

Produced jointly by:
Academy for Educational Development
Global Health, Population & Nutrition Programs
1875 Connecticut Ave., NW
Washington, DC 20009

Johns Hopkins Bloomberg School of Public Health
Center for Communication Programs
111 Market Place, Suite 310
Baltimore, Maryland 21202

www.aed.org

www.jhuccp.org

This publication may be reproduced without permission provided the material is distributed free of charge and organizations are acknowledged. Opinions expressed in this report are those of the author and do not necessarily reflect the views of sponsoring agencies.

Editor: Kim S. Martin
Designer: Rita C. Meyer / Teresa Tirabassi

Suggested Citation:

Seidel, R. (December 2005). Behavior Change Perspectives and Communication Guidelines on Six Child Survival Interventions. A joint publication of the Academy for Educational Development and the Johns Hopkins Bloomberg School of Public Health/Center for Communication Programs with support from the United Nations Children's Fund.

Photo Credits:

Cover and Title Page—UNICEF/HQ97-1074/Giacomo Pirozzi; page iii—Harvey Nelson; page vii—Ricardo Wray, CCP; page xi—Harvey Nelson; page 1—UNICEF/HQ03-0002/Shehzad Noorani; page 11—Rick Maiman, David and Lucile Packard Foundation; page 33—Lauren Goodsmith; page 55—Asem Ansari, ICDDR,B; page 81—Luke Mwanza, CCP; page 107—UNICEF/HQ98-1137/Giacomo Pirozzi; page 129—Kristen Marsh.



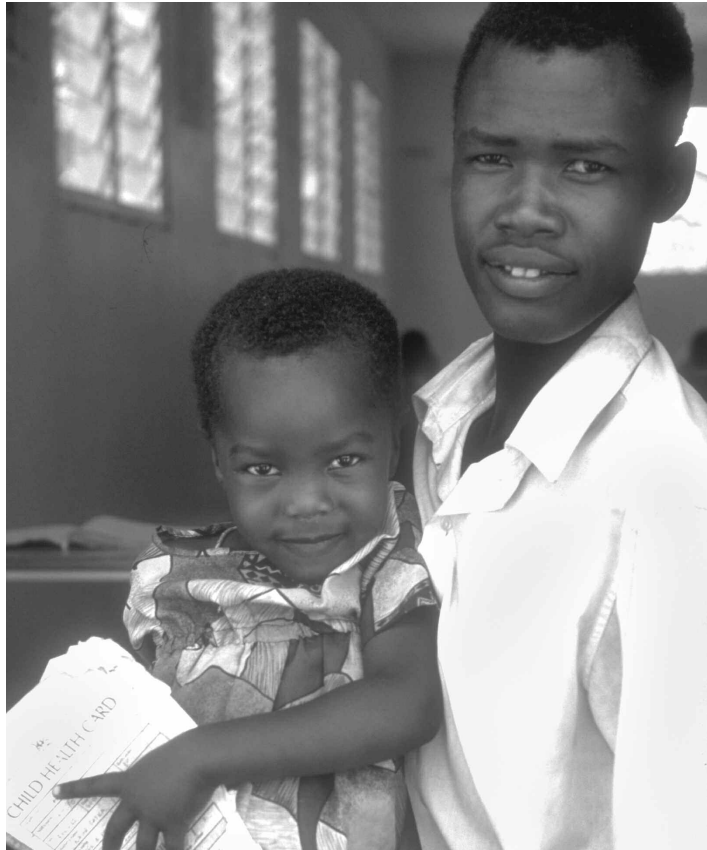
JOHNS HOPKINS
BLOOMBERG
SCHOOL of PUBLIC HEALTH

Center for Communication Programs



Academy for Educational Development





Behavior Change Perspectives and Communication Guidelines on Six Child Survival Interventions

2005

*Renata Seidel**

**Academy for Educational Development*



Acknowledgments

This document was based in part on extensive interviews with experts in the six major child survival interventions. The author is especially grateful to the colleagues below who shared their time, expertise, and perspectives so generously. Opinions expressed in this report are those of the author and any errors are the author's alone.

NEWBORN HEALTH

Robert Johnson, MNH
Gary Darmstadt, SNL/JHU
Indira Narayanan, PATH/BASICS
Ron Parlato, SNL
Elisabeth Sommerfelt, AED
Steve Wall, SNL

ACUTE RESPIRATORY INFECTIONS

Karabi Acharya, AED
Eric Starbuck, SAVE
Steve Wall, SNL
René Salgado, JSI/BASICS
Peter Winch, JHU

CONTROL OF DIARRHEAL DISEASES

John Murray, BASICS I
Robert Northrup, Project Hope
René Salgado, JSI/BASICS
Youssef Tawfik, JHU/HCP

IMMUNIZATION

Lora Shimp, JSI/BASICS
Michael Favin, Manoff/CHANGE
Rebecca Fields, AED/CHANGE
Silvio Waisbord, AED/CHANGE

NUTRITION

Mike Favin, Manoff/CHANGE
Nadra Franklin, AED/LINKAGES
Marcia Griffiths, Manoff
Luann Martin, AED/LINKAGES
Ellen Piwoz, AED

MALARIA

Mike Favin, Manoff/CHANGE
David McGuire, AED/NetMark
Nancy Nachbar, AED/NetMark
Lonna Shafritz, AED/CHANGE
Susan Zimicki, AED/CHANGE

ENVIRONMENTAL HEALTH AND OTHER

Mike Favin, Manoff/CHANGE
Alfonso Contreras, MSH/BASICS
Peter Gottert, AED/HCP
Nancy Keith, AED/HCP

Abbreviations and Acronyms

ACT	Artemisinin-based Combination Therapy	IMCI	Integrated Management of Childhood Illness
AFASS	Acceptable, Feasible, Affordable, Sustainable, and Safe	IPT	Intermittent Preventive Treatment
AIDS	Acquired Immuno-deficiency Syndrome	IRS	Indoor Residual Spraying
ANC	Antenatal Care	ITM	Insecticide Treated Material
ARI	Acute Respiratory Infection	ITN	Insecticide Treated Nets
BCC	Behavior Change and Communication	LAM	Lactational Amenorrhea Method
BCG	Bacille Calmette-Guerin	LBW	Low Birth Weight
CDD	Control of Diarrheal Disease	LLIN	Long-lasting Insecticidal Treated Net
CHW	Community Health Worker	MIS	Management Information System
CQ	Chloroquine	MOH	Ministry of Health
DPT	Diphtheria-Pertussis-Tetanus	MTCT	Mother-To-Child Transmission
ENA	Essential Nutrition Actions	NGO	Non-governmental Organization
EPI	Expanded Program on Immunization	NIDS	National Immunization Days
FCHV	Female Community Health Volunteer	OPV	Oral Polio Vaccine
FES	Focused Ethnographic Assessment	ORS	Oral Rehydration Salts
GAVI	Global Alliance for Vaccines and Immunization	ORT	Oral Rehydration Therapy
HB	Hepatitis B	OTC	Over the Counter
Hib	Haemophilus influenzae type b	PMTCT	Prevention of Mother-To-Child Transmission
HIS	Health Information System	PMV	Patent Medicine Vendor
HIV	Human Immuno-deficiency Virus	PVO	Private Voluntary Organization
HW	Health Worker	Q&A	Question and Answer
IEC	Information, Education, and Communication	RED	Reaching Every District
		RBM	Roll Back Malaria

RUTF	Ready to Use Therapeutic Food
SP	Sulfadoxine-Pyrimethamine
STD	Sexually Transmitted Disease
SSS	Sugar Salt Solution
STI	Sexually Transmitted Infection
TBA	Traditional Birth Attendant
TT	Tetanus Toxoid
UNICEF	United Nations Children Fund
USAID	United States Agency for International Development
VA	Vitamin A
VAD	Vitamin A Deficiency
WHO	World Health Organization



Contents

	Page
Acknowledgements	iii
Abbreviations and Acronyms	v
Executive Summary	ix
CHAPTER 1: Introduction	1
What Every Minister of Health Knows	2
The Contribution of Theories—The Value of Experience	3
Three Simple Principles	3
The Interventions	5
The Program Challenge—Integration and Rollout	6
The Systems Challenge— Behavior Change at Multiple Levels	10
CHAPTER 2: Newborn Health	11
The Invisible Child	11
The “Impossible” Intervention	13
Behavior Change and Communication in the Context of a New Program	13
Criteria for Selecting Priority Behaviors	14
Advocacy and Program Development	17
Assessing Behaviors that Make a Difference	19
Integrating with Safe Motherhood	21
The Birth Event and Essential Care	23
Postpartum Follow-up	25
Family Care of the Non-normal Newborn	25
Summary	29
CHAPTER 3: Childhood Immunization	33
Individual Good, Public Good	33
The Behavioral Objective—“Completing the Series by Age One”	34
Immunization is Local	35
The Provider May be Primary	39
Motivating and Supporting Client-Health Worker Relations	44
Using Data to Bridge the Community/Health System Gap	45
Accelerated Disease Control—Beyond Routine Behaviors	47
Summary	51

CHAPTER 4: Diarrheal Disease	55
Preventing the Disease	56
Preventing Dehydration and Death	56
From Success Story to New Advocacy and Behavioral Challenges	57
Managing Diarrhea—Recommended Family Behaviors	59
Managing Diarrhea—Provider Behaviors	60
Understanding Behaviors, Improving Programs	61
Building on the Community’s Perspective	63
What do Mothers Really Want?—Facing the Competition	69
Supporting Public and Community Providers	70
Partnering with Private Providers	70
Launching the New Product	73
“Repositioning” ORS and ORT in the New Era	74
Summary	77
CHAPTER 5: Malaria	81
Three Interventions	81
Malaria Prevention	82
Careseeking and Presumptive Treatment of Childhood Malaria	90
Summary	101
CHAPTER 6: Acute Respiratory Infections.	107
A Careseeking and Caregiving Intervention	108
The Very Short History of ARI	108
Promoting Policies, Advocating for Programs.	109
Recognizing ARI—The Fundamentals	112
Community Perceptions and Relevant Programs	115
Elements of Community-Level Programs	117
Practical, Skill-Based Training and Supervision	118
Materials and the Marvelous Timers	120
Supervision	120
Variations on Effective CHW Programs	122
Summary	125
CHAPTER 7: Nutrition	129
Advocating for Nutrition	131
Integrating Nutrition in Child Health and Community-Based Programs	131
Exclusive Breastfeeding Through Six Months	133
Complementary Feeding and Continued Breastfeeding, 6-24 Months.	138
Vitamin A	146
Other Micronutrients	150
Food Fortification.	152
Severe Malnutrition	152
Nutrition, Health, and Poverty	154
Summary	155
References & Resources	161



Executive Summary

This document is meant for those who want to incorporate behavior change and communication strategies into their child survival programs, as well as those who already plan and carry out such activities. It focuses on six major interventions and the key practices associated with these. It examines the challenges associated with improving these practices in developing country contexts, and aims to provide insight into how to design effective strategies.

Over the last two to three decades, behavior change and communication approaches have contributed to substantial improvements in the health status of children in the developing world. (See box on next page.) Many significant gains were made in the 1980s and 1990s in home use of oral rehydration therapy, completion of childhood immunizations, breastfeeding and other nutrition-related practices, timely careseeking for acute respiratory infections and malaria, and various home hygiene and sanitation measures. Systematic communication strategies based on an understanding of the beliefs, barriers, and

motivations of families clearly helped bring about the reductions in mortality seen in many countries.

In recent years the impressive gains in child survival have leveled off; in sub-Saharan Africa and South Asia some positive trends have even reversed. Reasons vary by country and include worsening economic disparities, armed conflict, and the human and structural degradation caused by HIV/AIDS. Worldwide attention has also been drawn away from child survival. Governments as well as donors have shifted funding from many of the primary interventions. In 2003 more than ten million children died from causes that are largely preventable—exceeding deaths due to HIV/AIDS, malaria, and tuberculosis combined.¹

The public health community is now re-examining its commitment to child survival. This reassessment should include a review of what we have learned about the communication challenges associated with the major child survival interventions. It should also include a re-emphasis on how behavior change and communication strategies at multiple levels can

¹ Black et al. 2003.

contribute to child health. This paper attempts to help address that need.

A TIME TO RE-ASSESS

A major aim of this document is to move communication programs beyond *demand creation* to a systems view of behavior change. To many theorists it may seem this objective was accomplished long ago. In the last 20 years health communication methodologies successfully shifted our focus to the perspective of the family—the immediate caretaker and decision maker as well as others in the broader community who influence health-related choices. An array of behavioral models,

as well as lessons from applying these in developing country settings, have also helped us design strategies that respond to parents' concerns and offer benefits they value. We have adopted the “consumer’s perspective,” as social marketers say.

At the same time, a focus on the family has not advanced the behavioral component of many child survival programs beyond *promotion of products and services*. This is partly because governments tend to relegate any discussion of behavior change to functions such as Information/Education/Communication (IEC) or community-based activities, which they typically take up as final steps in health program design when

CONTRIBUTING TO RESULTS

Communication and community-based behavior change programs have had significant impact on large populations across all the child survival interventions.

Diarrheal Disease A combination of radio and health worker training programs introduced ORS to Honduras in the 1980s. Within two years, 60 percent of rural women reported trying the product; 35 percent of all cases were treated with ORS.

Acute Respiratory Infections A program in Nepal trained community health volunteers to educate communities and actively detect and treat ARI among young children. The initial pilot, which began in 1987, led to a 28% reduction in the risk of death from all causes by the third year of services. The program has scaled up to 14 districts, saving thousands of lives each year.

Nutrition In Madagascar, radio, traditional and popular media, and a facility-based intervention all contributed to an increase in exclusive breastfeeding during the first five months of life. In 2001 (after 22 months of intervention), rates improved from 46 to 83 percent in ten target districts.

Measles Immunization In the Philippines, a mass media campaign focused on measles as a “hook” to bring children into the regular EPI service system. The six-month nationwide urban campaign in 1990 increased measles coverage of 9- to 23-month olds from 54 to 68 percent and also increased complete immunization rates as well as timeliness of completion.

Newborn Health In Gadchiroli district, India, training programs specially tailored for low-literate village health workers supported a newborn care pilot in the mid-1990s that brought about a 62 percent reduction in neonatal mortality compared to control villages. Deaths due to infection declined from 16.6 to 2.8 percent (of all newborn deaths) over three years.

Malaria In the Tigray region of Ethiopia, mother coordinators taught women in their own communities to recognize symptoms of malaria and promptly treat them with antimalarials available from the volunteers. In 1997, after the program's first year, the percent of child deaths due to malaria dropped to 19 percent (of all child deaths), in contrast to 57 percent in the control area.

(See the chapters that follow for details and sources.)

crucial decisions (other than which media materials or social mobilization activities to fund) have already been made. A very legitimate focus on the *family's perspective* can also make those involved in “communication” or “community-based activities” forget the importance of players at other levels and the possibility of affecting *their* behaviors.

The formal “lists” of key practices laid out for different interventions deal primarily with caretakers. These actions are linked by a solid base of evidence to the health outcomes that programs are targeting. A subset of these behaviors is usually assigned the status of program indicators.

However, we know that assuring performance of these “lists” will probably require attention to health providers, to community volunteers, to pharmacists, to district officers, to policy makers. These other audiences/actors (whom we usually term secondary) may in fact deserve the *most* attention in some contexts, depending on where problems—and promise of solution—lie. Planners always face a difficult task in weighing the importance of different factors and deciding where scarce funds should be targeted. Programs implemented at large scale must be lean. Communication planners, like other child survival experts, must be aware of how one piece of the system (or rather one player) affects another, and make difficult choices within that broader perspective.

The corollary of a systems view is that behavior change and communication experts must be knowledgeable and credible in the health areas in which they work. Without being immunization or nutrition or malaria experts, they must understand how an intervention is supposed to be delivered, how it *is* delivered, who the players are at different levels, what the coverage data are, and what the reasons are for both successes and gaps. Such understanding also assures that a communication expert is able to talk the same language as his or her technical counterparts, and in

turn is more likely to be included early in planning processes.

BEHAVIOR CHANGE, SOCIAL CHANGE, AND COMMUNICATION

This document does not look at the merits of different behavioral theories or explain the mechanics of specific state-of-the-art approaches. It discusses the behavioral issues and a range of key determinants for major audiences in each child survival area, and refers generically to “behavior change” and often “communication” or “community-based approaches” as an array of different tools. These vary substantially and include frameworks such as social marketing, and techniques such as social mobilization, enter-education, advocacy, and participatory training. References to certain methodologies are made throughout the chapters. But this is not a how-to manual. A bibliography at the end of the *Introduction* and each intervention chapter provide more detail on implementation approaches.

Child survival interventions aim to achieve improvements on a large scale and to sustain these over time. Their ultimate goal is to bring about shifts in social norms. This requires the direct involvement of communities at many levels. However, *social and community* approaches are often thought of as arising from principles distinct from those aimed at changing *individuals*. Collective action is motivated in different ways, and leads to fundamental social benefits beyond those captured by health indicators. The need for a combination of approaches is reflected most vividly in this document as we stumble time and time again upon the importance of improving “relations” among different groups—families and health workers, health workers and community volunteers, and so forth. In areas of highest risk, the pressures on human and structural resources are most extreme. The ability to solve problems collectively—to find transportation for

a pregnant woman or to supply kerosene to maintain the local cold chain—is critical.

As we shift our attention from audience to audience we easily forget that building partnerships and strengthening communication between them is likely to be the most important factor of all. All behavior change programs must help bridge this gap between individual and social change perspectives.

THE INTERVENTIONS

This document focuses on interventions targeting the major causes of mortality in the 42 countries claiming 90 percent of global child deaths in 2000.² These same interventions are the subject of a series of papers in the *Lancet* in 2003. They include:

- Newborn/neonatal health
- Childhood immunization
- Control of acute respiratory infections
- Control of diarrheal disease
- Malaria prevention and treatment
- Nutrition

Although the chapters that follow begin with what we used to call “vertical” slices of child health, the reality is that most children die from multiple, interrelated causes. Each section discusses the important overlapping disease and behavioral issues.

Rarely is a child’s death the result of a single episode of illness. Children die from the cumulative effects of multiple disease processes. Nutritional problems contribute to more than half of child deaths.³ Research has also shown that gaps in coverage of certain interventions are more likely among malnourished populations. Equity issues lie at the heart of child survival. Those who are at risk are almost

always vulnerable economically, socially, and have poorest access to services designed to help. A behavioral program should always begin with a population view, just as an epidemiologist does, and consider the major causes of disease, who is at greatest risk, and who is not being reached. Although underlying factors cannot always be targeted directly, any program that loses sight of these is unlikely to make a difference. In addition, as programs become successful and increase their focus on those truly “left out,” behavior and communication strategies may require fundamental changes.

² Black et al. 2003.

³ Bryce et al. 2005.