

A Conversation on Social and Behavior Change with Elizabeth Fox, Deputy Coordinator for Maternal and Child Survival and Senior Advisor to the Bureau for Global Health.

Bea Spadacini: Hello and welcome to USAID Bureau for Global Health's podcast. My name is Bea Spadacini and I am a Senior Communications Advisor in the Bureau for Global Health at USAID. This episode focuses on social and behavior change as an approach to programming health interventions. Many of our USAID's global health programs revolve around the need to promote healthy behavior that can save and improve lives. But individual and collective behaviors are often influenced by deep rooted social and cultural norms, hence the need to design activities, or interventions, that take into account a variety of disciplines and multiple approaches. Social and behavior change programming, has long been an area of strategic priority for USAID. To talk about this topic here today we have Elizabeth Fox, Deputy Coordinator for Maternal and Child Survival and Senior Advisor to the Bureau for Global Health. Elizabeth has been with USAID for twenty years and has served in a variety of senior positions. Elizabeth holds a PhD in international relations, an MA in Communications, and a degree in journalism.

We are delighted to have you with us today Elizabeth. Let me start by asking you a simple question, you have been a global health professional for many years, how did you get involved in social and behavior change programming?

Elizabeth Fox: Well, before I was a global health professional, I was a communication professional, and a journalist and a social scientist. So, you should be asking me how did I get involved in health, not in social and behavior change. I started working as a journalist and I worked for many years in Latin America on communication policy and it was a natural evolution to go from the way countries set up their radio systems or look at educational television to begin to look at what was the content on those programs, and in many cases for development, the content that was most prevalent was health content. And it was looking at simple, preventive messages about seeking health services. So, I applied my communication skills and I applied my social science skills to global health. That's the way I got here, not the other way.

Bea Spadacini: Many global health programs revolve around promoting healthy behaviors such as handwashing or doing regular prenatal care visits and sleeping under insecticide-sprayed bed nets. What does a social and behavior change approach to global health programming entail?

Elizabeth Fox: It entails bringing to these questions that you have just identified, how do you get people to sleep under an insecticide sprayed net or wash their hands, it entails bringing to that question all the tools of social science. So, you are looking at sociology, you are looking at anthropology, you are looking at behavioral economics, and you are saying, let's understand the behaviors and the context in which those behaviors occur and see what are the barriers, what are the incentives, what are underlying values that would bring a mother to take her child to be vaccinated or not or breastfeed and then look at the tools we have, and we have lots of

tools, and they are not all communication tools, looking at the tools we have to influence that behavior. And some of the tools we have are policy tools. Some of the tools we have are more directly communication tools. People don't know things and if they knew them, maybe they would act on them or people know them but they do not think it is the right thing to do so they don't act on them. So, bringing a social and behavior change approach to global health programming, takes it away from the just tell people to do stuff and they'll do it to really analyzing what are behaviors and then what are the social context within which those behaviors take place.

Bea Spadacini: Interesting, is a bit like in the U.S. wearing a seat belt or smoking?

Elizabeth Fox: Exactly. You look at a combination of tools. Seat belts are pretty good, and in the United States it is basically an enforcement. If you don't wear a seat belt and a cop stops you, you get a ticket, in most places. Stopping smoking, if you smoke, nobody is going to give you a ticket. There it is a question of looking at policy on pricing, taxes, availability but also looking at the underlying culture of smoking. Looking at peer pressure, looking at when you start smoking, looking at social marketing and a lot of those tools we have used when working with our development partners. For example, smoking is one of them though USAID does not work on smoking but looking at things like breastfeeding. Breastfeeding is a good thing to do. It certainly saves the lives of mom. It certainly saved the lives of kids, it helps mom's health. But saying how you are going to mandate that and you can't. You can make policies at the workplace better and more friendly; you can change some of the policies at hospitals, but you also have to look at the family.

Bea Spadacini: I understand that social and behavior change communication focuses more on a range of communication approaches for influencing behavior, for instance using radio or TV drama or launching a mass media campaign but social and behavior change is broader than this social and behavior change communication approach. Can you speak to this broader approach and what the difference between the two are?

Elizabeth Fox: I can certainly speak to the broader approach. I don't know that I can clearly outline the difference because when we talk about communication, we are talking about transferring information and values and a lot of our work involved both so we have a communication element to almost all the social and behavior change work that we do but in some cases, it is non-verbal. In some cases, as you said before, it is policy. For example, one of the projects we are working on is using behavioral nudges and so what we are doing is making small tweaks or changes in a referral card so that when moms come in for an anti-natal care visit the referral card is done in a way that is much more explicit, the different stages of pregnancy and what they need to be looking at that stage in terms of seeking care.

Bea Spadacini: So, are these visual nudges?

Elizabeth Fox: They are visual. They are not, I mean that is communication because they are also reading it but in other cases, for example, you are looking at changes in policy that have

nothing to do with communication, which would make a big difference or, when we look at provider behavior, it is not a policy change but in the case of using more respectful care with women when they come into a clinic and to say that the clinic should have a curtain hung where the woman will be examined so that she has some privacy. Is that a? It is going to change the behavior of the provider. It makes the woman feel more respected but that is not communication. That's looking at how we can do different things with behavior that can be influenced in ways to make someone feel more at ease or to work with providers when they are counselling people so that, for example, they touch them at some point and so there is at least the perception that there is less distance and there is less bias. A lot of the work that we do for example on gender stereotypes have more intangible type changes in behavior that are going to make a difference in the way people do things.

Bea Spadacini: So how are these behaviors influenced? In that case, would it be through training or face to face?

Elizabeth Fox: Yeah, sometimes training, sometimes peer learning. Lots of times is peer learning. Lots of times if modeling behavior. For example, finding a provider that is well respected, looking at what are the behaviors that that provider does and then modeling that behavior throughout a clinic. Handwashing is one where you do that too or latrine use, another place where you do that, modeling behaviors or making it easier to do certain behaviors. A lot of the modeling is then picked up by communication. For example, when you do a soap opera, you are basically modeling behaviors. You have bad people that bad things happen to and you are looking at how people learn by watching how other people behave.

Bea Spadacini: I think even community theater?

Elizabeth Fox: Exactly. It is modeling. It is play acting. Its having people see their peers and how they behave in different situations and then relating to it. What would you do if this happened to you or how do you confront, for example, domestic violence? Is it acceptable? Is it not acceptable?

Bea Spadacini: But, yet it provides a safe place because it is not like someone is being pointed out, right?

Elizabeth Fox: It is playacting in a safe space but it is learning and it is changing behavior by looking at how you are affecting community norms and social norms. Some behaviors take a lot of time to change. Some behaviors can change very, very rapidly. I have just come back from Liberia and I was looking at the post Ebola recovery but I was really looking at how behaviors had changed and the thing, a couple of things, that made the most impact on the Ebola epidemic and stopping it, were community behaviors and those behaviors, once the right channels and the right way to reach the community through which, community leaders for example, were identified, changed very quickly. You see handwashing all over the place now.

Bea Spadacini: So, these are sustained also right?

Elizabeth Fox: It's a good question. Sustaining, they are sustained now obviously, the handwashing. Obviously, the safe burials are something that does not need sustaining but the trust in the health services is being rebuilt, if you talk about sustaining in terms beginning to go back to access health services.

Bea Spadacini: So, speaking of behaviors, can you tell us a little bit about accelerating behaviors?

Elizabeth Fox: Accelerator behaviors. What we did, because the social and behavior change people are not health people. They are the social scientists so sometimes the problem with social and behavior change programs is that we focus on everything. There is not a way to prioritize. You want people to do this and that and that and moms receive messages that have five different things they have to do, so we looked across the field of child and maternal health and nutrition, including malaria and including family planning, and came up with a list of ten behaviors that would have the biggest impact on mortality reduction and then we tracked them, because in most cases, there is either DHS data or mixed data on these behaviors by country and we were able, because we used it as an advocacy tool so we were able to speak to decision makers and we were able to say, here is what you get if your population level of breastfeeding were to go up by 20 percent, you would have x percent reduction in mortality, so it becomes an advocacy tool as well. Everybody wanted more accelerator behaviors. It is hard to say no. So, the list of 10 has grown a bit. It is now grown to about 17 but we are trying to keep it small because we don't want everything to be an accelerator behavior, the word accelerator is important here.

Bea Spadacini: So, have you seen national governments, for instance, focus their efforts on accelerator behaviors?

Elizabeth Fox: We have. We are working with missions that work with governments in DRC for example, the Democratic Republic of the Congo. We are working in Ghana. We have worked in Senegal to both influence the way our programming works but then also to integrate these accelerator behaviors into national health programs.

Bea Spadacini: Thank you so much for sharing this with us today.

Elizabeth Fox: Great, thank you!

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