referral; and counseling mothers in danger signs and home care. All of these are interdependent and should one level not perform adequately, all other levels will be compromised.

¹⁵ World Relief/Mozambique.

¹⁶ PLAN/Cameroon.

¹⁷ Counterpart Int'l/Uzbekistan. Former Soviet Union countries are known for having hierarchical, top-down health structures based on curative services and pharmacological medication.

2. Difficulties and gaps

There are frequent disconnects between what behaviors are in evidence (or not) and the kind of interventions being planned. In an example of an immature program, one well construction activity¹⁸ plans to drill boreholes in selected communities and then turn them over to the communities to maintain, through the establishment and management of community funds. This kind of endeavor involves planning and passing through a number of progressively complex organizational behavior stages. No evidence of this kind of programming appears or is referenced in the DIP. No formative research examined this community's cultural experience with communal property and revolving fund mechanisms. In another instance, one project intends to introduce ITNs¹⁹ into a community, that, according to formative research, does not know that mosquitoes carry malaria, nor that nets provide a barrier to mosquitoes. Although one can assume that education will treat this issue, neither the logical framework nor the message development plan listed knowledge acquisition about malaria and mosquitoes as an indicator for behavior change.

One DIP provided a Step Progression²⁰ of the perceptions of women about malaria and mosquito nets that describes the evolution of knowledge and attitudes necessary to spur and support an action such as purchasing and using an impregnated mosquito net. It would have been advantageous to juxtapose the project's complementary activities along side the illustrative table. Other DIPs that propose to conduct ITN marketing activities would do well to study this example.

Despite the fact that many DIP narratives described challenges at the policy level that could hinder program progress, there were few appropriate interventions outlined in the DIP activity plans. Generally, some projects indicated an effort would be made to influence, change or support government or private sector policy on a variety of topics. Some of these issues include: the need to change laws to enable CHWs to administer medications (cotrimoxazole, birth control pills, etc.); import tax regulations on imported mosquito nets; policy governing the establishment of local NGOs; decentralization of health facilities management; MCH insurance; addition of mineral supplements to foods; and iodized salt imports. While the projects outline training, management and supervision strategies regarding all of these issues, the review was unable to turn up a distinct plan for advocacy for any of them. Advocacy for policy development includes information dissemination and training, but also requires a public relations plan that can identify persons, language and in-roads that might be susceptible to and aid in, policy development or change. It may be that nationally focused policy interventions are out of the scope of many PVOs. If policy determinants are key to influencing a particular child survival behavior yet the PVO does not work at the policy level, the PVO needs either to select another behavior on which to focus, or look for strategic alliances with other organizations who can focus on policy aspects while the PVO focuses on determinants that they can address.

¹⁸ Africare/Ethiopia.

¹⁹ PLAN/Cameroon.

²⁰ PSI/Rwanda.

3. Using multi-level interventions to influence individual and collective behavior

Some projects emphasize goal setting as an activity for personal and collective behavior change. In Rwanda and Mozambique, members of Care Groups must achieve individual goals and the group as a whole must also achieve and maintain a specific level of competency. This interdependence at the individual and community level is both supportive as well as highly motivational.

An important demonstration of the concept of planning a balanced program shows up in some DIP work plans for multi-level and staged interventions supported by performance indicators to be measured at different mid-points in the life of the project.²¹

4. Conclusions

- Some programs are mature enough to manage the Stages of Behavior Change in an organizational framework;
- The interdependence of multi-level, multi-audience interventions is manifest principally in the training activities;
- Many projects seem to underestimate some potentially obstructive covert attitudes, and do not develop plans for addressing these (for example, plans for cash contributions for well maintenance in a cash-poor community, women purchasing and using condoms independent of husband's consent).

5. Recommendations

- Better alignment of key behavioral determinants and the appropriate intervention strategies;
- Itemization of critical behavioral increments that are linked with key messages ("phasing");
- Deliberate expression of behavioral increments in the process indicators in work plans and for monitoring and evaluation. For instance, this might be articulated as Awareness phase, Knowledge phase, Attitudes/Skills phase; Trial phase, and Behavioral Maintenance phase.

²¹ IRC/Rwanda, PSI/Rwanda.

SECTION II. THE MECHANICS OF A BEHAVIOR CHANGE STRATEGY

INTRODUCTION

This section focuses on an assessment of the more ‘mechanical’ aspects of the DIP Behavior Change components – the basic processes that are universally recognized as necessary to engineer and produce behavior change activities, built upon the solid foundation of the programming principles.

The indicators for each capability were defined first in terms of ‘present or absent’, and then the degree to which the capability appears to have been achieved, using a scale of **3,2,1**. Each project DIP was evaluated, given a score, and then a collective score was assigned to each capability (see matrix in annexes). In this section, the discussion is of the conclusions, which permit a snapshot of the overall strengths and weaknesses in the capabilities and not the specific project DIPs.²² However, examples from specific projects can be found in Table 2 in the annexes.

A. Demonstrated Capability: A Behavior Change Concept that includes Capacity Building

“ Capability is to articulate a recognized concept that the project intends to develop, i.e., product social marketing, social mobilization, peer education, interpersonal communication, mass media...the concept is tailored to the selected interventions...provisions are made for capacity building to reinforce IEC/BCC planning and implementation skills that will eventually transfer these capacities

In 65% of the project DIPs, all of the indicators are present in the plan. The communication concept is well defined according to “industry standards.” It is appropriate for the type of interventions, i.e., choosing product social marketing to promote iodized salt sales or social mobilization to increase vaccination compliance by the first birthday. The concept meets the scale of the project, i.e., it is consistent with the number and experience level of staff and partners. The concept is appropriate for the profile of the beneficiaries, i.e., a print campaign is not the media of choice for a pre-literate target group. Nonetheless, capacity building generally means training for most projects, while the other aspects such as material, equipment and financial capacity for behavior change program management are not addressed. Where projects kept their IEC/BCC interventions simple and low cost (“high touch, low tech”), the links to sustainability were clearly stated. Finally, the limitations of the catchment area in socioeconomic and geographic terms were accounted for, i.e., distribution of materials and feasibility of travel for contact IEC activities.

27% of the project DIPs accounted for over half of the above criteria, but there were gaps that bear attention. A number of organizations seem to interpret behavior change or communication strategy strictly along social mobilization lines. A few referred only to information delivery, and spoke of the target groups as “recipients” of BCC.

²² A matrix exists for each DIP, should that be requested.

Four project DIPs fell out because of conceptual contradictions or gaps in the stated concept and the eventual planned activities. In some cases, the projects plan for technical assistance to recommend and design the conceptual framework, but this does not align with work plans. It suggests a less than serious undertaking in the arena of behavior change strategy, relying perhaps too much on bio-medical and material interventions to produce results.

B. Demonstrated Capability: Behavior change language within Logical Frameworks

“ The project logical framework includes behavior and/or communication objectives. The objectives are stated in behavioral outcomes, not just epidemiological results. There are process indicators that identify behavior change increments.”

The communication/behavior change objectives cited in the logical framework are coherent, with links to verifiable indicators, means of verification, and expected impact for 60% of the project DIPs. A number of the frameworks offer excellent examples of the process indicators for incremental behavior change.

21% almost achieved all of the indicators, the weak link being the ability or foresight to identify some process indicators for the stages of behavior change as the beneficiaries evolve over the life of the project. Nine projects did not identify anywhere in the document the necessary stages of behavior change, least of all in the project logframe. This relates specifically to the projects’ performance in Section 1. regarding key behavior determinants and multi-level interventions.

C. Demonstrated Capability: Presence of a Communication Plan, or Allowance for a Plan

“There are specific communication activities complementary to technical or clinical interventions. There is trained staff, or allowance for training staff in communication and behavior change activities.”

All of the referenced indicators are present in 59% of the projects. The goals and objectives for communication or behavior change results are subsets of the meta goals of the project. The communication activities are clearly identified and are integral to the technical or clinical activities. The chosen communication activities are tailored to the particular determinants. The staff indicated for implementation of the communication activities will have adequate time and resources for their purposes. The procedures or indications for product/material development are technically sound.

Thirty-four percent showed a nearly achieved communication plan. The area most often deficient was in the assignment of (trained) staff to develop and manage the component. Lessons learned suggest that resources, both human and material and time, are often underestimated for behavior change processes.

Low ratings were due to the inadequacy of the communication activities in keeping with the interventions. For a few PVOs, sales activities²³ will be undertaken, but there are no plans for social marketing strategies. There are many documented project experiences of failure when a product sales strategy does not include a well-planned marketing approach.

D. Demonstrated Capability: A Media Plan Supporting the Multi-level Interventions

“ The project cites a media plan, or the intention to develop one. Target group segmentation is cited. There is a procedure for product and/or material development, and allows for pre-testing.”

In less than half (44%) of the DIPs, all of the referenced indicators are present. In these plans the projects account for media planning, with a strategy and work plan reference to scheduling, delivery, production and monitoring. The procedures or indications for product/material development are technically sound. Target group segmentation is coherent, and consistent with formative group research.

For over half of the DIPs, a media plan is limited to a general laundry list of materials to be produced, and/or a list of messages to disseminate. In those cases where distinctions have been made for target groups, only a few actually specify different messages, materials or products for different groups.

Additionally, the procedures for materials development were often described in general terms, and do not necessarily indicate the importance of pre-testing. Again, lessons learned from production fiascos suggest that these procedures need to be well thought out, and contingency plans outlined.

Finally, a number of the projects intend to develop materials in the first year, with no future allowance in time or resources for incremental development and distribution of materials that would reflect the progressive evolution of the target group towards behavioral change.

F. Demonstrated Capability: Budgeting for Behavior Change and Communication Activities

“ The project budget allows for specific communication and/or behavior change expenses.”

For those project documents that provided budgets (11 out of 16), realistic estimates are indicated for materials production, use of consultants, and distribution costs in three of the eleven. In addition, training costs for communication activities are itemized, not

²³ Iodized salts, ITNs, ORS, wells maintenance.

absorbed in global training expenses. Good budget estimates are consistent with the serious intent to put resources where they will produce lasting results.

Eight project budgets folded IEC/BCC expenses into general training and supply categories. The concern here is that expenses for training and materials production are often underestimated. In at least three project budgets, the narrative indicates that a consultant will be engaged for IEC/BCC, but the complementary budget item does not appear. Budget narratives rarely give satisfactory detail on the IEC/BCC material costs, and do not indicate whether any cost investigation has occurred. Theatre and radio in particular, are often more costly than anticipated. Some projects plan to offer incentives, but no budget line item specifies this. In the case of social marketing activities, one project intends to do product packaging (iodized salt), but does not budget for this.

Five project DIPs did not have a budget attached, as it was not required unless changes had been made since the original submission.

G. Demonstrated Capability: Monitoring and Evaluating BCC/IEC Activities

“ The project monitoring and evaluation plan encompasses monitoring for results from the communication and/or behavior change activities. “

In some cases where the logical framework does not make reference to behavior change results, the project monitoring and evaluation plan does. A detailed outline of the type of monitoring and the frequency provides some process indicators. Apart from performance monitoring through supervision records, other data will reveal if the audience is being exposed to the intended messages, and eventually if the KABP (Knowledge, Attitude, Beliefs, Practice) are changing or not. A number of projects plan to conduct LQAS surveys on a timely basis. It will be essential to have mechanisms for assuring correspondence between LQAS indicators and the processes of behavior change. For example, if LQAS shows that immunization rates are not going up, troubleshooting should include a review of the frequency and attendance rates at IEC activities for immunization, as well a perusal of service delivery statistics, stock-outs, etc.

SUMMARY CONCLUSIONS AND RECOMMENDATIONS

The adoption and integration of behavior change principles and programming into the core fabric of Child Survival programs seems to have evolved favorably, in this the sixteenth cycle of USAID funding. The language of behavior change concepts has become a standard feature, much as preventative care gradually assumed a place next to curative care in the evolving years of primary health care program development. The complexity of planning for behavior change has been acknowledged by some of the organizations that participate in CSXVI, and the preparatory research, resources and expertise are being assembled. In much the same way that projects tend to engage medical personnel for the bio-medical success of the interventions, there are a small number of behavior science professionals or sociologists being engaged to assure the behavioral successes.

All of the DIPs demonstrated a grasp of the principles of behavior change. In some cases, there does not appear to be a real comprehension of the graduated distinction between IEC and behavior change. Wherein most projects recognize the dynamic interaction between bio-medical and behavioral interventions to produce real epidemiological impact, there are still remnants of the “delivery” approach. Some of the projects embrace behavior change both conceptually and operationally. At the same time, they acknowledge a gap in their current ability to develop programming, and make plans for technical assistance. A minority of the DIPs actually champion behavior change programming as the critical dynamic element in bringing about results across the landscape of factors – epidemiological, political, service delivery and overt/covert lifestyle modifications.

The areas of considerable strength include the conduct of formative research, and the use of a rich variety of methods. This in itself suggests that program planners are growing in awareness about how much information is to be ‘mined’ from studying the internal and external factors that influence behavior. In addition, the analyses recognize that these factors cannot always be manipulated by curative or commodity injections. There is general acknowledgment also, that BCC training is critical to engineering a strategy that rolls out in a systematic way.

While the intervention-specific key messages may be technically accurate, it is not always evident that they are actionable. In addition, plans did not always match the stage of behavior to the intervention (i.e., the type of program offered vs. the condition of the population). A number of the project plans call for BCC training and interventions at one interval in the work plan. Often the training occurs in the first year, and then specific activities are projected at finite times throughout the project. In a manner of speaking, it appears to be a way of “checking off” the menu. This approach seems static, and belies the dynamic nature of behavior change. It also suggests that they may not really believe behavior can be modified.

Finally, most behavior change strategies recognize and include the establishment of monitoring and evaluation mechanisms that will track the correlation between

epidemiological improvements, incremental behavior changes and changes in key factors or antecedent behaviors that accompany them.

* * * * *

For continued growth and more palpable success in incorporating a behavior change approach, the challenges lie in a number of areas. More rigorous examination of the findings of formative research, while time-consuming, should yield more insight into key areas of potential success or failure, ways to eliminate existing or potential barriers, and offer leads by way of examples from other non-health arenas. Planners can apply these findings more effectively to hypothesize the conditions for success. Notwithstanding the laundry list of usual barriers and constraints (distance, lack of transport and money, etc.), thoughtful analysis of formative research findings should provide some solutions for overcoming these.

It is essential that determinants be prioritized among the plethora of factors that can come up. In articulating key behavioral determinants, the potential benefits in performing the behaviors need to be ‘packaged’ in terms that have value for the individual, the household and the community. This may not always be the most obvious determinant. As noted in some of the documents, what is abnormal for informed project planners (underweight babies, fathers with little interest in the health of their wives, grandmothers opposed to pre-natal care), may be considered normal in the cultural setting. Values clarification, wealth ranking, and comparison listings are methods that can be used to assist in crafting the language of value, and adding value.

Truly understanding the incremental steps to achieving a new behavior requires careful delineation of what those steps look like, and how hard or easy it is to take them. Specifying an action such as buying a mosquito net when the target audience is ignorant of the relationship between mosquitoes and malaria (pre-contemplation) is a quantum leap that will not happen. A useful exercise for project planners is to develop a schematic, based on a casual model, that delineates each incremental step, and the necessary pressures, resources and behavioral supports that must accompany it – best done in reverse fashion. The TIPS activity can aid in this process.

Staging the interventions and the behavior change activities in the work plans needs more synergy between what the projects do technically and what they expect behaviorally from the target groups.

Finally, behavior change programs that have an advocacy dimension to them must plan accompanying public relations activities for policy and decision-makers as carefully as they do for their target beneficiaries.

Annex A.

METHODOLOGY

The review process began with a consultation of current technical literature on Behavior Change, including the processes involved in behavioral assessment and behavioral intervention plans. Reference materials include those listed by USAID in TRM, as well as BASICS literature and the Hearth Nutrition Model.

The review chose to apply universally recognized principle guidelines to serve as the key capabilities framework for evaluation. These guidelines, which were developed by AED under the BASICS I project¹, include: 1) conduct formative research; 2) identify key behavior determinants; and 3) plan multi-level interventions.

In addition a set of indicators assessed the ‘mechanical’ capabilities of the DIP plans. These included the basic denominators of IEC/BCC programs:

- Overall communication concept, including capacity building;
- Logical framework and cohesion to behavior change intended results;
- The communication plan;
- The media plan;
- The budget for communication/behavior change activities;
- The monitoring and evaluation plans for IEC/BCC.

A checklist was used to assess each DIP against these indicators, and then assigned a degree of achievement. It was not intended to conduct individual critiques of each DIP, and so a cumulative rating for each indicator, and not each DIP, was assigned. The reference tables are attached.

Following this, another matrix was used, in order to gather illustrative examples of the specific capabilities, and strengths and weaknesses within each category. This tool served as the principle outline for the narrative summary. The matrix is attached.

¹ BASICS Quarterly Technical Newsletter, Number 2, Spring 1996.

Numbered List of DIPS

1. Catholic Relief Services – Philippines
2. Aga Khan Foundation – Tajikistan
3. Project HOPE – Peru
4. World Relief – Mozambique
5. International Rescue Committee – Rwanda
6. World Vision – Cambodia
7. ADRA – Haiti
8. Save the Children – Bolivia
9. Save the Children – Mozambique
10. PSI- Rwanda
11. World Relief – Malawi
12. Africare – Ethiopia
13. CARE – Peru
14. ADRA – Guinea
15. Counterpart International – Uzbekistan
16. PLAN - Cameroon

CHECKLIST OF BASIC CAPABILITIES AND INDICATORS: COMPILATION OF 17 DIPS

Capability	Indicator	Yes 3	In part 2	No 1	N/I 0	Degree of Achievement
A.) The essential three guidelines for increasing impact for behavior change: 1) formative research, 2) key behavior determinants, and 3) multi-level interventions; are used to articulate project approach.	A.1. Formative research has been conducted or referenced.	1,3,4 5,6,8 9,10,11 , 13,141 6	2,7,1 2, 15			<p>3 = All of the three indicators are present in the plan. Formative research conforms to “industry standards”, providing justification for the choice of interventions and directing the design of key messages. Key behavior determinants are credible (obstacles) and realistic (desired behavior). Multi-level interventions are outlined that correspond to the target group’s behavioral profile, and are appropriate for the type of expected outcome.</p> <p>2 = Three-quarters to half of the referenced criteria are present. That which is included may lack depth, or be underutilized.</p> <p>1 = Less than half of the referenced criteria are present.</p> <p>N/I= No corresponding section or discussion was included.</p>
	A.2. Factors that influence key behaviors are identified, both external and internal, positive and negative.	4,5,8,9 11,13	1,2,3 6,7 10,14 15, 16	12		
	A.3. The project outlines multi-level behavior change interventions, i.e., at the policy level, the service delivery level, the community level, household and individual level as necessary.	4, 5,9, 10, 11, 13,141 5	1,2,3 6, 7,8 12,16			
	XX/POSSIBLE	78/144	42/96	1/48		
	%	54%	43%	2%		

Capability	Indicator	Yes 3	In Part 2	No 1	N/I 0	Degree of Achievement
B.) Project has a Communication Concept that includes capacity building.	B.1. The project has a recognized communication concept that it intends to develop, i.e., social marketing, social mobilization, IEC, or communication for behavior change.	1,2,3 4,5, 7,8, 10,11, 13,15 16	14, 12			<p>3 = All of the indicators are present in the plan. The project's communication concept is well defined according to "industry standards" It is appropriate for the type of interventions. The concept meets the scale of the project, i.e., it is consistent with the number and experience level of staff and partners. The concept is appropriate for the profile of the beneficiaries. Finally, the limitations of the country in socioeconomic and geographic terms are accounted for, i.e., constraints in terms of distance and financial accessibility to goods or services are mitigated.</p> <p>2 = Three-quarters to half of the referenced criteria are present in the communication concept.</p> <p>1 = Less than half the referenced criteria are present in the communication</p> <p>N/I = No corresponding section or discussion was included.</p>
	B.2. The concept is tailored to the selected interventions.	1,3, 5,6,8 9,10, 11,13 15	4 14	2, 7, 12 16		
	B.3. Provisions are made in Section I.G. on Capacity Building that clearly include reinforcement of communication planning and implementation skills among either staff or partners. Certain capacities are gradually transferred to collaborators or partners. Capacity building for IEC/BCC is geared toward sustaining new behaviors and behavioral environments.	8,9,10 11,13 15,16	1,2, 4,5,6 7,12, 14			
	XX/POSSIBLE	93/144	26/96	4/48		
	%	65%	27%	8%		

Capability	Indicator	Yes 3	InPart 2	No 1	N/I 0	Degree of Achievement
C. Capability: Logical Framework contains behavior change language.	C.1. <i>Project logical framework includes behavior or communication objectives.</i>	1,3,4 5,6,7, 8,9,10, 11,13, 15,16	2,14 12			3 = All of the referenced indicators are present. The communication/behavior change objectives cited in the logical framework are coherent, with links to verifiable indicators, means of verification, and expected impact. 2 = Three-quarters to half of the referenced criteria are present in the communication plan. 1 = Less than half of the referenced criteria are present in the communication plan. N/I = No corresponding section or discussion was included.
	C.2. Objectives are stated in behavioral outcomes.	1,4,7 8,9,10 13,15, 16	2,3,6 11, 14	5,12		
	C.3. Process indicators identify behavior increments.	6,7,9, 10,15, 11,16	4 13	1,2,3 5,8 12,14		
	XX/POSSIBLE	87/144	20/96	9/48		
	%	60%	21%	18%		

Capability	Indicator	Yes 3	InPart 2	No 1	N/I 0	Degree of Achievement
D. Project has a Communication Plan, or allows for the development of one.	D.1. There are specific communication activities complementary to technical or clinical interventions.	1,2,3 4,5,7 8,9,10 11,13 14	6,12 15,16			<p>3 = All of the referenced indicators are present. The goals and objectives for communication or behavior change results are subsets of the meta goals of the project. The communication activities are clearly identified and are integral to the technical or clinical activities. The chosen communication activities are tailored to the particular interventions. The staff indicated for implementation of the communication activities will have adequate time and resources for their purposes</p> <p>2 = Three-quarters to half of the referenced criteria are present in the communication plan.</p> <p>1 = Less than half of the referenced criteria are present in the communication plan.</p> <p>N/I = No corresponding section or discussion was included.</p>
	D.2. There is trained staff, or allowance for training staff in communication and behavior change activities.	1,2,4 10, 11 14,15	3,6,7 8, 9 12,13	5, 16		
	XX/POSSIBLE	57/96	22/64	2/32		
	%	59%	34%	6%		

Capability	Indicator	Yes 3	InPart 2	No 1	N/I 0	Degree of Achievement
E.) A Media Plan supports the multi-level interventions.	E.1. The project cites a media plan, or the intention to develop one. Target group segmentation is cited.	4,7,10 14,15	1,2,3 5,6,8 9,12 13,16 11			3 = All of the referenced indicators are present. Project accounts for media planning, with a strategy and work plan reference to scheduling, delivery, production and monitoring. The procedures or indications for product/material development are technically sound. Target group segmentation is coherent, and consistent with formative research. 2 = Three-quarters to half of the referenced criteria are present in the communication plan. 1 = Less than half of the referenced criteria are present in the communication plan. N/I = No corresponding section or discussion was included.
	E.3. There is a procedure for product and/or material development, and allows for pre-testing.	3,4,5 8,10 12 13,15 16	1, 2 7, 9 14,11	6		
	XX/POSSIBLE	42/96	34/64	1/32		
	%	44%	53%	3%		

Capability	Indicator	Yes 3	InPart 2	No 1	N/I 0	Degree of Achievement
F.) Budgeting for Communication and Behavior Change Activities	F.1. The project budget allows for specific communication and/or behavior change expenses.	1 10 14	3 5 6 7 12	9 8 16	2 4 11 13 15	<p>3 = All of the referenced indicators are present. Realistic estimates are indicated for materials production, use of consultants, and distribution costs. Training costs for communication activities are itemized, not absorbed in global training expenses.</p> <p>2 = Three-quarters to half of the referenced criteria are present in the communication plan.</p> <p>1 = Less than half of the referenced criteria are present in the communication plan.</p> <p>N/I = No corresponding section or discussion was included.</p>
	XX/POSSIBLE	9/48	10/32	3/16	5/0	
	%	19%	31%	19%	0	

Capability	Indicator	Yes 3	In Part 2	No 1	N/I 0	Degree of Achievement		
G.) Monitoring and Evaluation of Communication and/or Behavior Change Activities	G.1. The project monitoring and evaluation plan encompasses monitoring for results from the communication and/or behavior change activities.	4				3 = All of the referenced indicators are present. The monitoring and evaluation plan will reveal if the audience is being exposed to the intended messages. The M/E plan will reveal if the KABP (Knowledge, Attitude, Beliefs, Practice) are changing or not. 2 = Three-quarters to half of the referenced criteria are present in the communication plan. 1 = Less than half of the referenced criteria are present in the communication plan. N/I = No corresponding section or discussion was included.		
		5		1	2			
		6		3				
		7		12				
		8						
		9						
		10						
		11						
		13						
		14						
		15						
		16						
			XX/17	36/48	6/32		1/16	
			%	75%	19%		6%	

TABLE 2: ILLUSTRATIVE EXAMPLES*

A. Capability: Application of Essential Guidelines	DIP Example	S	W	Reference
A.1. Formative Research: types, depth, use in developing project direction and strategy.	World Relief/Mozambique Aga Khan/Tajikistan Save the Children/Bolivia ADRA/Haiti	X X	 X X	Variety, links Lack of... Health workers Lack of...
A.2 Key Behavior Determinants: identify behaviors – current positive and negative; i.d. influencing factors (credible obstacles)...define desired behaviors (realistic)...describe increments of action. Objectives articulated in behavioral terms.	World Relief/Malawi Save the Children/Mozambique World Vision/Cambodia	X X	 X	Thoroughness Trad. Healers No exploration of Know/Pract. Gap
A.3 Multi-level Interventions: demonstrating an understanding of the need to change attitudes/ behavior at various levels: policy; service delivery, community, household, individual.	World Relief/Moz.Malawi PSI/Rwanda PLAN/Cameroon	X X	 X	BC stages Includes other NGOs... Too linear...
B. Capability: Communication Concept that includes Capacity Building		S W		
B.1. Recognized communication concept to be implemented: Mass media, social marketing, interpersonal communication, peer support groups...	PSI/Rwanda CARE/Peru Africare/Ethiopia	X X	 X	Social marketing “vision-based.” Lacks cohesion
B.2. The concept is tailored to the selected interventions: the scale and scope match stated EPI objectives.	IRC/Rwanda Africare/Ethiopia	X	 X	Refugee setting “Conveys infor’tn”
B.3. Capacity building includes plans for IEC/BCC training, material and human resources; and is geared toward sustaining new behaviors and behavioral environments.	Save the Children/Bolivia PSI/Rwanda	X	 X	Skills transfer Expressed concerns re: sustainability
C. Capability: Logical Framework contains behavior change language.		S W		
C.1. Objectives are stated in behavioral outcomes.	World Relief IRC/Rwanda	X 	 X	EPI results are behavior dep’nt. Non-specific-who?
C.2. Process indicators identify behavior increments.	PSI/Rwanda Aga Khan/Tajikistan CRS/Philippines	X X	 X	ITN Behavior progression Outcomes bio-med. Clear links to obj.

* These are not exhaustive nor exclusive, and only provide an example of the strength or weakness.

D. Capability: Project has a Communication Plan	DIP example	S	W	Reference
D.1. Specific communication activities are integral to technical or clinical interventions.	World Vision/Cambodia Africare/Ethiopia		X X	Direct delivery ≠ local capacity; Parallel ?
D.2. There is trained staff, or allowance for training staff in communication and behavior change activities.	World Relief/Moz.Malawi PLAN/Cameroon	X	X	Experienced staff. No ITN/SM exp.
E. Capability: A Media Plan supports the multi-level interventions.		S	W	
E.1. Work plan has references to scheduling, production, delivery and monitoring.	PSI/Rwanda World Vision/Cambodia	X	X	Thorough Weak on detail
E.2. There is a procedure for product and/or material development, and allows for pre-testing.	Project HOPE/Peru IRC/Rwanda	X X		Good procedures Emphasis PT
E.2. Target group segmentation is cited.	World Relief/ Mozambique Counterpart Int'l./Uzbekistan	X X		Good profiling Using local networks
F. Capability: Budgeting for Communication/Behavior Change		S	W	
F.1. Project budget allows for specific IEC/BCC activities.	Save the Children/Bolivia PSI/Rwanda ADRA/Guinea	X X X		Detailed Very thorough Detailed
F.2. Realistic estimates are indicated for materials production, consultants, distribution, etc.	PSI/Rwanda IRC/Rwanda ADRA/Guinea	X	X X	Realistic Underestimated? Sufficient
G. Capability: Monitoring and Evaluation Plans for IEC/BCC		S	W	
G.1. The M/E plan encompasses monitoring for results from the IEC/BCC activities.	IRC/Rwanda ADRA/Guinea	X X		Plans LQAS BCC matrix
G.2. M/E plan will reveal if audience is being <u>exposed</u> to messages.	World Relief/Mozambique Save the Children/Bolivia	X X		Links to major activities HIS sensitive to BCC
G.3. M/E plan will reveal if KABP are being <u>changed</u> .	IRC/Rwanda	X		LQAS

Annex B.

PVO PHILOSOPHICAL APPROACHES TO BEHAVIOR CHANGE

Apart from adherence to USAID-directed guidelines, the PVOs do invest their organizational philosophies and mission statement into their interpretation of behavior change. It is important to credit this, as it has a distinct influence on how the particular projects go about programming, planning and identifying conditions for success in behavior change. There appear to be a handful of philosophical platforms that underpin the different approaches, and can perhaps be classified as follows.

A. Faith-Based Philosophy

The faith-based organizations (World Relief, World Vision, ADRA) state clearly and unequivocally that they use the Christian concept of transformation (but not conversion) as a fundamental condition for success in behavior change. They are motivated by a belief that religion can be instrumental in helping people overcome problems and unhealthy lifestyles. These organizations use churches and church-bound networks (bible study groups, women's groups, etc.) as principle channels for project activities. Plans for, and processes of behavior change apply scientifically sound methodologies yet in a context that appeals to the spiritual condition of beneficiaries. The concept of critical mass is fundamental to efficacy. However, there are elements in the role of religion that cannot be demonstrated scientifically ("a matter of the heart", "caught, not taught", DREAMS listing), and often this leads to a dependence on anecdotal evidence. It may also make it difficult to replicate their approach in a secular setting.

B. Liberation Philosophy

Some organizations do not profess a faith-based philosophy, rather they maintain a commitment to behavior change through 'empowerment' and/or 'liberation'. Empowerment of disenfranchised persons to obtain better states of health for themselves and their communities, liberation from conditions that serve as obstacles to self-actualization. They may take their principles from Paolo Friere's themes of "magical consciousness → self-awareness"². Terms such as 'dignity', 'self-determination' express the essence of what is sought. The assumption is that working with people to liberate one category of their lives will create critical mass to do so in other areas. PVOs such as Catholic Relief Services³, Project HOPE, International Rescue Committee would appear to be in this category. Outcomes can be attributed to clearly delineated secular processes.

C. Psycho-Social Philosophy

Most secular organizations operate on the premise that behavior change based solely in a bio-medical perspective has limited and short-term impact. Behavior change strategies must also engage the psychological and social realms that underpin medical and health

² Pedagogy of the Oppressed; Paolo Friere, @1968.

³ Despite its denomination, it does not operate from a platform of Christian or Catholic dogma.

conditions in which people operate. Both of the categories A and B also include dimensions of this philosophy. Essentially, this philosophy maintains that it is possible to orchestrate a scientific set of strategies to manipulate the mechanisms of psychological and social processes to which people are subjected. Personal goal setting is an often-used approach. Cause and effect are basic tools both in understanding those processes and in attribution for impact. Save the Children, CARE, and Africare would probably be in this category.

D. Institutional Change Philosophy

For lack of a more precise philosophical description, this could describe an organization with a mission to effect change through some type of institutional alteration or enhancement. This could include PSI, which, in addition to its psycho-social philosophy, also promotes the adoption of a product (condom, ORS, nets) that should be institutionally integrated into the society or community in order to maintain the desired behavior. This would also capture in some sense, the Aga Khan Foundation approach, which emphasizes introduction of health commodities (iodized salt, multi-micro nutrients). Both organizations also promote and foster the establishment of local institutions to carry on the work.

These philosophies have direct bearing on the types of communication and behavior change components that the DIPs developed. It would be remiss not to take their perspectives into account.

Annex C.

1. BASICS BEHAVIOR CHANGE MATRIX

<i>Ex: Growth Monitoring</i>					
Current Behavior	Justifying factors	Influencing Agents	Obstacles impeding practice of desired behavior	Enabling factors to practice of desired behaviors	Desired Behavior; key messages
Irregular weighing	“healthy babies don’t need weighing”	The norm	Cost, distance	Local service; mothers’ interest in weighing...	Bring your child to weigh every month. Baby gains weight every month.

2. TARGET GROUP BEHAVIORAL PROFILE

Target group Profiles	Health beliefs	Health-seeking behavior	Lifestyle influences on decision -making (rank in order of importance)	Media habits (information source - in order of frequency of use)
Rural mother: average age, education level, family status, number of children, marital status.	“ I am weak and can’t treat my own problems...” Grandmothers know best...”	Consults other women; consults hilot; self-treats. Uses home remedies.	Family – Reference group – Media Culture(tradition) – Religion -	Female grapevine Radio Written materials church
Caregiver: other sibling? Grandmother?				