

Strengthening Social and Behavior Change Measurement in the RISE II Program



The Sahel region faces widespread public health challenges. Despite high fertility rates, demand for contraception is low, as reflected by the relatively low unmet need for family planning (FP). In both Burkina Faso and Niger, fewer than 20% of women have an unmet need for FP and only a third of women attended four or more antenatal visits prior to their last birth.¹⁻³ Breastfeeding in the first hour after birth is uncommon, and exclusive breastfeeding ends prior to six months for half of all children in Burkina Faso and three-quarters in Niger. While access to improved water is better in Burkina Faso than in Niger, both countries lack improved sanitation facilities, particularly Niger, where a lack of knowledge about the importance of sanitation and the perceived simplicity of open defecation remain barriers to latrine use.⁴ The U.S. Agency for International Development (USAID) Resilience in the Sahel Enhanced (RISE) initiative was developed in 2012 to

KEY POINTS

Social and behavior change (SBC) is an evidence-based, theory-driven process that identifies factors that influence people's behaviors and addresses these by using approaches that are most likely to improve health and development outcomes.

SBC-related indicators measure processes and approaches implemented to facilitate and increase uptake and/or maintenance of health behaviors among intended audiences. SBC indicators also measure intermediate outcomes such as attitudes and norms and health outcomes that are influenced by these processes and approaches.

Current SBC measures related to family planning; maternal, newborn, and child health; nutrition; and water, sanitation, and hygiene in Niger and Burkina Faso are extremely limited and are mostly concentrated at output-level measures and individual health outcomes.

Governments, donors, SBC implementing partners, and other stakeholders must consider expanding the use of SBC indicators, particularly those related to programmatic reach and intermediary outcomes, to narrow programmatic focus, monitor progress toward goals, and determine effectiveness and programmatic impact.





strategically layer and sequence humanitarian assistance while reducing vulnerability in regions of Burkina Faso and Niger over five years. Through the partners in the Resilience Food Security Activity (RFSA), a RISE II (2018–2023) builds on the experience from RISE I and introduces several adjustments, including emphasis on local ownership, culturally sensitive behavior change programming, targeted areas for joint action across the health and development sectors, and the agency of women and youth.

Social and behavior change (SBC) is an evidence-based, theory-driven process that identifies and addresses target behaviors as well as factors that influence these behaviors. SBC draws from several fields to develop approaches that address these influencing factors, ultimately leading to improved health and development outcomes. Due to the complexity and interactions between the underlying determinants and norms that influence the RISE II priority health outcomes (maternal, newborn, and child health [MNCH]; FP; nutrition; and water, sanitation, and hygiene [WASH]), SBC programming can be an effective tool to achieve program goals. In RISE II, the RFSA partners use a variety of SBC approaches, including community mobilization, interpersonal communication through peer group activities, and mass media, to address priority health behaviors described in Table 1.

^aThe RFSA in Niger includes Hamzari (led by Care), Girma (led by Catholic Relief Services), and Wadata (led by Save the Children). The RFSA in Burkina Faso is Victory against Malnutrition (ViM) led by ACDI/VOCA.

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TABLE 1 RISE II PRIORITY HEALTH BEHAVIORS

 <p>MNCH</p>	<p>Use of antenatal care Delivery at a facility</p>
 <p>FP</p>	<p>Use of modern contraception</p>
 <p>Nutrition</p>	<p>Exclusive breastfeeding for children 0–5 months Complementary feeding for children 6–9 months Minimum acceptable diet among children 6–23 months</p>
 <p>WASH</p>	<p>Household access to handwashing stations</p>

Rationale for SBC measurement

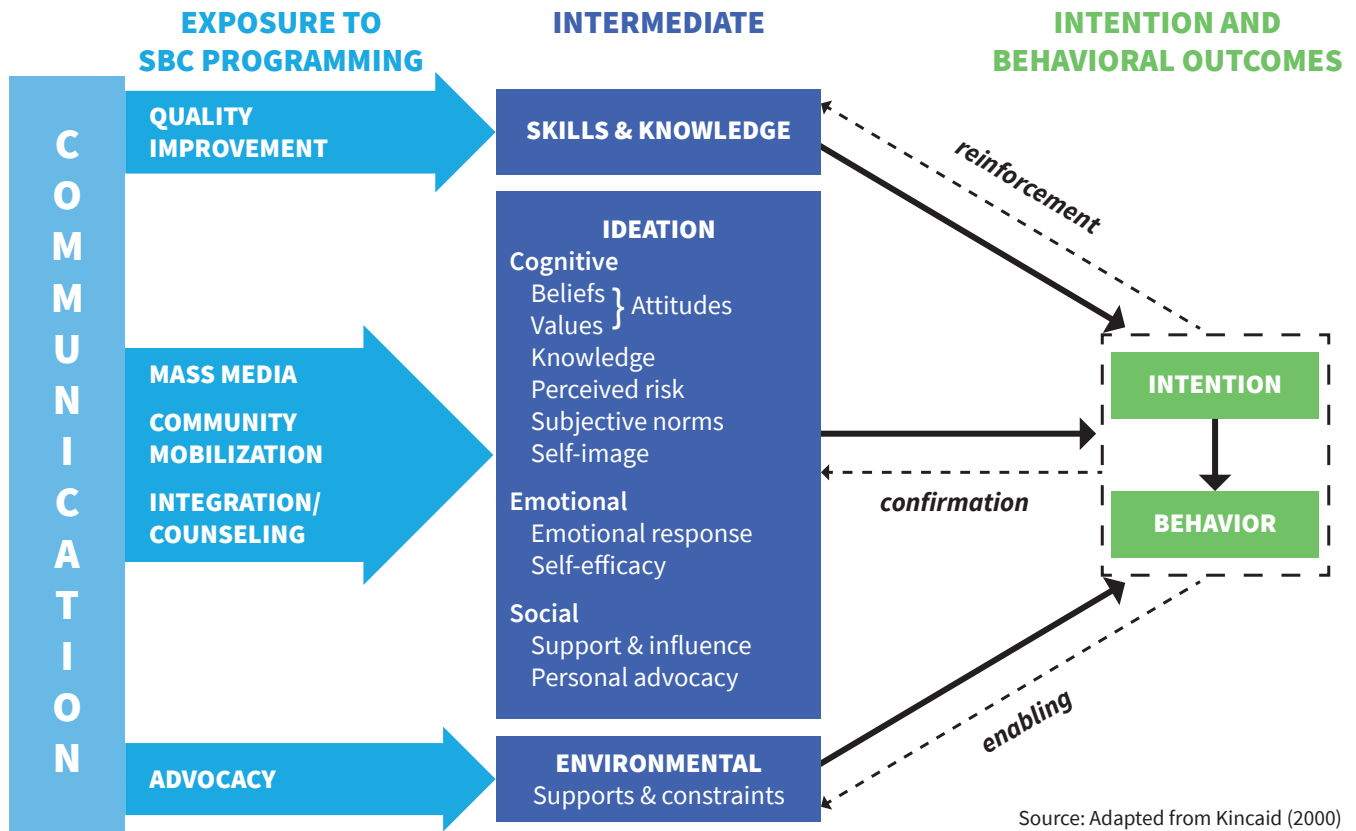
SBC can directly improve health outcomes through pathways that address intermediate outcomes in the cognitive domain (such as knowledge, attitudes, subjective norms); emotional domain (such as self-efficacy); and social domain (such as support and influence), all influencing health behaviors. Measurement is a tool to narrow programmatic focus, monitor progress toward goals, and determine effectiveness and programmatic impact. SBC indicators measure processes and approaches implemented to motivate and increase uptake and/or maintenance of health behaviors among intended audiences. These processes and approaches may occur at the individual, community, facility/institution, or national policy level. SBC indicators also measure intermediate outcomes such as attitudes and norms and behavioral outcomes that are influenced by these processes and approaches. Given the focus of SBC in the RISE II program, monitoring and evaluation systems should incorporate measures that align with SBC models, such as the ideational model, which considers how SBC approaches influence knowledge; skills; cognitive, emotional, and social determinants; and ultimately behavioral intentions and outcomes (see Figure 1).

Mapping SBC indicators

Breakthrough RESEARCH conducted a mapping of MNCH, FP, nutrition, and WASH indicators in Niger and Burkina Faso to assess the availability of SBC-related data, including standardized indicators that could inform RISE II partner



FIGURE 1 IDEATIONAL MODEL⁵



Source: Adapted from Kincaid (2000)

programs and support the identification and selection of standardized SBC indicators for routine programmatic data collection.

Specifically, the mapping exercise sought to understand:

1. What indicators are collected related to MNCH, FP, nutrition, and WASH programs overall, and among these indicators, what proportion are considered SBC-related indicators?
2. To what extent do SBC indicators collected reflect a range of indicators, including output, reach, and intermediate and outcome, and how are various socioecological levels captured?
3. What measurement gaps exist, and what additional SBC indicators can RISE II partners adopt to increase the availability and utility of routine SBC data to inform their programming?

We interviewed government stakeholders and partners in both countries implementing MNCH, FP, nutrition, and WASH activities from 2015 through 2019.^b As a part of the

interview process, we collected documentation pertaining to MNCH, FP, nutrition, and WASH activity objectives; program descriptions; monitoring, evaluation, and learning plans; and indicator reference sheets. We compiled information by indicator in an Excel indicator matrix where we summarized information on partner/donor, data collection frequency,^c geographic level, and description of the indicator, and then coded by indicator type and socioecological level (see Figure 2, page 4) as well as if it was an SBC-related indicator as defined in the box below.

SBC-related indicators measure processes and approaches implemented to motivate and increase uptake and/or maintenance of health service–related behaviors among intended audiences. SBC indicators also measure the intermediate outcomes such as attitudes and norms and health outcomes that are influenced by these processes and approaches.

Animas Sutura, Breakthrough ACTION, Palladium HP+, and Performance Monitoring and Accountability (PMA), among others.

^cDue to incomplete and inconsistent reporting of information related to data collection frequency, we were unable to analyze or provide recommendations related to this element of the Excel indicator matrix.

^bGovernment stakeholders and partners included the Department of Statistics, Care, CRS, Pathfinder, PSI, Save the Children, Winrock,

Table 2 presents illustrative indicators by type.⁶ We prepared heat maps (i.e., color-based representations of the number of indicators) for the subset of SBC-related

indicators based on the indicator matrix by type of indicator and socioecological level.

FIGURE 2 TYPE OF INDICATORS AND SOCIOECOLOGICAL LEVELS

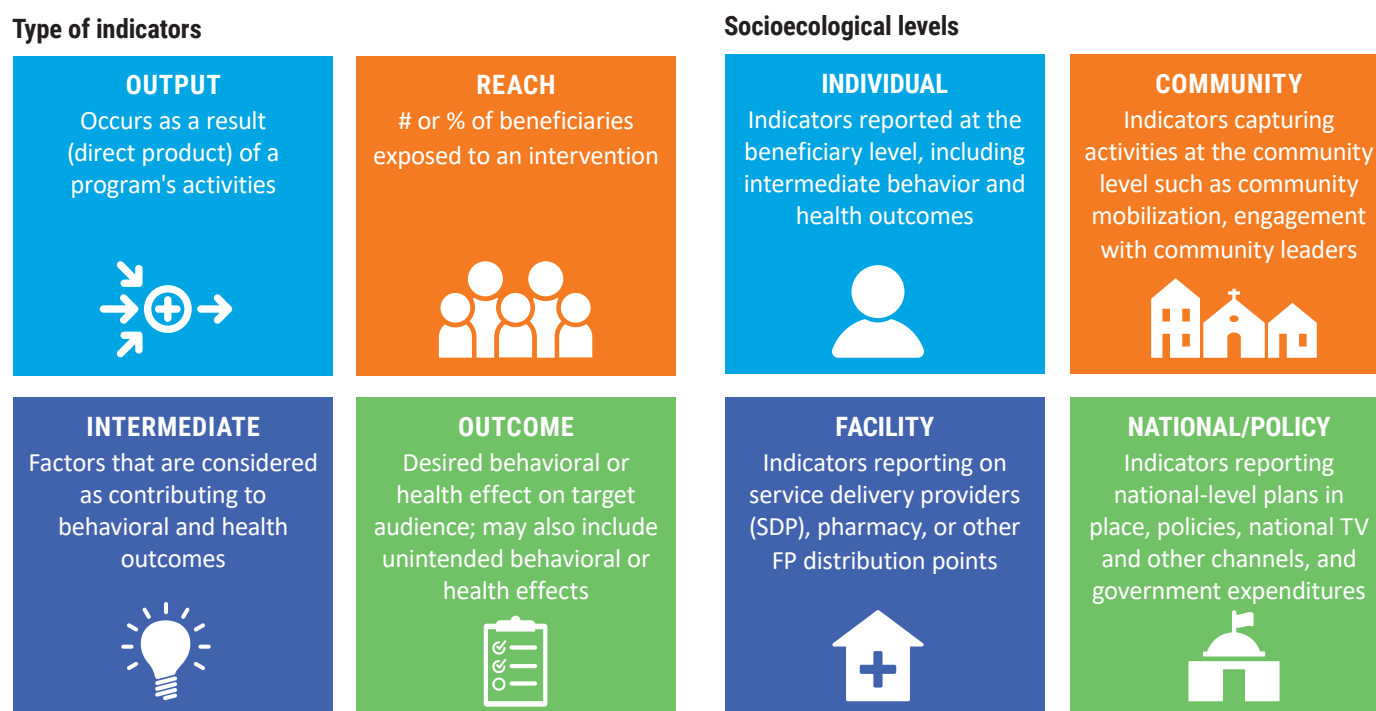


TABLE 2 ILLUSTRATIVE INDICATORS BY TYPE

	OUTPUT	REACH	INTERMEDIATE	OUTCOME
Individual	Number of male condoms distributed	Percentage of audience who recall hearing or seeing a specific product, practice, or service	Percentage of intended audience who believe that most people in their community approve of people like them using FP	Percentage of women of reproductive age in union who are using, or whose male partner is using, a modern FP method
Community	Number of community-level activities for FP conducted in project sites	Number of community members participating in community-level activities for FP in the last 6 months	Percentage of community leaders who believe they are capable of advocating for FP use (self-efficacy)	Percentage of villages in a district with community-based distribution of contraceptives
Facility	Number of providers trained in high quality counseling	Percentage of health care providers in the facility exposed to a quality improvement intervention	Percentage of providers at maternal and child health service delivery points who know the range of contraceptive options that do not interfere with breastfeeding	Percentage of providers who provided FP counseling according to quality standards
National/policy	Number of workshops conducted with government leaders to speak out in favor of FP	Number of government leaders trained to speak out in favor of FP	Number of government leaders who feel they are able to speak out in favor of FP	National FP communication strategy approved by the ministry

Findings from indicator mapping

MNCH key findings

We collected nearly 270 MNCH indicators in Burkina Faso and Niger, of which slightly over half (n = 157) were related to SBC. Among the MNCH SBC-related indicators shown in Figure 3, there was a range of output-level indicators collected across the socioecological levels. There were virtually no indicators collected that measure programmatic reach, and the few that measured the intermediate level included only knowledge and spousal communication. Among outcome-level indicators, the majority focused at the individual level. Given the gaps in programmatic reach and intermediate-level indicators, MNCH programs may not be able to document the pathway from output measures to behavioral outcomes. As a result, there may be missed opportunities to intervene or adapt programming to address programmatic limitations.

FP key findings

We collected over 700 FP indicators in Burkina Faso and Niger, of which 62% (n = 457) were related to SBC. Output indicators spanned across the socioecological levels (Figure 4). There were few indicators at the community, facility, and policy levels across reach and intermediate and outcome indicators, and almost all indicators found in these categories did not pertain to SBC. By contrast, SBC-outcome level indicators were primarily at the individual level.



FIGURE 3 HEAT MAP OF MNCH SBC INDICATORS BY COUNTRY, TYPE, AND SOCIOECOLOGICAL LEVEL

BURKINA FASO SBC (n=95)	OUTPUT	REACH	INTERMEDIATE	OUTCOME	LEGEND
Individual	8	0	0	64	
Community	9	0	0	0	64
Facility	3	0	0	2	
Regional/national/policy	0	0	0	9	
NIGER SBC (n=62)					
Individual	3	0	8	43	
Community	0	0	0	1	43
Facility	1	0	0	5	
Regional/national/policy	1	0	0	0	

FIGURE 4 HEAT MAP OF FP SBC INDICATORS BY COUNTRY, TYPE, AND SOCIOECOLOGICAL LEVEL

BURKINA FASO SBC (n=339)	OUTPUT	REACH	INTERMEDIATE	OUTCOME	LEGEND
Individual	8	26	27	138	
Community	20	1	1	1	138
Facility	19	0	0	0	
Regional/national/policy	83	15	0	0	
NIGER SBC (n=118)					
Individual	0	9	34	31	
Community	14	0	1	2	34
Facility	3	0	0	0	
Regional/national/policy	19	3	1	1	



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Without facility- or community-level measures, programs may fail to recognize limitations in client-provider interactions and how building trust between communities, clients, and service providers can contribute to improved individual-level outcomes.

Nutrition key findings

We collected nearly 200 nutrition indicators in Burkina Faso and Niger, of which 75% (n = 154) were related to SBC. SBC-related indicators were more common among nutrition projects since nutrition activities are less focused on service delivery. SBC-related indicators focused at the individual level as seen in Figure 5. Overall, Niger had fewer SBC indicators than Burkina Faso but had a broader range in terms of indicator type and socioecological level. A focus on individual outcomes without understanding the intermediate outcomes influencing these behaviors may limit a program’s ability to narrow the programmatic focus and develop more cost-effective targeted interventions.

WASH key findings

We collected approximately 200 WASH indicators in Burkina Faso and Niger, of which about 27% (n = 53) were related to SBC. Across health areas, WASH had the fewest SBC-related indicators (Figure 6). There were few reach

FIGURE 5 HEAT MAP OF NUTRITION SBC INDICATORS BY COUNTRY, TYPE, AND SOCIOECOLOGICAL LEVEL

BURKINA FASO SBC (n=82)	OUTPUT	REACH	INTERMEDIATE	OUTCOME	LEGEND
Individual	3	10	0	66	0 66
Community	0	0	0	0	
Facility	0	0	0	3	
Regional/national/policy	0	0	0	0	
NIGER SBC (n=72)					
Individual	2	12	4	40	0 40
Community	0	1	1	0	
Facility	5	0	0	3	
Regional/national/policy	0	0	0	4	

FIGURE 6 HEAT MAP OF WASH SBC INDICATORS BY COUNTRY, TYPE, AND SOCIOECOLOGICAL LEVEL

BURKINA FASO SBC (n=30)	OUTPUT	REACH	INTERMEDIATE	OUTCOME	LEGEND
Individual	0	2	1	3	0 11
Community	3	0	0	2	
Facility	0	0	0	0	
Regional/national/policy	11	0	2	6	
NIGER SBC (n=23)					
Individual	2	0	3	6	0 9
Community	0	0	1	9	
Facility	0	0	0	1	
Regional/national/policy	0	0	0	1	

and intermediate-level indicators. Among the few intermediate-level measures captured, the focus was exclusively on knowledge. WASH indicators were primarily at the outcome level. Among outcome-level indicators, the majority focused at the individual level. WASH programs provide benefits to outcomes across health areas. However, there are few WASH indicators relative to other health areas. This suggests that there might be an opportunity to develop unified measures that link communications related to WASH and other health indicators to achieve greater programmatic reach.

Recommendations

1. Integrated SBC programs should consider identifying measurement gaps or needs by health area and intentionally designing measures that capture unifying concepts and strategies that link the promotion of key behaviors for target audiences. For example, SBC strategies may address gender norms related to household decision making that influences multiple health behaviors and can be captured through a unified measure.
2. While there were a number of programmatic reach indicators identified for FP, there were very few and in some cases no reach indicators related to MNCH, nutrition, and WASH. There is a need for increased measurement of program reach to understand implementation strength and the extent to which audiences are exposed to SBC programs. MNCH, nutrition, and WASH programs can consider including measures that assess exposure by various channels and recall of specific messages to understand if key audiences are reached by SBC activities.
3. We found limited use of intermediate outcomes across each health area, suggesting that indicators related to behavioral determinants beyond knowledge should be collected for SBC program design and monitoring. For each context, programs should consider what are the most important behavioral determinants that should be addressed to foster enabling environments and facilitate behavioral outcomes. Measuring intermediate outcomes can support program managers in monitoring steps toward behavior change, thereby identifying progress and where additional support is required.
4. There is a dearth of cost-related SBC measures available to inform programs. We identified only two cost-related indicators across all four health areas, and neither focused on SBC programs. Programs should leverage the availability of SBC costing guidelines to develop cost measures that can support advocacy, program prioritization, and agenda setting.

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