UNITED STATES AGENCY FOR INTERNATIONAL DEVELOPMENT
BUREAU FOR GLOBAL HEALTH
OFFICE OF HEALTH, DISEASE, AND NUTRITION

# CHILD SURVIVAL AND HEALTH GRANTS PROGRAM

# TECHNICAL REFERENCE MATERIALS

# 2014

# Social and Behavior Change

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# ABBREVIATIONS AND ACRONYMS

| | |
|---|---|
| AIDS | Acquired Immuno-Deficiency Syndrome |
| BCC | Behavior Change Communication |
| CSHGP | Child Survival and Health Grant Program |
| DHS | Demographic and Health Survey |
| EmOC | Emergency obstetric care |
| HIV | Human Immunodeficiency Virus |
| KPC | Knowledge, Practice, and Coverage Survey |
| M&E | Monitoring and Evaluation |
| MCHIP | Maternal and Child Health Integrated Program |
| MNCH | maternal, newborn, and child health |
| MOH | Ministry of Health |
| NGO | Non-Governmental Organization |
| PVO | Private Voluntary Organization |
| SBC | Social and Behavior Change |
| TRM | Technical Reference Material |
| USAID | United States Agency for International Development |

# INTRODUCTION TO THE TECHNICAL REFERENCE MATERIALS

The Technical Reference Materials (TRMs), products of the Bureau for U.S. Agency for International Development, Global Health, Office of Health, Infectious Disease, and Nutrition (USAID/GH/HIDN), are a series of guides to help program planners and implementers consider the many elements in a particular technical area of the Child Survival and Health Grants Program (CSHGP). These guides are not an official policy for practice; rather, they are basic everyday summaries to be used as field reference documents. They also may be accessed in the form of electronic toolkits on the Knowledge for Health website.

The TRMs are organized in modules that correspond to the primary interventions and key strategies that are central to CSHGP. Each module covers the essential elements that need to be considered during implementation, resources for nongovernment organizations (NGOs) and others implementing community-oriented programs to consult when planning interventions, and examples of tools most commonly used among CSHGP grantees to collect baseline population-level data.

The TRM modules cover the following topics:

| Technical Interventions | Cross-cutting Strategies |
| --- | --- |
| • Family Planning and Reproductive Health | • Social and Behavior Change |
| • Immunization | • Health System Strengthening |
| • Malaria | • Monitoring and Evaluation |
| • Maternal and Newborn Care | • Quality Assurance |
| • Nutrition | |
| • Pneumonia Case Management and Control of Diarrheal Disease | |

Technical specialists in the USAID Collaborating Agency community, CORE Group Working Groups, USAID technical staff, and community-oriented practitioners all contribute to updating the TRMs on an ongoing basis. The revision date for each TRM module is at the bottom of each page. The modules are living documents, and we depend on readers to tell us of the usefulness of the information, the need for additions or amendments, and general comments. We ask that users of these documents tell us of their usefulness and let us know information that should be amended or changed, additions and subtractions, and general comments. This will help us keep the modules alive and responsive to your needs. Please share comments with Maternal and Child Health Integrated Program (MCHIP) at info@mchipngo.net.

MCHIP is grateful for the many contributions and reviews by staff of the different Offices of the Bureau of Global Health, and many of their Collaborating Agencies, CORE Group Working Groups, and most of all to our private voluntary organization (PVO) and NGO partners that continue to use these guides and provide valuable insight on how to improve them. Contributors to this update from USAID include Milton Amayun, Katherine Farnsworth, and Niyati Shah. Other contributors include Claire Boswell, Independent; Amelia Brandt, Medicines for Humanity and CORE SBC Working Group; Mary Helen Carruth, Medical Teams International and CORE SBC Working Group; Loretta Dostal, Independent and CORE SBC Working Group; Paul Freeman,

# KEY TERMINOLOGY

**Advocacy** comprises the processes through which individuals or groups attempt to bring about social or organizational change for a particular health goal, program, interest, or population. Advocacy activities are both similar to and different from traditional health communication in various respects and have an important role in achieving SBC objectives.[1]

**Appreciative Inquiry** is an approach to organizational change based on strengths rather than weaknesses, on a vision of what is possible [now and that which can be aspired to long term as skills and knowledge increase] rather than an analysis of what is not.[2] It is an asset- or strength-based approach that starts with the belief that every organization, and every person in that organization, has positive qualities to build upon. It asks questions like "What's working well?", "What's good about what you are currently doing?" rather than "What are the problems?" or "What needs to be fixed?"

**Barrier Analysis** is a rapid assessment tool used to identify determinants associated with a particular behavior so that an effective behavior change strategy, including communication and support activities, can be developed.[3]

**Behavior Change Communication (BCC)** involves communication-related processes and strategies to change individuals' knowledge, attitudes and beliefs. It is a component of broader social behavior change (SBC) processes that seek to achieve change in communities or environments.

**Caretaker** refers to an individual who has primary responsibility for the care of a child. This term usually refers to the child's mother, but it also could be his or her father, grandparent, older sibling, or other member of the community.

**Communication for Social Change** "describes an iterative process where *community dialog* and *collective action* work together to produce social change in a community that improves the health and welfare of all of its members" [Figueroa, 2002 p. iii].[4]

**Community mobilization** is a sub-strategy of social mobilization. Social mobilization includes building coalitions on certain issues and usually takes place at a national level among civil society organizations, donors, and government. Community mobilization can do the same at a community level with similar techniques. Coalitions can be formed among community leaders, spiritual and traditional leaders, women's groups, and other groups in the community. Techniques used for both social and community mobilization include publicity, public discussions, information dissemination through mass and community media, participatory development methods, and stakeholders' training and coordination.[5]

**Gatekeepers** are individuals or groups that can facilitate or hinder effective work. They are able to tactfully negotiate entry into a community with the individuals who control, both formally and informally, the political climate of the community. They know their community, how it functions, and how to accomplish tasks within it.[6]

**Gender** "is a culturally defined set of economic, social, and political roles, responsibilities, rights, entitlements, and obligations associated with being female and male, as well as the relationships between and among females and males. The definition and expectations of what it means to be a male or female varies across cultures and over time. Transgender individuals, whether they identify as men or women, can be subject to the same set of expectations" [USAID, 2014].[7]

**Information, Education and Communication** (IEC) "combines strategies, approaches, and methods that enable individuals, families, groups, organizations, and communities to play active roles in achieving, protecting, and sustaining their own health. Embodied in IEC is the process of learning that empowers people to make decisions, modify behaviors, and change social conditions" [UNFPA, 1999].[8]

**Interpersonal Contact** is a face-to-face interaction between two people during which information can be exchanged. With this type of communication, the sender can immediately receive and evaluate feedback from the receiver, which allows the sender to further specify and personalize the message more than some other forms of communication.

**Positive Deviance**[9] is an approach to behavioral and social change based on the observation that in any community, there are people whose uncommon but successful strategies enable them to find ways to practice healthier behaviors than their peers, despite facing similar challenges and having no extra resources or knowledge than their peers. These individuals are referred to as positive deviants. The goal of the approach is to encourage other community members to adopt the solutions of the positive deviants.

**Social Behavior Change Communication** (SBCC) is the systematic application of interactive, theory-based, and research-driven processes and strategies to effect change at individual, community, and social levels. SBCC examines challenges from multiple sides by analyzing personal, societal, and environmental factors in order to find an effective way to achieve sustainable change. SBCC also employs strategies that influence the physical, socio-economic, and cultural environment to facilitate healthy norms and choices and remove barriers to them.[10]

**Tipping point** is the critical point in a situation, process, or system beyond which a significant and often unstoppable effect or change takes place. It can result from a naturally occurring event or a strong determinant, such as political will, that provides a final push to move barriers to change or provide the energy needed for change.[11]

# Overview

## A COMPREHENSIVE BEHAVIOR CHANGE APPROACH

Social and behavior change (SBC) is essential to improving maternal, child, family, and community health. A comprehensive SBC approach explores factors that influence multiple levels—individuals, families, influential community members, communities as a whole, health care providers, and policymakers—to devise a maximally effective behavior change strategy.

The development of an evidence-informed SBC strategy, and selection and implementation of an appropriate set of SBC interventions, can lead to the improvement of health behaviors and practices, as well as better interactions between health service providers and community members and also address advocacy and policy issues affecting the issues at hand.

A comprehensive SBC approach recognizes that individual behavior change does not result from improved knowledge alone and cannot be promoted in isolation from the broader social context in which it occurs. An SBC approach explores a wide range of factors that must be addressed at multiple levels to promote change effectively.

## THE SBC APPROACH AS A PROCESS

An SBC approach is a strategic, interactive process that aims to change not only individual behaviors but also social conditions. It requires understanding the situation, designing a focused strategy, developing interventions and materials, implementing, monitoring, evaluating, and adjusting. The process allows program staff, communities, and other key stakeholders to approach a problem from various angles to define key determinants (both positive and negative) of behaviors and to plan and implement a well-planned, comprehensive set of interventions that focuses on these determinants at multiple levels to achieve a health objective.
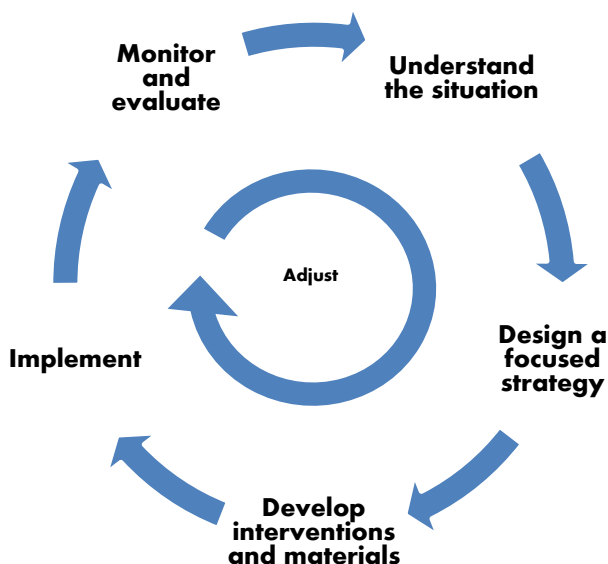
## THE THREE KEY SBC STRATEGIES

The SBC approach applies three key strategies:

### 1. BCC
- Influences knowledge, attitudes, and practices

### 2. Social mobilization
- Fosters wider participation, coalition building, and ownership
- Changes community norms

### 3. Advocacy
- Raises resources
- Secures leadership commitment

By broadening the planning lens to an SBC approach, individual BCC becomes just one of several strategies. Information conveyed through education or BCC can be critical to changing behaviors, but often other factors are also important, such as availability of products and services, national policies, and household and community support mechanisms. Focusing on the goal—social and behavior change—takes into consideration that changes among individuals and groups are more likely to take place within a supportive environment that results from interventions at multiple levels. Taking time to identify how best to influence structures, policies, social norms, and target behaviors can increase program effectiveness.

## THEORIES OF CHANGE

An SBC strategy should be grounded by evidence and theory. Theories and models guide the design and implementation of evidence-based programs. They help planners understand a given problem and identify effective actions to address it. It should be noted that adequately addressing an issue may require more than one theory, and that no one theory is suitable for all cases.[12] Theories and models address human behaviors on one or more of three levels of change: (1) individual and household, (2) community, or (3) environment.

### Change Theories at the Individual Level

Health Belief Model (HBM)

The Health Belief Model[13] focuses on the individual and "individuals' perceptions of: (1) their vulnerability (perceived susceptibility) to a health condition; (2) the perceived severity of the health condition; (3) the perceived benefits of reducing or avoiding risk; (4) the perceived barriers or costs associated with the condition; (5) cues to action that activate a readiness to change; and (6) confidence in ability to take action (self-efficacy)." [C-Change, p. 43]

Theory of Planned Behavior, also called Theory of Reasoned Action

This Theory of Planned Behavior, Theory of Reasoned Action[14] "posits that behavioral intention is the most important determinant of behavior. Behaviors are more likely to be influenced when individuals have positive attitudes about the behavior; the behavior is viewed positively by key people who influence the individual (subjective norm); and the individual has a sense that he or she can control the behavior (perceived behavioral control)." [C-Change, p.43]

Stages of Change (Transtheoretical Model of Behavior Change)

Another theory of change at the individual level is the Transtheoretical Model of Behavior Change,[15] often referred to as the Stages of Change. These five stages have been conceptualized for a variety of desired behaviors—to change a person's own behavior and improve his or her heath:

1.  *Pre-contemplation, Pre-awareness:* There is no intention to change behavior in the fore-seeable future. Many individuals in this stage are unaware or under-aware of the problem. They may not believe that the problem is relevant to them or that they could overcome the problem.

2.  *Contemplation, Awareness:* There is awareness that the problem exists, and an individual is seriously thinking about overcoming it but has not yet made a commitment to take action.

3.  *Preparation:* Intention and behavioral criteria are combined in this stage. Individuals intend to take action in the next month and have unsuccessfully taken action in the past year. This could include buying an insecticide treated net, talking about delivering with a skilled birth attendant, or getting a condom, among others.

4.  *Action:* An individual modifies his or her behavior, experiences, or environment (sometimes though many steps) to overcome the problem. Action involves the most overt behavioral changes and requires considerable commitment of time and energy.

5.  *Maintenance:* An individual works to prevent relapse and consolidates the gains attained during action.

Program designers need to be aware of the stage of change individuals in a community are in so that they can design an effective SBC strategy to meet their needs. For example, if people are already well aware of the benefits of giving birth in a health facility with a skilled provider, there is no need to spend a significant amount of time and effort raising awareness about its benefits. It is also important to consider that maintenance is not an endpoint; people may move back into a previous stage or cycle between action and maintenance as new actions are needed to address the new situation.

## THEORIES OF CHANGE AT THE COMMUNITY LEVEL

### Social Learning Theory, Social Cognitive Theory

These theories[16, 17, 18, 19] describe the dynamic interaction of the person, behavior, and the environment in which the behavior is performed. Five key factors can affect the likelihood that a per-

son changes a health behavior: (1) knowledge of health risks and benefits, (2) self-efficacy (confidence in one's ability to take action and overcome barriers), (3) outcome expectations (the cost and benefits of adopting a behavior), (4) goals people set (and strategies for realizing them), and (5) perceived social and structural facilitators and impediments or barriers to the desired change. The concept of reinforcement suggests that responses to a behavior decrease or increase the likelihood of its recurrence. In addition, the theories suggest that people learn not only from their own experiences, but also by observing others performing actions and the benefits they gain through those actions. This concept of modeling has been influential in developing entertainment-education programs.[20]

## Diffusion of Innovations

Since they are recognized as opinion leaders in a given issue, specific members of a community may lead by example. Their opinions and behaviors may encourage people to try new behaviors and continue to maintain practices. Imitation of positive behavior may be the result of people following opinion leaders who are admired and trusted around specific issues. Opinion leaders in one area (e.g., breastfeeding, sanitation practices) are not necessarily influential around other issues. [21,22]

## Communication for Social Change

The Communication for Social Change Model[23] describes an iterative process where community dialog and collective action work together to produce social change in a community that improves the health and welfare of all of its members. The model describes a dynamic, iterative process that starts with a catalyst-stimulus that can be external or internal to the community. This catalyst leads to a dialog within the community that, when effective, leads to collective action and the resolution of a common problem.

## MULTILEVEL THEORIES

### The Socio-Ecological Model

When practitioners realized the limitations of models that focus exclusively on individuals, with the assumption that they are in full control of their behaviors and living conditions, ecological models of change gained traction. An ecological perspective considers several factors:

- Factors at multiple levels influence SBC.

- Levels can include individual, interpersonal; community and organizational; and national, political, and environmental.



Socio-Ecological Model for Change

*These concepts apply to all levels (people, organizations, and institutions). They were originally developed for the individual level.

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

**Figure 1. The Socio-Ecological Model**

- Influences interact across levels.
- Multilevel interventions are more robust and potentially more sustainable than individual-level interventions.

The Social-Ecological Model, depicted in Figure 1[24], sees individual behavior as a product of multiple, overlapping social and environmental influences. An individual is influenced by family, peers, and community, as well as the enabling environment. It also shows other cross-cutting factors that affect the individual: information, motivation, ability to act, and norms. The model underscores the need to expand beyond ad hoc interventions to a coordinated social movement and work in coherence with national directives that favor positive outcomes and support sustainability. The Social-Ecological Model makes use of several theories of change; the Transtheoretical Model is just one of these.[25]

## The PEN-3 Model

PEN-3[26] organizes the study of health beliefs, behaviors and outcomes around an understanding of culture, placing it at the center of health interventions and evaluation. A literature review[27] found that this model helped to focus research on the context from which health behaviors emanate and on the collective influence of individuals in that context on those behaviors. This model facilitates examination of cultural practices that influence positive and negative health behaviors as well as those that have a neutral impact on health. It has three primary domains: cultural identity, relationships and expectations, and cultural empowerment and each domain includes three factors that form the eponymous acronym. The cultural identity domain includes person, extended family, and neighborhood, the main points of entry for health intervention. The relationships domain includes perceptions, enablers, and nurturers, examining societal and familial influences on health behaviors. The cultural empowerment domain includes positive, existential, and negative, which are categories of beliefs, values and practices related to health. It has been applied to HIV, cancer, hypertension, diabetes, malaria, nutrition, smoking and other issues that require a grounding of health behavior in cultural context.

**Key SBC Overview Resources:**

- [C-Modules: A Learning Package for Social and Behavior Change Communication](). *C-Modules* were developed by C-Change, funded by USAID under Cooperative Agreement No. GPO-A-00-07-0004-00. The six modules can be freely downloaded and used, provided full credit is given to C-Change as follows: C-Change (Communication for Change). 2011. *C-Modules: A Learning Package for Social and Behavior Change Communication.* Washington, DC: FHI 360/C-Change.
- NIH Cancer Institute, 2005, [Theory at a Glance: A Guide for Health Promotion Practice]() (Second edition),
- [The Communication Initiative Network]()
- [The CHANGE Project]()
- Stetson, Valerie and Robb Davis. Health Education in Primary Health Care Projects: A Critical Review of Various Approaches. Washington, D.C.: CORE 1999.
- JHUCCP, 2011, [Social & Behavior Change Interventions Landscaping Study: A Global Review.]()
- Green, Lawrence and Marshall Kreuter. Health Promotion Planning: An Educational and Ecological Approach. 3rd ed. Mountain View, CA: Mayfield Publishing Company, 1999.

# PROGRAM DESIGN

An SBC strategy must go well beyond simply providing information to target audiences. To be effective, SBC strategies must help create an environment that enables the desired behavior change and supports the people who want to adopt or facilitate the change. This could include making the service more accessible, having respected leaders voice support for and model the change, getting special interest groups involved, training service providers, and more—depending on what the research reveals. Taking a holistic, well-informed view will help to develop a strategic and effective plan.

When taking a comprehensive SBC approach, program planners need to consider these five key decisions[i] :

1. **Behavior.** What is the feasible and effective behavior to promote? The definition of the behavior should be clear, specific, observable, and measureable.

2. **Priority and Influencing Groups.** Who are the people we are encouraging to adopt a specific

## Essential elements

- Action is what counts – changing beliefs and knowledge is necessary but not sufficient.

- Address multiple levels to influence social and individual behavior change.

- Use both qualitative and quantitative information to assess current behaviors and influencing factors.

- Work from the community's perspective

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[i] outlined on page 48 of CORE Group's [Designing for Behavior Change ]()curriculum, 2007.

behavior (priority group)? Who influences the priority group (influencing group)? Who else must we reach to bring about the desired behavior change?

3. **Determinants.** What are the most powerful determinants? These are determined through qualitative research and include items such as access, self-efficacy, perceived social norms, perceived positive consequences, perceived negative consequences, perceived severity, perceived susceptibility, action efficacy, perception of divine will, and cues for action.

4. **Bridges to Activities.** How do we want to change the determinants? Which direction do we want the determinants to move? What structures, policies, and social norms need to change to support the desired behavior?

5. **Activities.** What activities need to be implemented to change the determinants in the desired direction? How can we best influence and support the improved behaviors? How can we address those determinants that we identified as most influential in changing the targeted behavior? Do we need materials to support those activities? How will achievement of these activities be measured?

## UNDERSTANDING THE CONTEXT THROUGH A SITUATION ANALYSIS: FORMATIVE RESEARCH

Before designing SBC interventions, program planners must understand the community's context, including capacity and strengths. The first step in a situation analysis is a literature review. A thorough review of available literature will help to identify what is known about a particular behavior and gaps in knowledge.

### Conducting Formative Research

In most cases, the literature review will not provide a complete picture of a community's reality. Research may be required to fill in gaps and gather more information about the target behavior in a specific context. Research that helps to plan, or form, an intervention is commonly referred to as formative research and is a critical step in program design. Research results help program planners understand the feasibility of the behaviors they hope to promote from the point of view of the target audience whose behaviors are expected to change as a result of the program. Using formative research tools to understand the context of behavior contributes to what can be learned from existing data. Community dynamics are an important part of context, and a thorough situation analysis requires involving people from different social levels within the community (i.e., not only community leaders, but also people of lower status in the community). Facilitators often need to be intentional in engaging marginalized members of community. Formative research will also explore gender, age, education level, and language, which will later inform the design of program activities.

Formative research helps program planners to address the first three decisions in the Designing for Behavior Change Framework:

- Behavior—identify feasible and effective behaviors to promote, prioritizing a few key behaviors (two or three), rather than many

- Priority and Influencing Groups—understand priority groups and meaningful audience segments and who may influence them.

- Determinants—understand the determinants (i.e., behaviors, benefits, barriers, and social context) from the point of view of the priority groups, rather than from that of the program planners and implementers, including exploring what levels to focus program activities (individual, household, community, health system, or other institution or policy) and preferred channels of communication.

Researchers must decide what questions must be answered, who can provide the necessary information, how the information will be collected, and how the data will be analyzed and used. Several types of assessments can be used to determine convincing ways to reinforce enabling factors, address barriers, overcome resistances, and effectively motivate desired behavior changes.

## Formative Research Methods and Tools

Formative research uses both qualitative and quantitative methods to conduct a situation analysis and inform program design. A growing number of innovative tools are available to ensure that methods are appropriate to the research questions asked, that the questions asked are appropriate to inform the proposed behavior change, and that proposed interventions respond to the complexities of multilevel interventions. Table 1 provides examples of research methods that can be used for each type of assessment.

**Table 1. Formative Research Assessments**

| Type of Assessment | Purpose | Examples of Research Methodologies and Tools |
|---|---|---|
| Health risk | <ul><li>Determine the relative priority (magnitude and severity) of health problems according to members of the community to prioritize project health objectives.</li><li>*This assessment will yield the perceived risk and needs to be considered along with the epidemiological assessment of risk, which may be quite different.*</li></ul> | Secondary data sources: <ul><li>DHS</li><li>MICS</li><li>Other national surveys</li><li>Other surveys</li><li>Surveillance data</li></ul> Primary data sources: <ul><li>Project area surveys/ Assessments</li><li>KPC surveys</li><li>Needs assessments</li></ul> |
| Behavioral or audience | <ul><li>Identify key behaviors relevant to the health problems of interest and the most influential associated factors—both barriers and incentives</li><li>Identify and profile audience segments and needed levels of intervention</li><li>To assess preferences for var-</li></ul> | Doer/non-doer surveys(e.g., Barrier analyses): <ul><li>Positive deviant or discovery inquiries</li><li>Focus groups</li><li>In-depth interviews</li><li>ProPan</li><li>Small group discussion (community café)</li><li>Panel discussion (of experts)</li></ul> |

| | | |
|---|---|---|
| | ious kinds of interventions and channels | |
| Environmental | • To assess community structures and assets, health systems, and policy issues affecting health behaviors to yield community preferences and perceptions concerning intervention approaches. | Participatory Rural Appraisal (PRA) or action research<br>• Participatory Learning and Action (PLA)<br>• Policy environment scores<br>• Missed opportunity surveys<br>• Focus groups<br>• Integrated Health Systems Assessment<br>• ProPan<br>• Community mapping<br>• Assets inventory<br>• Daily activity schedule<br>• Seasonal calendar |
| Pretests or trials of behaviors | • To assess the feasibility and effectiveness of proposed behaviors;<br>• To identify strengths, assets and resources available among families and communities to foster collaborative development of indigenous solutions. | Trials of Improved Practices (TIPS)<br>• Observation studies<br>• Positive Deviance/HEARTH Model |

Once research is complete, program planners then need to analyze research results, identify the core problem, and develop a problem statement. Tools for presenting gathered information about causes and effects, people involved, and behavioral determinants of the identified problem include a problem tree (see Figure 2[28], below), the Designing for Behavior Change Framework (see Resources box), and the Social-Ecological Model visual (see Figure 1).
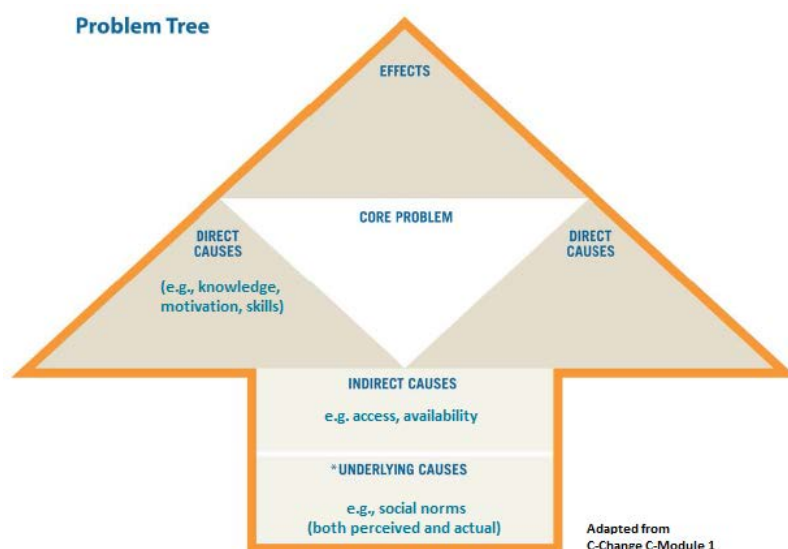


**Figure 2. Problem Tree**

Gender Analysis

A thorough situation analysis involves assessing the social, economic, and cultural position of women relative to men and design of strategies and interventions that take these into consideration.

It is recommended that all programs and projects conduct a gender analysis as part of their formative research and a capacity and needs assessment to help ensure that programs and projects address the proper context and do not rely on assumptions. A gender analysis will bring a greater understanding of divisions of power, roles, and responsibilities, as well as a better understanding of both women's and men's attitudes about perceived roles (e.g., who makes the decision that a pregnant woman can attend antenatal care at a health facility). Understanding how decisions are made at a household level will identify barriers and key enabling factors that will inform design of project strategies and messages.

There are many different tools that can be used to conduct a gender analysis. The Harvard Framework[29] for gender analysis is an example of a project-level tool that can be easily adapted for use as a participatory community-based tool. The framework has four steps:

1. *Activity Profile*. Maps roles in households and communities by asking who, what, where, and for how long regarding productive (e.g., agriculture, income generation), reproductive (e.g., child care, water-related, fuel-related), and community (e.g., religious, health committees) activities.

2. *Access and Control Profile*. Identifies resources (e.g., cash, land) used for activities identified in the activity profile and the benefits (e.g., food, medical treatment) of these resources. The profile then maps who has access to and control of the resources and benefits of the resources.

3. *Influencing Factors.* Charts the socio-cultural, political, economic, and environmental factors that influence the activities and access and control of resources.

4. *What does this mean for the program or project?* Considers differential access to and control of resources in defining project objectives and strategies, and considers how the location, time, and time spent on activities by women and men may affect timing and structure of project activities.

USAID has also developed guidelines to conduct a gender analysis. These guidelines identify gender-based constraints or opportunities that shape women's, men's, boys' and girls' health and well-being and ability to live productive lives. The areas of analysis include these categories:

• Access to and Control over Assets and Resources: this looks at whether females and males own or have access and the capacity to use productive resources—assets (land, housing), income, social benefits (social insurance, pensions), public services (health, water), technology—and information necessary to be a fully active and productive participant in society.

- Knowledge and Beliefs: refers to cultural norms in a given society about what are appropriate qualities, life goals, and aspirations for males and females.

- Practices, Participation, and Time Use: refers to the influence that gender roles have over a person's behavior, participation in public and private life, and how they use their time.

- Laws, Policies, Regulations, and Institutional Practices: refers to influence on the context in which men and women act and make decisions and includes formal statutory laws, as well as informal (institutional practices and behaviors) and customary legal systems.

- Power and Decision making: the ability of women and men to decide, influence, and exercise control over material, human, intellectual, and financial resources in the family, community, and country.

There are several ways that project teams can collect information for each of these steps that can be included in methods likely already planned as part of formative assessments. Focus group discussions, conducted separately with women and men (and disaggregated by age), are a great way to understand the project context, including perceived roles and responsibilities in the community. Key informant interviews are another method that can be used to further explore themes that emerge from focus group discussions or to answer other, perhaps sensitive, questions.

Key findings from a gender analysis can easily be incorporated into program design, particularly as part of an SBC strategy. One approach is involving men in projects designed to improve the health status of women and children. The Designing for Behavior Change Framework is one tool that can be used to develop and report your SBC strategy.

## Developing Behavioral Objectives

Once formative research is complete, program planners use the information gathered to develop objectives based on the defined behaviors and the identified priority and influencing groups. Performance indicators for both community-oriented and service delivery projects are often stated as general health objectives (e.g., reduced child mortality or reduced frequency of diarrheal diseases) or are not specific enough to be accurately measured (e.g., to improve home care and case management of childhood diarrhea or to increase the number of mothers who exclusively breastfeed their babies). In developing an SBC strategy, program planners need to first base health objectives on recommended practices (e.g., exclusive breastfeeding up to six months), and then analyze each one by its social and behavioral determinants in order to develop a set of SBC objectives for each.

A behavior is an observable action that is specific (time, place, quantity, duration, frequency), measurable, feasible, and directly linked to an improved outcome. A behavior statement includes an actor, an action (in the form of an active verb), and specific details. Refocusing objectives in behavior terms will often help meet the SMART (specific, measureable, assignable, realistic, and time-bound) criteria. Following are some specific examples of objectives restated in behavioral terms:

**Health Objective**

Improve home care and case management of childhood diarrhea

**Refocused in Behavioral Terms**

Mothers and other caregivers:

- Wash hands with soap before preparing, feeding, or eating food, and after using the toilet and handling children's feces.
- Continue feeding and increase fluids during diarrheal illness.
- Increase the frequency of feedings, if breastfeeding.
- Breastfeed on demand, day and night.
- Prepare and administer oral rehydration solution or appropriate recommended home fluids.
- Seek appropriate care from a trained health worker when the child suffers from certain specific symptoms.

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**Health Objective**

Increase the percentage of mothers who exclusively breastfeed their babies

**Refocused in Behavioral Terms**

Mothers:
- Initiate skin-to-skin contact immediately after delivery and initiate breastfeeding within one hour of birth.
- Breastfeed exclusively for the first six months. This means no other food or liquid—even water—is given to the baby.
- Practice frequent, on-demand breastfeeding, day and night.

Other family members:
- Support the mother to breastfeed exclusively for the first six months and on-demand.

Community and facility health workers:
- Counsel the mother about the importance of immediate, exclusive, and on-demand breastfeeding.
- Counsel the mother on correct attachment and positioning.
- Support the mother if she experiences problems when trying to breastfeed.

## FOCUSING AND DESIGNING THE SBC STRATEGY

After conducting the situation analysis and using formative research to define the behaviors, identify priority and influencing groups, prioritize behavioral determinants, and define behavioral objectives, then program planners must use this information to develop the SBC strategy. The strategy design stage requires involving key stakeholders, presenting results of formative research, and soliciting input to design interventions that effectively address the identified behavioral determinants. Stakeholders then need to decide what changes the problem calls for and how

activities can contribute to these changes through advocacy, social mobilization, and BCC. Developing activities requires careful consideration of gender, age, education level, and language, which should have been explored during the situation analysis.

Because not all behavioral determinants involve an individual's beliefs, knowledge, and attitudes, program planners will need to expand the range of behavior change activities beyond communication, considering infrastructure, economic barriers, and other environmental factors linked to the identified determinants. To make communication activities more effective, they may need to be linked with training, health systems support, product and service improvements, and policy changes that may not otherwise have been recognized as essential components of a behavior change strategy. When using a socio-ecological model, program planners will nearly always develop activities for more than one level: individual or household; community, and enabling environment.

The following sections provide a general overview of SBC program design; for more in-depth guidance on how to design programs, see the key resources boxes.

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**Key SBC Design Resources:**

- CORE Group, 2013, Designing for Behavior Change: For Agriculture, Natural Resource Management, Health, and Nutrition.
- JHUCCP, 2003, A Field Guide to Designing a Health Communication Strategy.
- Michie, S. et al., 2011, The behaviour change wheel: A new method for characterising and designing behaviour change interventions. *Implementation Science.* 6:42
- Family Health International, 1996, How to Create an Effective Communication Project: Using the AIDSCAP Strategy to Develop Successful Behavior Change Interventions.

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## Promoting Individual and Household Change

Individual-level behavior change focuses on changing knowledge, attitudes, and practices through behavior change communication. Generally, the design of these activities assumes that the individual has control over the specified behavior and that he or she can be persuaded to change with information. Traditional BCC strategies include health talks—either in the community, through home visits, or at the health facility—conducted by volunteers or by health workers, mass media (radio or television), small media (fliers, posters), and community messaging through drama or songs.

## Encouraging Behavior Change at the Community Level

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

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

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

**Key Community-level SBC Resources:**

- JHUCCP, 2003, How to Mobilize Communities for Health and Social Change.
- JHUCCP, 2002, Communication for Social Change: An Integrated Model for Measuring the Process and its Outcomes.
- CORE/NGO Networks for Health, 2000, *Community Centered Approaches to Behavior and Social Change: Models and Processes for Health and Development*.
- Save the Children and JHU/PCS4 Project, 2003, How to Mobilize Communities for Health and Social Change
- Kretzman, John, and John McKnight, 1993, *Building Communities from the Inside Out: A Path Toward Finding and Mobilizing a Community's Assets.* The Asset Based Community Development Institute.
- AED/JHU CCP, December 1998, Empowering Communities: Participatory Techniques for Community Based Programme Development.
- IYCN Project, 2011, Community theatre for improved nutrition: A guide for program managers and theatre groups.
- Food Security Network, 2011, Mobilizing communities for improved nutrition: A manual and guide for training community leaders.
- IYCN Project, 2011, Strengthening community nutrition programming: Tools for reaching caregivers, households, and communities.
- Minkler, Meredith. *Community Building and Community Organizing for Health*. New Jersey: Rutgers Press, 1999.

## Creating an Enabling Environment

Strengthening Health Systems to Promote Change

An SBC strategy to increase demand for and utilization of health services may be influenced by access factors and acceptability of services. Access factors include concrete barriers, such as hours and location of services, as well as a sense of welcome at the point of service. Service acceptability from a client perspective is often based on perceived quality, availability of drugs, health worker attitudes, and client-provider interactions.

Knowledge alone does not change the behavior of health service providers. Training programs to improve technical skills and interpersonal counseling and communication skills alone are unlikely to result in sustained change in behavior or practice. Long-term changes in performance of health service providers are more likely when training includes analytical skills; addresses underlying attitudes, values, and cultural norms; includes behaviors that are feasible in the clinical setting; and gives health workers skills to manage organizational problems, such as a lack of time or staff for counseling. In addition, ongoing supervision is important for sustaining changes in clinical behavior[30].

Behaviors identified for change at individual and community levels should be systematically reflected in and linked to clinical protocols and training guidelines for health care providers. Motivational activities and team building initiatives help build bridges between communities and

health service providers and empower providers to recognize the need for change within the health system and to be more able to implement those changes. Dialog between professional health service providers and community health workers and between public and private sector providers supports effective institutional-level behavior change. The Partnership Defined Quality methodology is effective in supporting this level of behavior change.

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**Key Facility-Level SBC Resources:**

- Save the Children, 2005, Partnership-Defined Quality: A toolbook for community and health provider collaboration for quality improvement.
- WHO, 1995, Health workers for change: a workshop series to improve quality of care for women.
- Lisa Howard-Grabman, 2000, Bridging the gap between communities and service providers: developing accountability through community mobilization approaches. *IDS Bulletin*;31(1):88-96.
- Quality Assurance Project, Improving Interpersonal Communication Between Health Care Providers and Clients.
- IYCN Project, 2011, Strengthening Health Talks: Training Manual.

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Advocacy

Convincing policymakers to take action requires evidence-based information, strategic thinking, strong advocacy skills, and persistence. Together, these factors lay the foundation for successful advocacy campaigns. In addition to policy audiences, increased advocacy efforts are needed among all of those audiences that have the potential to influence leaders and society (NGOs, religious and traditional leaders, the media, women's groups, and youth), as well as to the general public to increase demand.

Reviewing the policy process and understanding the decision-making process is an important part of a situation analysis if a program plans to advocate for policy. Often, even though policies are created and endorsed, they may not get implemented. One way to use advocacy is to ensure that these commitments get translated into action.

Consider the indirect causes of the situation that you have defined. Does a policy exist that addresses behavioral determinants? If so, is it being implemented correctly? Program planners may need to conduct formative research to answer these questions. (For example, an open-vial policy for vaccines may exist in a country, but frontline health workers may not be following the policy; observation and key informant interviews may help planners understand why.) What are the strengths, weaknesses, and opportunities related to the policy? What does your organization have the capacity to address through advocacy?

Advocacy efforts require a political and social analysis of the key stakeholders and their intentions, potential losers and winners, and where support and opposition lie. It is important to pinpoint the key decision makers in order to reach and engage them[31]. Even more so, it is important to assess how to address any potential sources of opposition because they may be an intended audience. Once those individuals or institutions have been identified, practitioners need to dis-

cuss how significant their opposition will be and whether that opposition should be addressed directly in the campaign or not.

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**Key Advocacy Resources:**

- Spitfire Strategies, 2014, Smart Chart.
- Water Integrity Network, 2012, Advocacy Guide: A Toolbox for Water Integrity Action.
- AED, SARA Project, HHRAA, and USAID Africa Bureau, 1997, An Introduction to Advocacy: Training Guide.
- SARA Project, HHRAA, and USAID Africa Bureau in collaboration with Joint Health Systems Research (HSR), Essential National Health Research (ENHR) Africa Secretariat, and Council on Health Research and Development (COHRED), 1997, Making a Difference to Policies and Programs: A Guide for Researchers.
- CARE, 2001, Advocacy Tools and Guidelines.

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## Other Aspects of an Enabling Environment

Other aspects of an enabling environment include non-health sector approaches, like economic empowerment or employment programs, usually created in partnership and collaboration with experts these areas. Education initiatives can also shift factors in the environment. Program planning includes thinking about people's lives holistically and determining what kinds of activities will meet their needs and priorities, which may be different from external program implementers' health priorities. Addressing the environment in this way yields opportunities for partnerships that broaden the scope of a singularly focused program, but can also increase its impact through synergies created when communities' needs are met in different areas and on different levels.

Working to create an enabling environment could also include approaches to examine and shift social norms, like gender roles or norms about sexuality. Shifting social norms can be essential for sustaining new behaviors. Key components of social change include sustainability through local ownership; empowering communication; an emphasis on dialog, debate, and negotiation, rather than persuasion or information from external experts; an emphasis on outcomes that goes beyond individual behavior to include social norms and the environment; and communities as agents of their own change.[32]

## Creating Messages and Materials for Change

<u>Messages</u>

Using the formative research results, program planners should design messages to address the determinants identified as significant to the behavior and priority and influencing group. Messages should be personally appealing and discuss only one or two key points. The information should be new, clear, accurate, complete, and culturally appropriate. Messages should include specific suggestions on actions people can take. The messages that are most effective are not treated as standalones. Instead, they are incorporated into stories or multicomponent SBC programs with materials that address different audiences. Messages can be threads woven throughout materials and activities, and they should be consistent across all activities and levels. As messages are drafted, it is important to keep tone or appeal in mind.

<u>Materials</u>

Appropriate and well-designed activities and communication materials are essential to all SBC programs. The strategic design and approach are the most important, and usually intangible, elements of communication materials. Once a strategy is agreed upon, effective communication products, such as group discussion facilitation manuals, training manuals and job aids, television, radio or theater scripts, posters, brochures, and text or audio messages, for planned activities need to be created or adapted from existing resources. Products will need to be pretested and finalized.

Developing communication products combines science and art:

- There is science to creating concepts, visuals, and text that is based directly on analysis of the situation: the people, their culture, existing policies and programs, active organizations, and available communication channels.
- There is art in creating products that evoke emotion, motivate audiences, and fit within the chosen strategy.

Before creating anything new, see what already exists both globally and in country, and also see what is recommended (or required) by the country where the program is being implemented. If possible, develop materials with MOH and secure MOH approval. Most health issues are not new, although they may need to be addressed in different and nuanced ways in different settings. Can existing materials be complemented? Adapted? Improved? Expanded? Used in a different way?

A checklist of considerations to use when developing messages and materials:

- Are the messages accurate?
- Do the messages speak to the determinants of behavior change that were found to be significant?
- Can the messages be replicated across a variety of media?
- Are the messages and materials consistent?
- Are the messages and materials appropriate?
- Are the messages clear?
- Are the messages and materials relevant to the audience (e.g., age and gender)?
- Are communication channels appropriate for the message?
- Are messages and materials appealing?
- Are messages and materials of high quality?

Ideally, and as much as possible, practitioners should develop materials together with their audiences to understand if the messages are understood, how they make use of certain information, and what motivates them to change. There are three types of tests that should be employed when creating SBC products:

1. Concept testing takes place among the target audiences before materials are drafted and looks at the larger ideas, motivations, interests, and knowledge.

2. Draft materials are reviewed by partners, gatekeepers, and other key stakeholders.

3. Pretests and field tests take place among the target audiences when draft materials are available to identify aspects that might be misinterpreted, misunderstood, or not liked by audiences and users.

## Communication Channels

Before deciding what kind of materials to produce, program implementers need to determine which channels will reach the intended audience. Communication channels include mass media like billboards, internet and entertainment education, print media, community outreach and mobilization, advocacy, facility-based approaches, and interpersonal approaches. Johns Hopkins Bloomberg School of Public Health and Center for Communication Programs' Field Guide Designing a Health Communication Strategy describes each channel, its advantages and disadvantages, and the audience reached.

# IMPLEMENTATION

During the implementation stage of the project, plans turn into actions. SBC interventions are launched; trainings are conducted; improved services and products are promoted; and policy changes are initiated. Plans will require some flexibility; be ready to stop doing unproductive activities and alter plans when necessary. Allow the project to change course as the result of monitoring and evaluation and adjust implementation plans based on anticipated costs.

Four aspects of implementation are critical to success: (1) sequencing program elements; (2) timing against other events; (3) making activities mutually supportive; and (4) integrating complementary programs.

Sequencing is the order in which activities are implemented. In the case of SBC interventions, assure that interpersonal support materials are ready in time to be used with a campaign launch. Assure that facility-based health workers are properly informed about community health worker programs, supplied with necessary drugs and materials, and trained before community health workers refer patients to them. Assure that supervision and reporting structures are in place.

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

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

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

- Ensure that enough commodities are ready to support your efforts to promote their use. For example, are there enough long-lasting insecticide-treated nets available for National Child Health Day? If not, it may become more difficult to convince audiences to use such commodities if their last experience trying to get them was in vain.

- Ensure that services are of quality and can meet demand. If providers are promoted as friendly, but have not been trained to be friendly, a backlash might make future efforts to promote their services far more difficult. If there is not enough staff to provide quality counseling, potential clients will turn away and be much harder to convince to access those services in the future.

**Five Tips to Strengthen the Implementation of SBC Programs**

1.  Involve communities and other stakeholders throughout the program to negotiate and implement activities to change social norms and behaviors and address barriers.

2.  Learn from those who are doing the work, through mechanisms such as jointly developed quality improvement checklists and supportive supervision strategies.

3.  Encourage initiative and resourcefulness among staff.

4.  Demonstrate commitment by constantly seeking excellence in design, production processes, and services, not just in products.

5.  Consistently seek quality solutions, which are often not the cheapest option.

## TRAINING AND SUPERVISION

Key to effective implementation is training and supervising staff responsible for carrying out behavior change activities. Training techniques should take into account adult learning principles and use participatory training methods, those that staff themselves will use when teaching and training others. Supportive supervision involves including staff in setting standards for performance, allowing for personal reflection, emphasizing the positive, and seeking feedback on how to improve processes.

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**Key Implementation Resources:**

- Jane Vella. *Learning to Listen, Learning to Teach: The Power of Dialogue in Educating Adults.* Wiley and Sons, San Francisco, 2002.
- Freedom from Hunger/FANTA, 2002, Supervision and Support of High-Quality, Nonformal Education Services: The Use of Observation Checklists.
- Pink, Daniel. *Drive, The Surprising Truth About What Motivates Us.* Riverhead Books, New York, 2009.

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## MONITORING AND EVALUATION

### OVERVIEW

Monitoring and evaluation (M&E) are key aspects of any project, and "together they serve to support informed decisions, the best use of resources, and an objective assessment of the extent to which an organization's services and other activities have led to a desired result" [MSH, 2014].[33] What is different about M&E of SBC programs compared with M&E of other programs? The answer in many ways is "not much." The fundamental M&E principles (i.e., frameworks, indicators, and data sources) apply to SBC programs.

For an SBC program, monitoring tracks and measures progress being made toward achieving SBC objectives, usually focusing on process and output indicators. Monitoring questions ask

whether the activities in the workplan are or were implemented—did the program do what it said it would do—and whether implementation is or was of high quality. Process and output indicators, however, do not measure behavior change and are only useful if activities were appropriately selected to address key behavioral determinants. Monitoring is a continuous activity in the life of a project.

Evaluation involves data collection at discrete points in time to systematically investigate an SBC program's effectiveness in bringing about desired change in an intended population or community. Evaluations are usually conducted about half-way through a project (mid-term) and at the end (final) and compared to baseline studies (such as surveys and other formative research), but they can also be done more frequently. Evaluation enables an SBC program to determine whether its theory of change was accurate and whether the SBC strategy and activities were effective. It measures what has happened among intended audiences as a result of program activities. Evaluation questions are related to whether objectives were achieved and how, and if not achieved, why not. While effective SBC programs have the potential to contribute to improved health outcomes, it may not be possible to attribute them to an individual program or intervention. Attribution is particularly difficult with communication programs because it is impossible to conduct randomized-controlled trials (considered the gold standard for determining causality and attribution) with them.

The programs with the greatest impact and sustainability over time are often those that are able to adjust to changing circumstances and needs of their audiences. Annual small-scale surveys conducted by staff (e.g., using Lot Quality Assurance methodology) can be useful in assessing progress, identifying weak and strong performing areas, and determining if any changes need to be made to strategies or activities. If resources allow, a midline evaluation can be used to document outcomes to date and synthesize monitoring data on process and quality.

When deciding what quantitative and qualitative data to collect, it is important to consider what questions you want to answer and what information you need, which data sources provide this, how it will be collected, who will use it, and how will it be used.

## Developing Indicators

Process and output indicators for SBC programs are similar to those used for monitoring in other types of programs, and outcomes are often behavior or practice indicators, relevant to the program's technical intervention areas. Table 2 gives some examples.

**Table 2. Examples of indicators of SBC**

| Process | Output | Outcome |
|---|---|---|
| Number of public events held | Percentage of population that reported participating in a public event within the past two weeks, by type | Percentage of mothers who exclusively breastfed their children from 0–5 months |
| Number of trainings conducted | Number of trainees trained | Percentage of mothers who attended at least four antenatal care visits |
| Number of program materials | Percentage of population that has seen, | Percentage of mothers who gave |

| printed, by type | heard, or read program materials | birth in the presence of a skilled birth attendant |
|---|---|---|
| **Process** | **Output** | **Outcome** |
| Number of house visits conducted | Percentage of population that has had at least one house visit in the past month | Percentage of children with diarrhea in the last two weeks who were given the same amount or more liquid to drink |
| Number of group discussions held | Percentage of population that has attended at least two group discussions in the past month | Percentage of children who slept under an insecticide-treated bednet the previous night |

If audiences are being reached and quality activities are being implemented (see output indicators) but behavior is not changing, first reassess the appropriateness of the activity selected. Then reassess behavioral determinants. If audiences are being reached, quality activities are being implemented, and behavior is changing, there is no need to monitor or reassess determinants.

Gender Indicators

Integrating gender into M&E efforts means more than disaggregating beneficiary data by sex and collecting sex-disaggregated data, although both of these may be necessary and useful in specific contexts and for select indicators. A robust M&E system should integrate gender-specific indicators to track the status of project activities, as well as project outcomes. Participatory monitoring processes provide excellent opportunities to both gather gender data and increase project understanding and ownership.

Indicators should include measures of key determinants that were identified in your gender analysis, such as women being included in the decision to seek care outside the home for a sick child, and specific outcomes of these determinants, as well as their relationship with project objectives, as appropriate. Qualitative data on behavior may be the most useful in understanding what is happening and why. For more guidance on developing gender indicators and evaluating the success of gender integration, please see the Key Gender Resources text box in this document.

**Key M&E Resources:**

- K4Health, 2011, Monitoring and Evaluation Toolkit.
- USAID, 2011, Monitoring and Evaluation (M&E) Fundamentals.
- MEASURE Evaluation , M&E of Family Planning Programs—1 Day Module.
- Bloom S.S. and Arnoff E., 2011, Gender and Health Data and Statistics: An Annotated Resource Guide. Measure Evaluation.
- AIDSCAP Project. Family Health International, Assessment and Monitoring of BCC Interventions: Reviewing the Effectiveness of BCC Interventions.
- Sample Indicators for SBC Programming:
  - DHS Indicators
  - HIV and AIDS Survey Indicators Database (Measure DHS or UNAIDS)
  - UNGASS 2012 Country Reports

# SPECIAL CONSIDERATIONS

## SUSTAINABILITY

Project teams need to plan for the sustainability of SBC activities and the health outcomes they impact during the program design phase. Refer to MCHIP's comprehensive [Sustainability Planning and Assessment Manual](#) for detailed information.

## GENDER

Community-based global health programming often focuses on women, as both beneficiaries and gatekeepers of child and household health. This focus alone does not adequately address gender, which is not synonymous with women, but rather refers to social norms, roles, and relationships between men and women. Although gender is often viewed as an inherent component of community-based health programming, gender issues and efforts to address them are rarely articulated in program descriptions or clearly integrated into program design or M&E.

Gender integration (e.g., targeting men for infant and young child feeding (IYCF)[34, 35] or men and boys for Family Planning programs) not only accounts for distinctive impacts on women and girls, but it also examines the differential impacts on women, men, girls, and boys in a specific context. Integrating gender into maternal, newborn, and child health (MNCH) programs is, therefore, an important component of successful and sustainable programming.

### What do we mean when we talk about gender?

**Gender** refers to a culturally defined set of economic, social, and political roles, responsibilities, rights, entitlements obligations, associated with being female and male, as well as the power relations between and among women and men, boys and girls. The definition and expectations of what it means to be a woman or girl and a man or boy, and sanctions for not adhering to those expectations, vary across cultures and over time, and often intersect with other factors, such as race, class, age, and sexual orientation.

**Gender equality** is the state or condition that affords women and men equal enjoyment of human rights, socially valued goods, opportunities, and resources. Genuine equality means more than parity in numbers or laws on the books; it means expanded freedoms and improved overall quality of life for all people. [36]

**Gender equity** is the process of being fair to women and men, boys and girls. To ensure fairness, measures must be taken to compensate for cumulative economic, social, and political disadvantages that prevent women and men, boys and girls from operating on a level playing field.

**Gender blind** programs do not recognize, or may even ignore, local gender differences, norms, and relations in program and policy design, implementation, and evaluation.

**Gender awareness** programs explicitly recognize local gender differences, norms, and relations and their importance to health outcomes in program and policy design, implementation, and

evaluation. These programs fall into three categories: gender exploitative, gender accommodating, and gender transformative (see Figure 3[37]).

**Gender accommodating** programs approach project design and implementation in ways that adapt to or compensate for gender differences, norms, and inequities by working around the barriers created by existing gender norms. These approaches do not deliberately challenge unequal relations of power or address the underlying structures that perpetuate gender inequalities.

**Gender exploitative** approaches, which also result from gender awareness, take advantage of underlying conditions of gender inequality, including imbalances in power, to achieve health program objectives; this should never happen!

**Gender transformative** programs and policies explicitly engage women and men to examine, question, and change institutions and norms that reinforce gender inequalities, as well as strengthen institutions and norms that support gender equality, and as a result, achieve both health and gender equality objectives.

All projects should be gender aware because gender is often a major behavioral determinant, and integrated MNCH projects should strive for this. Projects should, at the very minimum, strive to be gender aware and gender accommodating, with the goal of moving along the continuum to gender transformative. Focusing on transformative interventions leads to positive impacts on gender equity and MNCH health outcomes.
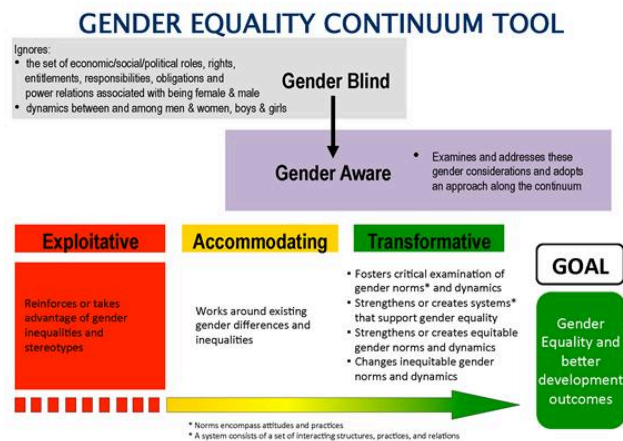


**Figure 3. Categories of Gender Awareness Programs**

**Key Gender Resources:**

- USAID, 2012, Gender Equality and Female Empowerment Policy
- USAID, 2013. ADS Chapter 205 Integrating Gender Equality and Female Empowerment in USAID's Program Cycle.
- USAID, 2010, Guide to Gender Integration And Analysis. Additional Help for ADS Chapters 201 and 203.
- IGWG, 2013, A Practical Guide for Managing and Conducting Gender Assessments in the Health Sector,
- USAID, 2010, Guide to Gender Integration And Analysis. Additional Help for ADS Chapters 201 and 203.
- FHI360, 2012, Integrating Gender in Care and Support of Vulnerable Children: A Guide for Program Designers and Implementers.
- IASC, 2010, Gender & Nutrition Checklist.
- Interaction, 2007, Catalyzing Equitable Development: An Initiative to Institutionalize a Gender Perspective in PVO and NGO Work in the Field.
- Social Watch, 2012, Gender Equity Index.
- USAID, 2013, Gender Integration Continuum Tool.

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