Operationalizing Key Family Practices for Child Health and Nutrition at Scale

The Role of Behavior Change

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Abstract
In developing countries, more children could be saved by ensuring that key preventive, case management, and care-seeking behaviors are adopted by large numbers of caregivers. This report presents the Steps Towards Expanding Partnership at Scale (STEPS) framework, which has been instrumental in operationalizing key practices for maternal and child health at scale by focusing implementation on a core set of high-impact, easy-to-change behaviors. The steps are (1) Developing a shared vision among partners, (2) Developing a behavior-centered strategy, (3) Designing an integrated package of communication and behavior change (CBC) materials, (4) Scaling up implementation of the CBC package from early implementation sites, and (5) Monitoring and reprogramming interventions based on results. Experiences from the Democratic Republic of Congo, Senegal, Benin, El Salvador, and Honduras provide highlights of successful CBC programs that used this approach. This report is accompanied by a CD-ROM containing tools to help program managers, communications planners, and others identify and prioritize core behaviors that impact child health.

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Special thanks to Elizabeth Fox, Mike Favin, and Rafael Obregón who reviewed the content and shared ideas for dissemination. And thanks in advance to those program managers, communication and behavior change professionals, and technical advisors from donor and cooperating agencies for documenting the lessons they learn after applying this framework and corresponding tools for operationalizing key family practices for child health and nutrition at scale.

And last but not least, our gratitude goes to the families and children for whom this publication is ultimately designed.
### Acronyms

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
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<tbody>
<tr>
<td>ADEMÁS</td>
<td>Agency for the Development of Social Marketing</td>
</tr>
<tr>
<td>AIN</td>
<td><em>Atención Integral a la Niñez</em> (Integrated Child Care)</td>
</tr>
<tr>
<td>ARI</td>
<td>Acute Respiratory Infections</td>
</tr>
<tr>
<td>BASICS</td>
<td>Basic Support for Institutionalizing Child Survival Project</td>
</tr>
<tr>
<td>BCG</td>
<td>Bacillus of Calmette and Guerin (tuberculosis vaccine)</td>
</tr>
<tr>
<td>CBC</td>
<td>Communication and Behavior Change</td>
</tr>
<tr>
<td>CRS</td>
<td>Catholic Relief Services</td>
</tr>
<tr>
<td>C-IMCI</td>
<td>Community-Integrated Management of Childhood Illness</td>
</tr>
<tr>
<td>COMSAIN</td>
<td><em>Comunicación para la Salud Infantil</em> (Communication for Child Health)</td>
</tr>
<tr>
<td>COSIN</td>
<td><em>Comunicación para la Salud Infantil</em> (Communication for Child Health)</td>
</tr>
<tr>
<td>DISC</td>
<td><em>Décentralisation et Initiatives de Santé Communautaire</em> (Decentralization and Initiatives in Community Health)</td>
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<tr>
<td>DPT</td>
<td>Diphtheria-pertussis-tetanus vaccine</td>
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<tr>
<td>DRC</td>
<td>Democratic Republic of Congo</td>
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<tr>
<td>EBF</td>
<td>Exclusive Breastfeeding</td>
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<tr>
<td>ECHP</td>
<td>Essential Child Health Package</td>
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<tr>
<td>EIS</td>
<td>Early Implementation Sites</td>
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<tr>
<td>ENA</td>
<td>Essential Nutrition Actions</td>
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<tr>
<td>ENC</td>
<td>Essential Newborn Care</td>
</tr>
<tr>
<td>HIV/AIDS</td>
<td>Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome</td>
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<tr>
<td>IEC</td>
<td>Information-Education-Communication</td>
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<td>ICC</td>
<td>Inter-agency Coordinating Committee</td>
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<tr>
<td>IMCI</td>
<td>Integrated Management of Childhood Illness</td>
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<tr>
<td>MADLAC</td>
<td><em>Monitoreo Apoyo Directo a Lactancia Materna</em> (Monitoring System for Breastfeeding Support)</td>
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<td>MBP</td>
<td>Mother-Baby Package</td>
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<td>MOH</td>
<td>Ministry of Health</td>
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<tr>
<td>MSH</td>
<td>Management Sciences for Health</td>
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<tr>
<td>NGO</td>
<td>Non-governmental Organization</td>
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<tr>
<td>OPV</td>
<td>Oral polio vaccine</td>
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<tr>
<td>PATH</td>
<td>Program for Appropriate Technology in Health</td>
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<tr>
<td>PIC</td>
<td><em>Paquet Intégré de Communication</em> (Integrated Communication Package)</td>
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<tr>
<td>PVO</td>
<td>Private Voluntary Organization</td>
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<tr>
<td>SANRU</td>
<td><em>Santé Rurale</em> (Rural Health Project)</td>
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<tr>
<td>STEPS</td>
<td>Steps Towards Expanding Partnership at Scale</td>
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<tr>
<td>TBA</td>
<td>Traditional Birth Attendant</td>
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<td>TIPS</td>
<td>Trials for Improved Practices</td>
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<tr>
<td>UNICEF</td>
<td>United Nations Children’s Fund</td>
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<tr>
<td>USAID</td>
<td>United States Agency for International Development</td>
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<td>WHO</td>
<td>World Health Organization</td>
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Executive Summary

The child health agenda is unfinished. After important declines in child mortality over the second half of the 20th century, the rate of decline since the 1990s has leveled off or even reversed in some countries. The majority of children in the Third World still continue to die at home, often with no contact with a health care facility. Significant impact on child survival could be achieved by ensuring that key preventive, case management, and care-seeking behaviors are adopted by large numbers of caregivers of children less than five years of age.

Experiences from the Democratic Republic of Congo, Senegal, Benin, El Salvador, and Honduras show that key caretaker behaviors in child health and nutrition can be promoted at scale using the Steps Towards Expanding Partnership at Scale (STEPS) framework presented here. This five-step framework has been instrumental in operationalizing key practices in maternal and child health at scale by focusing implementation on a core set of high-impact, easy-to-change behaviors.

Experience from the Basic Support for Institutionalizing Child Support Project (BASICS and BASICS II), in collaboration with ministries of health and other national partners, shows that five steps are critical for implementing large-scale communication and behavior change (CBC) packages in collaboration with national partners:

- Step #1: Developing a shared vision among partners
- Step #2: Developing a behavior-centered strategy*
- Step #3: Designing an integrated package of CBC materials
- Step #4: Scaling up implementation of the CBC package from early implementation sites
- Step #5: Monitoring and reprogramming interventions based on results

The STEPS framework is complemented by a set of tools for identifying and prioritizing a key set of high-impact, easy-to-change behaviors. This report and the tools referred to in it can be found on the accompanying CD-ROM. Both the framework and tools are intended to assist child health program managers, communication professionals, and behavior change technical advisors from cooperating agencies to design and implement integrated CBC packages at scale.

*Behavior-centered programming is a service mark provided by the Manoff Group, Inc. (2003).
Introduction

Substantial declines in child mortality were achieved during the second half of the 20th century. For example, the number of deaths of children less than five years of age decreased from an estimated 15 million in 1980 to 10.8 million in 2000. Despite this success, the rate of decline since the 1990s has leveled off and, in some countries, has reversed. The child survival agenda is unfinished, and continuing efforts are needed.

Many children’s lives in developing countries could be saved every year using simple health interventions readily available in industrialized countries. Currently, a vast scientific knowledge base and effective technologies are available to prevent and treat diarrhea, pneumonia, malaria, and measles—diseases that are responsible for about half of child deaths in the developing world. These conditions share common risk factors, have synergistic effects, and often co-exist. Indeed, failing to breastfeed is associated with increased risk of infections and illness, which in turn contribute to poor nutrition in the cycle of child malnutrition and illness. In fact, malnutrition is an underlying cause of death in over half of all child deaths.

Geography is also relevant to child mortality. In 2000, 19 countries accounted for 54% of child deaths worldwide. The present challenge in child survival is therefore to improve access to basic knowledge and quality services for those who need them most, and to implement at large scale what is known to work.

Caregiving, Care-seeking, and Quality of Care

The majority of children in the Third World continue to die at home with no contact with a health care facility. Results from a 1995 study conducted by the Basic Support for Institutionalizing Child Survival Project (BASICS) show how wrong turns on the Pathway to Child Survival can lead to death. Social and verbal autopsies from 271 deceased children in El Alto, Bolivia were used to learn step-by-step what happened from the time each child started getting sick to the time they died. The findings showed that most caregivers did not initially provide adequate care at home. Then, when the health of the child continued to deteriorate, 60% of caregivers did not recognize the danger signs and, therefore, did not seek appropriate care on time.

Unfortunately, only 14% of those caregivers who sought care for their children were found to have received adequate care at the health facility. Thus, comprehensive child health packages need to include access to good quality health care at facilities as well as behavior change interventions to improve health worker skills and caregiver practices at home. In developing countries, significant impact on child survival could be achieved by improving quality of services and ensuring that key practices are promoted and implemented at the household and community levels.

Key Practices for Child Health

Recently, much progress has been made in identifying key practices for child health. In 1997, BASICS, in collaboration with other global partners, developed a list of 16 emphasis behaviors for maternal and child health. The emphasis behaviors, which have been widely used, inspired

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*a The BASICS Project operated from 1995 to 1999; the follow-on project, BASICS II, operated from 1999 to 2004. In this document, “BASICS” will refer to the original project, while “BASICS II” will refer to the follow-on project.
global partners in the Integrated Management of Childhood Illness (IMCI) initiative to develop a list of practices specific to child health.

In a meeting held in Durban (South Africa) in June 2000, global consensus was reached on 16 key practices for IMCI at the community level (see the box). The consensus list includes a range of preventive and health promotion practices, as well as home management of illness, early recognition of danger signs, and timely care-seeking. It represented a breakthrough for the programming of well-focused behavior change interventions in child health. Once the goals became clearer, the focus shifted toward operationalizing the key practices.

Experience from early implementation countries demonstrated the complexity of putting the key practices into action. One important step is to break down each key practice into specific behaviors and phrase these behaviors in action terms that state “who does what, when, and how.” For instance, the practice of exclusive breastfeeding comprises a number of specific behaviors: early initiation of breastfeeding, avoiding water and any liquid other than breastmilk during the first six months, positioning the baby appropriately for breastfeeding, increasing the production of breastmilk, extracting and storing the breastmilk, and so forth. This breakdown results in a large number of behaviors that must be prioritized using meaningful criteria. Ideally, the process should be simple enough to engage participation at different levels, particularly with communities and sometimes involving people with low literacy skills.
This document describes a set of rapid tools and a five-step framework that have proven effective in operationalizing the 16 key family practices. (This report and tools for identifying and prioritizing a key set of high-impact, easy-to-change behaviors can be found on the accompanying CD-ROM.) Some best practices from a number of early implementation countries in Latin America and Africa are presented. The tools and approaches used and the lessons learned can help behavior change specialists from other countries guide operationalization of the key family practices at large scale for improving child health and nutrition.
The STEPS Framework: Achieving Sustainable Behavior Change Impact at Scale

In order to achieve significant public health impact, behavior change interventions—along with quality services—must be taken to scale. In practice, a large number of individuals, families, and communities need to practice and adopt healthy behaviors so that improvements in child health and nutrition indicators can be achieved nationally. In addition, to be successful, behavior change programs must be sustained over time through local and national initiatives. In many instances, these needs require going beyond an Information-Education-Communication (IEC) campaign or intervention towards a long-term (1–2-year or 5-year) cycle of behavior-centered programming. If the goal is to achieve sustainable impact at scale, long-term behavior-centered programming must be built into the design of the health program at the outset.

The STEPS framework (Figure 2) summarizes the BASICS projects’ recent experience in assisting countries to design behavior change packages around a priority set of key behaviors at national scale. STEPS, which stands for Steps Towards Expanding Partnership at Scale, comprises:

- **Step #1**: Early advocacy work takes place, and a shared vision among national stakeholders is built.
- **Step #2**: The foundation for designing a behavior-centered strategy is developed by prioritizing and selecting high-impact, easy-to-change behaviors through consensus among national and local partners.
- **Step #3**: An integrated communication and behavior change (CBC) package, including necessary job aids and communication materials, is completed while building local and national capacity to sustain innovations.
- **Step #4**: Quality expansion is supported through initial application in early implementation sites (EIS) and through strategic experience transfer to partners for eventual nationwide use.
- **Step #5**: Monitoring and evaluation activities are conducted to provide feedback for continuous improvement.

The STEPS process should be visualized as a set of building blocks in which several steps are built simultaneously by adding blocks both vertically and horizontally. For instance, program managers normally build the monitoring component of Step #5 while developing and implementing previous steps.

The step-like illustration in Figure 2 was developed to better capture the rationale behind sequencing actions in a systematic way.

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*Behavior-centered programming is a service mark provided by the Manoff Group, Inc. (2003).*
and building upon accomplishments from previous steps. For example, investing in advocacy and partnership early in the process may better serve the goal of program ownership and sustainability in the long run, rather than having partners trying to “sell” successful products or approaches to each other. The following sections include illustrations of how some countries recently applied the STEPS framework to develop CBC packages that contribute to improved child health and nutrition practices at national scale.

**Step #1: Developing a Shared Vision among Partners**

Action under Step #1 is geared towards building a national coalition of partners under the leadership of the Ministry of Health (MOH), with the common goal of integrating a set of key practices to improve child health and nutrition nationwide.

Extensive advocacy work is usually required to build consensus and strengthen partnership among stakeholders. One of the partners, in close collaboration with the MOH, may catalyze the process. In the developing world, a catalyst often involves better coordinated action between an MOH—with scarce human and financial resources—and a number of cooperating agencies, donors, internationally funded projects, and a group of private voluntary and non-governmental organizations (PVOs and NGOs) actively involved in child health.

Advocacy work by the catalytic team usually begins with individual visits to stakeholders and detailed information gathering on the work that they do. It is sometimes believed that stakeholders are more comfortable working independently and are somehow reluctant to discuss cooperation under the leadership of the MOH; on the contrary, they are usually eager to share the good work that they do.

Some countries hold a one-day workshop for technical exchange and for development of a common vision as part of building a national coalition for behavior change. The 16 key family practices may come into play during this “visioning” exercise. Experience from early implementation countries shows that the key family practices are a good starting point for discussion. A one-day workshop also provides a good opportunity for the MOH to delineate the main lines of work and formally invite partners to join national efforts to improve child health and nutrition. A closing ceremony, which may include media involvement, highlights partners’ enthusiasm. The momentum created during the advocacy workshop must be maintained.

Formation of a steering committee is the next step. This committee provides follow-up on the agreements made by the national coalition. The MOH may convene a small and dynamic group of recognized specialists in the field of behavior change; the mandate of this committee is to gather the collective knowledge and best practices in the country.

The advocacy work begins in Step #1, and continues to be reinforced during subsequent steps. The primary outputs of Step #1 appear in the box above. A discussion of coalition-building in the Democratic Republic of Congo (DR Congo) begins on the following page.

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**Step #1. Expected Outputs**

- Strategic partners identified
- Shared vision and common goals established among partners
- Preliminary list of key practices to improve child health and nutrition agreed upon and adapted
- National coalition formed under the leadership of the Ministry of Health
- Steering committee organized under the leadership of the Ministry of Health
Step #2: Developing a Behavior-centered℠ Strategy

The goal under Step #2 is to design a national CBC strategy—through consensus among national stakeholders—around a priority set of high-impact, easy-to-change behaviors aimed at improving the health of children.

One important task for the CBC national steering committee (formed in Step #1) is to take an inventory of all communication materials and quantitative and qualitative studies related to child health and nutrition practices for children less than five years of age. A quick and thorough assessment normally suffices to identify and reach consensus on information gaps that then guide the design of a targeted CBC strategy.

The CBC national steering committee may also determine whether formative research on specific practices is needed. Trials for Improved Practices (TIPS)℠ is a good example of tools available to conduct formative research on nutrition practices prior to developing counseling aids.

Coalition-building for Immunization and Child Health Communication in the Democratic Republic of Congo

Inter-agency Coordinating Committees (ICCs) have been formed in countries to improve coordination among partners in support of immunization programs and control of vaccine-preventable diseases. In the Democratic Republic of Congo (DR Congo), the ICC sub-committee* for immunization, led by the Ministry of Health (MOH), was initially formed in 1996 to harmonize approaches and support for polio eradication. It quickly expanded to address the needs and encourage national-level consensus among donors and key health colleagues for routine immunization in DR Congo. The immunization ICC serves as a partnership between:

- The MOH (Expanded Program on Immunization, epidemiological unit, nutrition unit, primary health care unit, etc.);
- World Health Organization (WHO);
- United Nations Children’s Fund (UNICEF);
- Foreign government donor partners (the United States Agency for International Development (USAID), the Government of Japan, the European Union, etc.), and their technical sub-contractors (BASICS II, the Rural Health Project (SANRU), etc.);
- Non-governmental and private voluntary organizations (NGOs and PVOs such as Rotary, Doctors Without Borders, Catholic Relief Services (CRS), etc.); and
- Missionary groups (Catholic Medical Bureau, Protestant Church of Christ in Congo, etc.).

The technical functions of the immunization ICC are further divided into two sub-committees with multi-agency representation: one to address technical and logistics issues; and the other to plan and implement communication, social mobilization, advocacy, and resource mobilization.

This latter sub-committee, the Social Mobilization and Resource Mobilization Sub-Committee, is comprised of communication experts in health and multimedia from the various partner organizations. This sub-committee has worked with the ICC to ensure that communication strategies and activities are included in immunization planning at all levels in the country, as part of technical documents produced to improve immunization service delivery and community engagement, and as a key component in immunization technical support. Through the last several years, this relationship has resulted in:

- National, provincial, and health zone immunization and health staff receiving standardized training and support in communication techniques;
- Implementation of strategy-specific and annual immunization plans and technical documents that include sections on communication; and
- Development and use of immunization communication guidelines for community mobilizers and health staff, as well as numerous communication materials (radio spots, briefing materials, counseling cards, theater sketches, etc.).

(continued)
A workable set of target behaviors is at the core of a well-conceived behavior-centered strategy, and development of these specific behavior targets is next. Rather than each partner developing separate IEC materials to influence any of the 16 key family practices, the challenge is for all partners to agree on the same key behaviors and coordinate multiple delivery mechanisms (Figure 3). To assist countries in accomplishing this task in a quick and participatory fashion, BASICS II adapted a three-stage approach based on well-known behavioral frameworks.9, 10, 11, 12, 13

**Analytical Stage**

In order to develop a behavior-centered strategy, a technical process is needed to operationalize the key practices. First, the key practices must be broken down into specific behaviors, then factors that constrain or facilitate such behaviors must be analyzed to derive a list of feasible behaviors. Figure 4 illustrates how
the process in this _analytical stage_ helps to identify the gap between ideal and actual behaviors and to complete a list of feasible behaviors for a target audience in a particular setting.

**Decision-making Stage**

After developing a comprehensive list of feasible behaviors, a _decision-making stage_ follows. During this stage, stakeholders agree on a priority set of target behaviors based on established criteria. The priority behaviors, selected from the list of feasible behaviors, are the ones that provide maximum impact and that are the easiest to change.

Some rapid and objective methods may be necessary during the decision-making stage. Figure 5 illustrates a method of assigning individual impact and feasibility scores to each behavior identified in the previous stage. Priority behaviors getting the highest scores in impact and feasibility would fall in the upper-left quadrant. The higher the combined impact and feasibility scores, the higher the behavior would go in the upper-left corner. Low-impact and difficult-to-change behaviors falling in the lower-right quadrant could be disregarded.

In addition to providing a visual result, this graphic tool enables participants to focus consideration on the behaviors falling in the remaining two quadrants. Those behaviors in the upper-right quadrant—high-impact but difficult-to-change—may be included in the list of priority behaviors for political reasons, including consistency with government policies. Low-impact but easy-to-change behaviors (in the lower-left quadrant) might be chosen in some instances for strategic reasons. For example, program managers may focus on these behaviors to show early progress.

**Planning Stage**

Once a manageable set of high-impact, easy-to-change behaviors has been selected, a _planning stage_ assists in the identification of appropriate interventions. Identifying primary and intermediary target audiences for each behavior aids in focusing on the
individuals and actions that contribute to alleviating inequities in health. A comprehensive and well-integrated behavior change package should allow caregivers and health staff to make informed decisions on behaviors to be applied through advocacy, strengthening of the health system, social mobilization, and interpersonal and mass media communication (Figure 6). It is at this stage when all the required communication materials and job aids for the CBC package are identified, and the need for capacity-building at different levels of the delivery system evaluated.

The BASICS and BASICS II experience suggests that rapid participatory approaches achieve expected results at the lowest cost. After receiving a short training, local staff members assist groups of 20–30 workshop participants in completing the three stages outlined above. The major benefits of using participatory approaches are ownership and consensus. Other expected outputs are listed in the box opposite. A discussion of Senegal’s experience developing a behavior-centered strategy begins on the following page.

Step #3: Designing an Integrated Package of Communication and Behavior Change Materials

The goal of Step #3 is to rapidly design, with inputs from technical and communication experts, a well-rounded package of CBC materials aimed at selected high-impact, easy-to-change behaviors. Any experienced IEC specialist knows that the work of designing IEC materials is lengthy and can be quite laborious. Designing a poster can take weeks, if not months, before a final piece incorporating inputs from strategic partners is created. For many countries, designing a comprehensive package of multimedia materials, adapted for different audiences and channels and developed in coordination with partners, is challenging. Recent experience from countries in Africa and Latin America, however, suggests that a well-planned design workshop can minimize the time and cost of designing a high-quality, integrated package of materials.

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**Figure 6. Planning Stage: Programming Communication and Behavior Change Interventions**

<table>
<thead>
<tr>
<th>Target behavior</th>
<th>Target audiences</th>
<th>Job aids</th>
<th>Capacity-building</th>
</tr>
</thead>
<tbody>
<tr>
<td>Communications</td>
<td>Social mobilization</td>
<td>System strengthening</td>
<td>Advocacy</td>
</tr>
</tbody>
</table>

**Step #2. Expected Outputs**

- Generic set of tools for the analysis and prioritization of behaviors to improve child health and nutrition adapted by steering committee
- Cadre of national facilitators trained, and capacity of health and communication experts improved
- Behavior change strategy developed around a priority set of high-impact, easy-to-change behaviors
- Strong sense of ownership among partners over the proposed communication and behavior change package
- Partnership strengthened
Strategy Development for an Integrated Communication Package in Senegal

PIC (Paquet Intégré de Communication) is an essential package of behavior change interventions at the household, community, and health facility levels to promote a set of key behaviors to improve child health and nutrition. It is implemented through partnership at the national level.

The Health Education Unit of the Ministry of Health (MOH), with BASICS II’s technical assistance, first presented the vision for PIC at a one-day advocacy workshop held in Dakar in April 2001. More than 50 participants, representing different levels of the MOH, the United Nations Children’s Fund (UNICEF), a large number of projects funded by the United States Agency for International Development (USAID), and private voluntary organizations (PVOs), attended the workshop. The generic list of 16 key practices was used to identify, by consensus, main areas of focus, including nutrition, malaria, immunization, diarrhea, acute respiratory infections (ARI), perinatal/neonatal health, and hygiene. In order to provide appropriate follow-up, a steering committee was created. Within a few months, this committee then completed an inventory of available resources related to the selected key practices. In case of perinatal/neonatal health, some formative research was conducted to better understand barriers and facilitators underlying maternal and newborn care practices.

Late in 2001, a five-day strategy design workshop was conducted in Louga with participants from Kébémer and Darou Mousty—the two early implementation districts selected for PIC. BASICS II, in collaboration with the steering committee, adapted and translated tools to assist in selecting a feasible set of high-impact behaviors for child health and nutrition. Four national facilitators from the MOH were oriented and received on-the-job training by assisting during the workshop. The workshop was attended by more than 40 people, including MOH staff working at national, regional, and district levels; representatives from UNICEF, AFRICARE, Management Sciences for Health (MSH), Program for Appropriate Technology in Health (PATH), Agency for the Development of Social Marketing (ADEMAS), Santé Catolique, World Vision, Décentralisation et Initiatives de Santé Communautaire (DISC), and Plan International; community-based groups such as relais (community volunteers); and members of the community health committee.

Following a bottom-up approach and working with districts to achieve national results, workshop participants were separated by the two initial districts, and then each district was divided into two manageable groups of about 10 participants each. For each district, participants were distributed to balance expertise and representation at different levels. For instance, those individuals in a district more likely to work on preventive issues were assigned to group #1, which dealt with immunization, growth promotion and nutrition, and perinatal/neonatal health. Individuals with clinical experience were assigned to group #2, which dealt with diarrhea, malaria, and ARI. In order to provide participants with relevant information for the decision-making stage, in which feasible behaviors were prioritized, a selected group of experts was asked to give a brief overview of the topic areas to be covered each day. Each expert, therefore, summarized behavioral aspects of the health problem, thereby helping the groups identify possible interventions.

Experience drawn from the two early implementation districts and staff input were used to conduct similar strategy design workshops over a two-month period for the remaining 13 USAID priority districts in Senegal in 2002. After consolidating results from the districts, 22 high-impact, easy-to-change target behaviors were selected for promotion through PIC. In the district of Kébémer, a demonstration site for a global initiative to improve perinatal/neonatal health, 11 perinatal- and neonatal-specific behaviors were added and referred to as “PIC Plus.” As part of the strategy, primary and intermediary audiences were identified, and job aids and support materials for advocacy, social mobilization, and communication were developed.

Most of the job aids and communication materials were developed at a 10-day design workshop conducted in October 2002. Following is a list of materials designed around the key behaviors to support implementation of PIC in Senegal:

- Counseling cards for relais, traditional birth attendants (TBAs), matrons, and health workers
- Technical guidelines (fiches techniques) for relais, TBAs, matrons, and health workers
- Maternal and Child Health booklet, including counseling aids and mother’s reminder materials
- Radio series of 36, three-minute episodes using the enter-educate format, weaving key messages for PIC into a radio soap opera

(continued)
An ideal CBC materials design workshop brings together multi-level child health and nutrition technical experts, communicators and media specialists, and professional graphic designers and artists, with the equipment needed to complete their tasks. Facilitators at the workshop ensure technical quality by:

- Linking contents of the behavior-centered strategy to the materials under development;
- Building local capacity;
- Facilitating consensus among partners; and
- Checking consistency of messages across different media formats.

In addition, the quality of the materials can be improved by ensuring that graphic designers and artists are in direct dialogue with technical staff, while working full-time with proper equipment on a single project. Though some changes in the design may be required as a result of field-testing after the workshop, the national CBC package should be ready for production more quickly by following this process.

Launching of the CBC package is a golden opportunity to capitalize on investments and leverage resources from partners for large-scale implementation. From a programmatic point of view, the launch could be perceived as a pretest for success of the initiative. Ideally, donors and sponsors should view the use of these standardized materials as mutually beneficial, with the MOH leading a national

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**Strategy Development for an Integrated Communication Package in Senegal (cont’d)**

- Five, 10-minute street theater sketches videotaped for live demonstrations, for a cinebus at community events, and for TV/VCR at health facilities
- Religious Leader’s Advocacy Guide, written in Arabic and extracting verses from the Koran, to support targeted perinatal and neonatal behaviors
- Poem and song with perinatal/neonatal messages
- Community-Integrated Management of Childhood Illness (C-IMCI) leader’s advocacy guide
- PALU board game, using the enter-educate format, to promote key caregiver behaviors for the prevention and home management of malaria
- Set of posters

In April 2003, PIC was officially launched in Senegal by the MOH in collaboration with partners and supported by extensive media coverage. By the end of 2003, PIC was well-established as a national communication and behavior change (CBC) package adopted by the MOH and its national counterparts. Each partner provided funding to reproduce PIC materials for use in different parts of the country and in coordination with the MOH.

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* Niang, C. I. 2003. *Formative research on perinatal health in the Kébémer health district (Senegal)*. Arlington, Va: BASICS.
†The term “enter-educate” is a combined form of “entertainment” and “education.” It describes communication that blends entertainment with a positive educational message.
‡A cinebus is an itinerant bus equipped with a large screen capable of showing movies in open areas to large audiences. It is used to conduct social mobilization activities.

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**Step #3. Expected Outputs**

- Workshop for the design of an integrated set of communication and behavior change (CBC) materials organized by the Ministry of Health, with participation of partners
- Integrated set of CBC materials designed around a priority set of high-impact, easy-to-change behaviors
- Integrated CBC package launched as a national initiative and adopted by partners
- Leverage of additional resources by partners
- Partnership and coordination strengthened
coalition of stakeholders in child health. At the launching ceremony, the work of individual partners is acknowledged, and partners announce their plans to support implementation of the CBC package at the national level.

In the box above are key expected outputs for program managers to monitor the unfolding of events during Step #3. Benin’s experience with a design workshop appears directly below.

Benin’s Experience in Creating an Integrated Package of Communication Materials Through a Design Workshop

In 1998, BASICS helped the Ministry of Health (MOH) in Benin develop a set of communication materials to promote behaviors in the Essential Nutrition Actions (ENA) package. Implementation funds had to be executed in less than nine months, so a three-stage work plan was developed for accelerating the design of a communication package.

The first stage consisted of gathering basic information necessary for the design. In addition to identifying key practices and selecting means for reaching audiences in different geographical regions, an inventory of existing communication materials was conducted to build on what was already available in the country.

For the second stage, BASICS, in collaboration with the MOH, decided to concentrate resources for creating a variety of communication materials into a 12-day design workshop. This workshop, during which a complete package of communication materials was designed, accelerated the production process and ensured consistency of messages across interventions. Work was facilitated with over 50 participants, including artists (comedians, traditional communicators, dancers), graphic designers, illustrators, and a photographer; radio professionals; field implementation staff (representatives of non-governmental organizations, rural development workers); MOH personnel; and technical representatives from cooperating agencies. The workshop was conducted in part in plenary sessions and then divided into three working groups: radio, printed materials, and traditional media. In general, the agenda for each of the working groups was as follows: (1) Review of available information regarding practices in ENA, (2) Planning of interventions, (3) Message development, (4) Pretest of draft materials, (5) Final design, and (6) Planning of activities for follow-up and evaluation.

The third and final stage comprised planning of implementation activities and advocacy work after the design workshop. A steering committee was formed to provide follow-up to the work plan developed during the workshop. This committee worked in coordination with local personnel supporting Information-Education-Communication (IEC) implementation. Subsequent evaluations conducted by Catholic Relief Services (CRS) and the United Nations Children’s Fund (UNICEF) documented significant increases in indicators, such as exclusive breastfeeding (EBF) rates in Borgou, which were previously the lowest EBF rates in the country. Though initial communication plans were developed to support ENA only in the department of Borgou in the northern part of the country, some IEC materials were adapted for national implementation through leveraged resources from The World Bank.

Step #4: Scaling Up Implementation of the Communication and Behavior Change Package from Early Implementation Sites

Step #4 focuses on achieving public health impact through quality expansion of CBC interventions, built upon experience from EIS.

Child survival initiatives often evolve from small-scale interventions, simply because no single institution or donor-funded project has the mandate, resources, or logistical capacity to deliver a full package of services nationwide. Although it is difficult to generalize, MOHs and other national counterparts in the child survival arena tend to concentrate their investments on a limited number of districts and communities. Well-documented accomplishments from focused interventions exist, but few of these interventions succeed in becoming national initiatives.
Large-scale initiatives are conceived as such from the outset, if they are to scale up from small-scale interventions. Quality expansion under Step #4 relies on building partnership and ownership in previous steps, rather than on trying to sell an effective CBC package to the MOH and other partners after its development. Over time, BASICS and BASICS II have assisted a number of countries to use EIS to guide quality expansion of CBC packages nationwide.

EIS are strategic settings selected for accelerated implementation, usually by one of the partners. They are used as learning sites or “living laboratories” from which experience can be transferred to national partners in order to scale up implementation of a CBC package nationwide. Unlike pilot and demonstration projects whose interventions must be proven effective before being implemented elsewhere, EIS involve quality expansion of interventions already known to work.

Experience from EIS is used to adapt, refine, and improve the design and delivery of state-of-the-art CBC interventions at large scale. EIS experience can be used to advocate with decision-makers to establish policies or reallocate resources needed for large-scale implementation. In addition, EIS can be used to build national capacity with partners involved in later stages of implementation.

In practical terms, application of the EIS strategy should result in accelerated implementation in strategically selected sites, with experience transferred to ensure quality expansion by implementing partners without delaying of national implementation. Above are some expected outputs for program monitoring of Step #4 and, on the following page, a discussion of EIS in El Salvador.

### Step #5: Monitoring and Reprogramming Interventions Based on Results

The goals of Step #5 are to (1) develop a self-monitoring system simple enough for people at different levels to understand what progress has been made and (2) enable data-based decisions that improve program performance and reprogram behavior change interventions as specific objectives are achieved.

A monitoring and evaluation plan is critical to determining whether a CBC package is effective. The steering committee should develop simple CBC process indicators using the expected outputs (included in each of the steps). Measuring changes in key practices can help evaluate mid-term progress toward improving child health and nutrition. For evaluation purposes, those countries achieving large-scale implementation of CBC packages should access and utilize data on key practices and child health and nutrition indicators from national surveys to save time and resources.

An appropriate information system to track progress and impact must support large-scale implementation of a CBC package. This is particularly relevant when the scope of the intervention

<table>
<thead>
<tr>
<th>Step #4. Expected Outputs</th>
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<tbody>
<tr>
<td>■ Rapid implementation of communication and behavior change (CBC) package in early implementation sites (EIS), advanced by a leading partner (in collaboration with the Ministry of Health (MOH) and steering committee)</td>
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<tr>
<td>■ Lessons drawn from EIS, and job aids and materials field-tested and made ready for large-scale implementation</td>
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<tr>
<td>■ Experience from EIS transferred to partners, and local capacity built for national expansion</td>
</tr>
<tr>
<td>■ Large-scale implementation of CBC package, with leveraging of resources from partners</td>
</tr>
<tr>
<td>■ Technical assistance for quality expansion provided from EIS through the MOH and steering committee</td>
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Early Implementation Sites in El Salvador Support Implementation of a Child Health Package at National Scale

In 1999, El Salvador designed an Essential Child Health Package (ECHP) to be implemented at national scale using three departments (Morazán, Cuscatlán, and Sonsonate) out of 28 as early implementation sites (EIS). These three departments were selected due to their poor child health conditions and their strategic locations. BASICS II concentrated resources for field implementation in the three EIS, while working with the Ministry of Health (MOH) and other partners to assist in quality implementation of the ECHP countrywide.

The ECHP was ultimately aimed at impacting morbidity and mortality of children less than five years of age by improving indicators for acute respiratory infections (ARI), diarrhea, malnutrition, and perinatal/neonatal health. The ECHP was divided into the following four components:
1. Community-Integrated Management of Childhood Illness (“IMCI Plus”), adding new content on growth promotion, counseling, and essential newborn care (ENC);
2. Growth promotion through community-based monthly monitoring of adequate weight gain and counseling (Atención Integral a la Niñez or AIN);
3. Perinatal/neonatal health through the promotion of ENC at the community level, and implementation at the institutional level of an expanded version of the World Health Organization’s Mother-Baby Package (MBP) that includes a self-monitoring system for the promotion of breastfeeding (Monitoreo Apoyo Directo a Lactancia Materna or MADLAC); and
4. Communication program (Comunicación para la Salud Infantil or COSIN) for the promotion of 11 high-impact, easy-to-change behaviors to improve child health and nutrition.

Field implementation of the ECHP was accelerated in the EIS in close collaboration with partners. The EIS were used as living laboratories for field-testing of each tool of the ECHP. Training of facilitators and community workers implementing the various components across the ECHP was also started and refined in the EIS before being conducted at national scale. In the case of MADLAC, self-monitoring tools, training, and counseling tools for the promotion of breastfeeding were introduced in three maternity hospitals from the EIS before expanding to the remaining 24 public hospitals in the country. Efforts were dedicated to timely documentation and transfer of early experiences from the EIS to ensure quality implementation for the ECHP at the national level.

Though AIN implementation started nationwide, BASICS II, in collaboration with the MOH, accelerated its implementation and monitoring in the EIS. A group of field coordinators who were trained in the EIS assisted with rapid implementation there before assisting with quality implementation in other parts of the country. Lessons learned from the EIS were then used to correct weaknesses in the local information system that was developed to monitor expected weight gain in AIN communities. In some instances, quick operational research was used to better document and influence national programming.

In 2001, the MOH approved a new policy to strengthen the work of health promoters supporting implementation of the perinatal/neonatal component of the ECHP at the community level. As part of their new job descriptions, health promoters were required to visit newborns in the community within 24 hours after delivery. BASICS II, in collaboration with the MOH, conducted rapid research to assess barriers to health promoters’ delivery of ENC. This information was used to guide decision-makers in updating the training curriculum for health promoters and to reorganize the community unit at the MOH to strengthen supervision of health promoters.

By the end of 2003, the various components within the ECHP became national programs adopted by the MOH and implemented countrywide in collaboration with major stakeholders. In relation to the EIS, initial efforts by BASICS II to accelerate field implementation shifted over time toward documentation, evaluation, technical assistance, and experience transfer at the national level. The catalytic role of the EIS drew to a close as national capacity was built for large-scale programming and self-monitoring of the ECHP.
is to be institutionalized and sustained as a national program. Though IEC campaigns can serve some short-term goals, behavior change requires long-term programmatic effort. Indeed, significant improvements in child health are more likely to be achieved through systematic interventions than through many unrelated, short-term campaigns. To this end, some additional indicators measuring behavioral outputs, such as shifts in caregiver behaviors across different stages of change (pre-contemplation, contemplation, preparation, action, maintenance and termination), could be developed from behavior change frameworks. Information needs to be available for making programmatic adjustments and monitoring program performance, and capable of supporting sustainability across the steps.

The expected outputs of Step #5 appear above. A discussion of the CBC experience in Honduras appears below.

### Monitoring Progress in Implementing COMSAIN in Honduras

*Comunicación para la Salud Infantil* (COMSAIN) is a diversified media communication package developed in Honduras in 2000 to promote 13 high-impact, easy-to-change behaviors to improve child health and nutrition nationwide. Initial funding for COMSAIN came from the United States Agency for International Development (USAID) as part of reconstruction efforts after Hurricane Mitch in September 1998. The task for COMSAIN was to strengthen communication aspects of *Atención Integral a la Niñez* (AIN), a comprehensive child health and nutrition package directed to promote growth and prevent illness of children through community-based monitoring of growth and education countrywide. COMSAIN comprised an integrated set of communication tools, including counseling cards, a radio series using the enter-educate format, posters, mother reminder materials, several leaders’ advocacy guides, and a kit of promotional materials for the launching of COMSAIN. It was used to reinforce counseling and social mobilization work by *monitoras* (community volunteers) and health workers.

COMSAIN was designed using the STEPS framework to become a national initiative under the leadership of the Ministry of Health (MOH) in partnership with all major stakeholders in child health in the country. Starting with an advocacy workshop in November 1999, COMSAIN was launched in September 2000. Figure 7 illustrates the status of implementation of COMSAIN, at six months and one year from its start, using the STEPS framework as a tool to monitor program implementation.

Changes in child health and nutrition practices were measured for the whole AIN package, not specifically for COMSAIN. However, some quantitative and qualitative information was collected to monitor COMSAIN’s performance. For example, interviews with mothers at home and at health facilities indicated that the “listenership rate” of the radio series steadily increased from approximately 51% of caregivers in the third month of broadcasting to 56% in the sixth month and 60% in the ninth month. Interestingly, in a sample of communities where the *monitoras* promoted the radio series at the monthly weighing session, listernership reached up to 95% of caregivers. Program monitoring results helped the national steering committee assess progress and make programmatic adjustments while fostering enthusiasm and partnership.

(continued)
At the time of this publication—three years after the seed funding for COMSAIN was spent—the national steering committee has continued to function under the leadership of the MOH, reprogramming activities now funded with resources leveraged by partners. As new funding became available, new content areas were added to COMSAIN, reinforcing and refreshing key immunization and perinatal/neonatal behaviors. The original steering committee formed for COMSAIN served later as a national committee providing oversight and supporting implementation of AIN countrywide.

**Figure 7. Status of Implementation of COMSAIN Using the STEPS Framework: Six Months and One Year from its Inception**

I Sharing vision  
II Designing behavior-centered strategy  
III Designing integrated communication and behavior change package  
IV Expanding with quality from early implementation sites  
V Monitoring and reprogramming
References


