### CARE FOR PNEUMONIA

#### HEALTH GOAL
Improve maternal and child survival

Caregivers appropriately manage care for signs and symptoms of ARI for children

Percentage of children born in the five years preceding the survey with acute respiratory infection taken to a health facility

#### BEHAVIOR ANALYSIS

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<tr>
<td>What steps are needed to practice this behavior?</td>
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<td>How might we focus our efforts based on this analysis?</td>
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<tr>
<td>1. Recognize signs and symptoms of ARI</td>
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<tr>
<td>2. Mobilize transport, resources and logistics</td>
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<td>3. Obtain appropriate diagnosis and treatment from a qualified provider</td>
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<td>4. Adhere to full course of prescribed treatment</td>
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<tr>
<td>5. Continue or increase breastfeeding appropriate for age</td>
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<td>6. Continue other fluids and feeding as possible during illness</td>
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<td>7. Provide extra food according to age for at least 2 weeks following illness</td>
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#### FACTORS

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<td></td>
<td>ACCESSIBILITY: Easy transport to distant facilities often unavailable</td>
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<td></td>
<td>ACCESSIBILITY: The cost of services and treatment options is frequently more than caregivers can pay</td>
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<td>SERVICE EXPERIENCE: Poorly equipped, supplied and staffed health care facilities discourage caregivers from seeking help</td>
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<td>FAMILY AND COMMUNITY SUPPORT: Caregivers often lack encouragement from spouse or influential social actors for careseeking when child is ill</td>
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<td>NORMS: Often cultural beliefs discourage care-seeking at health care facilities</td>
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<td></td>
<td>ATTITUDES AND BELIEFS: Caregivers do not perceive the illness as serious enough to require care seeking at a health care facility</td>
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<td></td>
<td>KNOWLEDGE: Most caregivers do not know the symptoms and danger signs of ARI</td>
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#### SUPPORTING ACTORS AND ACTIONS

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<tr>
<th>INSTITUTIONAL</th>
<th>Policies and Governance: Formulate national policy to provide free treatment for children under five</th>
<th>Policies and Governance: Formulate policies that ensure community involvement in how health care facilities are staffed and supervised</th>
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<tr>
<td>Logistics Personnel: Proactively monitor stock levels and forecast needed medical supplies and drugs</td>
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<tr>
<td>COMMUNITY</td>
<td>Community Leaders: Establish community transport schemes for urgent careseeking</td>
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<tr>
<td>HOUSEHOLD</td>
<td>Family Members: Encourage caregivers to seek treatment with trained health providers at onset of symptoms</td>
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#### POSSIBLE PROGRAM STRATEGIES

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<tr>
<th>ENABLING ENVIRONMENT</th>
<th>Policies and Governance: Formulate policies that ensure community involvement in how health care facilities are staffed and supervised</th>
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<tr>
<td>SYSTEMS, PRODUCTS AND SERVICES</td>
<td>Quality Improvement: Train and equip village health workers to diagnose and treat pneumonia</td>
<td>Quality Improvement: Train private pharmacies to recognize and appropriately treat or refer children with symptoms of pneumonia</td>
</tr>
<tr>
<td>DEMAND AND USE</td>
<td>Communication: Utilize all well-child health touchpoints to work with mothers and families on the recognition of symptoms of childhood illness, including ARI and the need for immediate care-seeking</td>
<td>Skills Building: Train and equip community and religious leaders to facilitate careseeking through community mobilization and transport or financing schemes</td>
</tr>
</tbody>
</table>
## Steps

1. Recognize signs and symptoms of diarrhea
2. Obtain ORS and full course of zinc from a sanctioned source
3. Give child ORS throughout the diarrheal episode
4. Give child a daily zinc supplement (usually for 10 to 14 days)
5. Continue or increase breastfeeding appropriate for age
6. Continue other fluids and feeding as possible during illness
7. Provide extra food according to age for at least 2 weeks following illness

## Behavior Analysis

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<td><strong>How might we focus our efforts based on this analysis?</strong></td>
</tr>
<tr>
<td><strong>Structural</strong></td>
<td><strong>Institutional</strong></td>
<td><strong>Enabling Environment</strong></td>
</tr>
<tr>
<td>Accessibility: ORS and zinc are either out of stock or not always readily available beyond the health system</td>
<td>Policymakers: Begin dialogue to ensure private sector is engaged and sanctioned</td>
<td><strong>Financing:</strong> Expand free or low-cost access to ORS and zinc</td>
</tr>
<tr>
<td>Accessibility: Zinc is expensive, even when co-packaged with ORS</td>
<td>Policymakers: Seek policies to promote equitable access to ORS and zinc</td>
<td><strong>Partnerships and Networks:</strong> Engage the private sector in recommending and distribution of ORS and zinc at local pharmacies</td>
</tr>
<tr>
<td>Service Provider Competencies: Providers tend to over-prescribe antibiotics and not emphasize the importance of ORS with zinc</td>
<td>Providers: Prescribe ORS/Zinc instead of antibiotics for diarrhea and explain benefit to caregivers</td>
<td><strong>Systems, Products and Services</strong></td>
</tr>
<tr>
<td>Service Experience: Caregivers do not go to sanctioned providers because they prefer informal sector sources that are nearby for treatment of diarrhea</td>
<td>Logistics Personnel: Actively monitor stock levels and forecast needed medical supplies and drugs</td>
<td><strong>Products and Technology:</strong> Combine ORS and zinc packets in grocery stores, pharmacies, kiosks, etc</td>
</tr>
<tr>
<td><strong>Social</strong></td>
<td><strong>Community</strong></td>
<td><strong>Demand and Use</strong></td>
</tr>
<tr>
<td>Norms: Caregivers do not seek immediate care for diarrhea because it is considered common and expected for young children</td>
<td>Community Health Workers and Peer Educators: Follow-up with families whose children have diarrhea to ensure that ORS is properly mixed and that a full course of zinc is taken</td>
<td><strong>Communication:</strong> Provide pictorial instructions for mixing and administering ORS and daily reminders for zinc supplements</td>
</tr>
<tr>
<td>Internal</td>
<td><strong>Collective Engagement:</strong> Conduct ongoing community activities about the dangers of dehydration resulting from diarrhea, the need for immediate care seeking, effectiveness of ORS and zinc, and the need for recuperative feeding after illness</td>
<td><strong>Quality Improvement:</strong> Ensure health care personnel (public and private) practice appropriate antibiotic prescription vs use of ORS and zinc and train them on how to communicate that to caregivers</td>
</tr>
<tr>
<td>Attitudes and Beliefs: Caregivers do not use ORS and zinc because they are skeptical about their effectiveness and prefer antibiotics</td>
<td><strong>Demand and Use:</strong> Engage the private sector in recommending and distribution of ORS and zinc at local pharmacies</td>
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<tr>
<td>Attitudes and Beliefs: Caregivers will not complete the full course of zinc believing that once the diarrhea has stopped it is not necessary</td>
<td><strong>Collective Engagement:</strong> Conduct ongoing community activities about the dangers of dehydration resulting from diarrhea, the need for immediate care seeking, effectiveness of ORS and zinc, and the need for recuperative feeding after illness</td>
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<tr>
<td>Knowledge: Some caregivers are unaware of the benefits of ORS and many do not know about the use of zinc, and the need for special recuperative feeding after illness</td>
<td><strong>Collective Engagement:</strong> Conduct ongoing community activities about the dangers of dehydration resulting from diarrhea, the need for immediate care seeking, effectiveness of ORS and zinc, and the need for recuperative feeding after illness</td>
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<tr>
<td>Skills: Most caregivers do not follow the full 10-14 day zinc regime because they do not understand the instructions</td>
<td><strong>Collective Engagement:</strong> Conduct ongoing community activities about the dangers of dehydration resulting from diarrhea, the need for immediate care seeking, effectiveness of ORS and zinc, and the need for recuperative feeding after illness</td>
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**Steps**

1. Accept first course of vaccinations at birth or at the first well-baby visit
2. Mobilize transport, resources and logistics
3. Seek immunizations on schedule from a qualified provider
4. Complete all immunizations per age requirements

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**Factors**

- **What factors may prevent or support practice of this behavior? These should be analyzed for each country context.**

  - **Structural**
    - **Service Experience:** Caregivers do not return for immunizations because vaccines were not available during past visits
    - **Accessibility:** Caregivers do not use immunization services because they are often located far from households and they lack transportation options
    - **Accessibility:** Caregivers are unable to immunize their children because of lack of vaccines
    - **Service Provider Competencies:** Caregivers do not visit health providers for vaccinations because they don't trust them or believe they are doing a good job
    - **Service Provider Competencies:** Caregivers do not visit health providers because they feel mistreated by them

  - **Internal**
    - **Attitudes and Beliefs:** Many caregivers do not take their child for vaccinations because they fear side effects
    - **Attitudes and Beliefs:** Many caregivers do not take their child for vaccinations because they feel that immunization is not important and does not prevent illnesses

  - **Social**
    - **Norms:** Many caregivers do not take their child for vaccinations because of religious opposition

  - **Knowledge:** Caregivers do not adhere to the immunization schedule because they do not know when their child should return for their next vaccine.

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**Supporting Actors and Actions**

- **Who must support the practice of this behavior?**

  - **Institutional**
    - **Policymakers:** Ensure vaccinations are available through regular mobile outreach
    - **Managers:** Conduct regular supervision to reinforce competencies of providers
    - **Providers:** Discuss importance, schedule and any concerns regarding vaccinations with all new mothers
    - **Logistics Personnel:** Actively monitor stocks of vaccine and cold chain viability

  - **Community**
    - **Religious Leaders:** Actively support and encourage all new families to fully vaccinate their children

  - **Household**
    - **Family Members:** Encourage and provide support to caregivers to complete immunization schedule

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**Possible Program Strategies**

- **How might we focus our efforts based on this analysis?**

  - **Enabling Environment**
    - **Partnerships and Networks:** Increase ownership and governance of programs by involving local communities in the planning and supervision of activities
    - **Policies and Governance:** Ensure vaccines are offered for free and explore reimbursement or vouchers for transport
    - **Policies and Governance:** Ensure vaccine providers are both men and women or from religious groups to alleviate religious and cultural concerns

  - **Systems, Products and Services**
    - **Quality Improvement:** Implement pre and in-service education training and learning opportunities for health care providers that focus on vaccination, such as to proactively address caregiver concerns during consultations

  - **Demand and Use**
    - **Communication:** Highlight significant benefits of vaccinating children in communication activities to ensure that caregivers place high priority on immunization completion
    - **Communication:** Promote use of the Child Health Card to help families track immunizations
What steps are needed to practice this behavior?

1. Acquire sufficient ITNs to cover every sleeping space
2. Hang ITNs appropriately
3. Retreat, repair, or replace the net as needed

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<tr>
<td>What factors may prevent or support practice of this behavior? These should be analyzed for each country context.</td>
<td><strong>INTERNAL</strong>&lt;br&gt;Norms: Populations do not sleep under ITNs because malaria is considered normal and unavoidable&lt;br&gt;Norms: Some populations do not sleep under ITNs because they do not know when or how to do so</td>
<td>Policymakers: Add local requirements for ITNs (e.g., color, length, shape preference, hanging considerations) to the procurement process&lt;br&gt;Providers: Counsel caregivers on the use of ITNs and continuous distribution&lt;br&gt;Logistics Personnel: Use available tools (e.g., NetCALC) to ensure sufficient supply of ITNs for mass and continuous distribution&lt;br&gt;Managers: Couple distribution of ITNs with counseling and ongoing monitoring of correct and consistent use, especially in non-permanent sleeping spaces (such as outside, kitchens, etc.)</td>
<td>How might we focus our efforts based on this analysis?</td>
</tr>
<tr>
<td><strong>STRUCTURAL</strong>&lt;br&gt;Accessibility: Populations cannot access ITNs because ITNs are unavailable</td>
<td>Community and Religious Leaders: Advocate for correct and consistent use of ITNs, especially in non-permanent sleeping spaces (e.g., outside, kitchens, etc.)</td>
<td>Policies and Governance: Ensure accountability of health care providers, facilities, and system (e.g., availability of commodities, quality of services, adherence to protocols, etc.) to ensure that targeted population has access to ITNs</td>
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<tr>
<td><strong>SOCIAL</strong>&lt;br&gt;Norms: Populations do not sleep under ITNs because they fear possible adverse outcome from insecticides</td>
<td><strong>COMMUNITY</strong>&lt;br&gt;Community and Religious Leaders: Advocate for correct and consistent use of ITNs, especially in non-permanent sleeping spaces (e.g., outside, kitchens, etc.)</td>
<td>Supply Chain: Procure and distribute adequate ITNs for mass campaigns and routine distribution channels including at antenatal care and EPI visits to ensure that the most vulnerable populations have access to ITNs</td>
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<tr>
<td><strong>ATTITUDES AND BELIEFS</strong>&lt;br&gt;Populations do not sleep under ITNs because they do not understand the benefits of using an ITN to prevent malaria</td>
<td><strong>FAMILY MEMBERS</strong>&lt;br&gt;Family Members: Obtain, hang, and ensure everyone, especially pregnant women and children under five, sleeps under an ITN</td>
<td>Quality Improvement: Prioritize the importance of proper procurement, distribution and counseling with providers during in-service training, supportive supervision pre-service training</td>
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<td>Advocacy: Leverage community data to motivate communities and to create social accountability for ITN use</td>
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<td>Communication: Employ appropriate SBCC activities to reinforce caregivers' knowledge on the importance, efficacy, and benefits of ITN use</td>
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<td>Collective Engagement: Engage community members in local ownership of malaria control efforts to ensure community access to ITNs</td>
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**Intermittent Preventive Treatment of Malaria in Pregnancy**

**Health Goal:** Improve maternal and child survival

Pregnant women complete a full course of IPTp

- Percentage of women age 15-49 with a live birth in the two years preceding the survey who during the pregnancy took 3 or more doses of SP/Fansidar, with at least one dose during an antenatal care visit
- Percentage of women age 15-49 with a live birth in the two years preceding the survey who during the pregnancy took 2 or more doses of SP/Fansidar, with at least one dose during an antenatal care visit

**Behavior Analysis**

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<tr>
<td>1. Decide to seek ANC care early before the end of the first trimester</td>
<td>What factors may prevent or support practice of this behavior? These should be analyzed for each country context.</td>
<td>Who must support the practice of this behavior?</td>
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<tr>
<td>2. Obtain IPTp at each ANC visit, beginning in second trimester</td>
<td>Structural</td>
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<tr>
<td>3. Adhere to provider instructions on when to return for the next visit</td>
<td>Social</td>
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**SLEPS**

- **Service Provider Competencies:** Pregnant women do not receive SP at each visit because providers do not have the proper technical information to adhere to national MIP guidelines
- **Family and Community Support:** Pregnant women do not seek SP because it is not promoted or encouraged by community-based community health workers or agents
- **Attitudes and Beliefs:** Pregnant women refuse SP because they fear the side effects
- **Knowledge:** Pregnant women do not obtain SP or adhere to provider’s instructions because they are unaware of the benefits of SP for themselves and their unborn child

**Institutional**

- **Policy makers:** Incorporate IPTp into broader reproductive health programs in collaboration with MIP point of contact and reproductive health staff
- **Providers:** Counsel about protective benefits, timing and dosing of IPTp to all pregnant women and their partners
- **Logistics Personnel:** Procure sufficient stock of SP or other IPTp commodity supplies
- **Managers:** Conduct regular supportive supervisory visits with facility-based service providers to ensure proper administration of and counselling for IPTp
- **Community Leaders:** Create or support structures that promote social accountability to encourage community-based service providers to promote the benefits of IPTp as part of ANC services
- **Community and Religious Leaders:** Engage men and male heads of households to support the decision of pregnant women to seek ANC especially in the absence of community-based service provider support

**Strategy**

- **Enabling Environment**
  - **Partnerships and Networks:** Encourage delivery of ANC and IPTp in non-formal settings, such as through NGOs and by community health workers directly in the community to ensure that ANC is accessible to all women
  - **Policies and Governance:** Integrate IPTp into reproductive health programs to ensure that all women accessing these services receive IPTp
  - **Policies and Governance:** Create or leverage the power and influence of existing community leaders and members to advocate for accountability at health facilities

- **Systems, Products and Services**
  - **Supply Chain:** Strengthen commodities and supply chain for Fansidar/SP or IPTp protocol at all levels to ensure adequate stock for the recommended minimum number of doses per expected pregnant woman
  - **Quality Improvement:** Disseminate to providers clear IPTp guidelines and information to use in counseling women on benefits to ensure that all women are receiving recommended minimum number of doses per ANC
  - **Quality Improvement:** Create or leverage the power and influence of existing community leaders and members to advocate for accountability at health facilities

- **Demand and Use**
  - **Communication:** Use appropriate communication approaches to promote value of preventative services to mother and unborn child
  - **Communication:** Exploit direct-to-consumer digital tools, such as mobile technologies, interactive voice response (IVR), etc. to reach women directly to convey benefits of and value for IPTp as part of routine ANC visits
## Health Goal

Improve maternal and child survival

Caregivers manage prompt and appropriate care for symptoms of malaria

### Among children under age five with fever in the two weeks preceding the survey, percentage for whom advice or treatment was sought from a health facility or provider

### Steps to Practice This Behavior

1. Recognize signs and symptoms of malaria
2. Decide to seek care
3. Mobilize transport, resources and logistics to get to a qualified provider who can test properly for malaria
4. Obtain diagnosis from a qualified provider
5. Obtain treatment based on diagnosis of the provider
6. Adhere to full course of prescribed treatment
7. Continue to feed during illnesses and offer recuperative feeding for at least two weeks

### Factors

- **Structural**
  - Accessibility: Caregivers cannot access health facilities because facilities are too far
  - Accessibility: Caregivers cannot receive care because malaria prevention, diagnosis and treatment supplies are unavailable
  - Accessibility: Caregivers do not access formal health facilities because they exhaust all local options first
  - Service Provider Competencies: Caregivers do not seek the care of providers because they may be poorly treated
  - Service Provider Competencies: Caregivers cannot receive care because providers do not follow National Malaria Case Management guidelines
  - Service Experience: Caregivers do not seek care because health facilities may be poorly equipped and maintained

- **Social**
  - Norms: Caregivers do not seek care because fever is considered normal and is accepted

- **Internal**
  - Attitudes and Beliefs: Caregivers do not seek care for fever because they feel treatment is unnecessary or ineffective

- **Knowledge**: Caregivers do not seek care because they are unaware that prompt diagnosis and treatment can prevent symptoms and complications of and death from malaria

### Supporting Actors and Actions

- Who must support the practice of this behavior?

- **Institutional**
  - Providers: Prescribe anti-malarial per the national surveillance guidelines for all positive RDT results
  - Providers: Diagnose malaria using rapid diagnostic tests for all suspected malaria cases
  - Providers: Counsel caregivers on severity of malaria, importance of diagnosis, treatment, danger signs, and when and where to seek care during all interactions
  - Logistics Personnel: Procure sufficient stock of malaria diagnostics and supplies
  - Managers: Conduct regular supervisory visits to ensure that providers are following approved guidelines and facilities are properly equipped and maintained

- **Community**
  - Community Leaders: Support social accountability structures to ensure facilities are properly equipped, maintained, and provide quality services
  - Community and Religious Leaders: Emphasize the severity of malaria, importance of seeking care for fever, and efficacy of diagnosis and treatment options

### Possible Program Strategies

- How might we focus our efforts based on this analysis?

- **Enabling Environment**
  - Financing: Establish transportation systems and transport within the communities to ensure access to care

- **Systems, Products and Services**
  - Supply Chain: Set up effective supply chain and quality control systems to public and private sectors to ensure diagnostic tools and treatment for other febrile illnesses are available

- **Quality Improvement**
  - Train providers to adhere to test results and ensure treatment as per national guidelines, and explain protocol to caregivers

- **Demand and Use**
  - Communication: Implement SBCC activities to educate caregivers on malaria symptoms, danger signs, severity, etc.

- **Collective Engagement**
  - Conduct community mobilization activities for caregiver and caregiver support systems around malaria care seeking, diagnosis, treatment and counseling to promote prompt careseeking
Pregnant women complete a full course of quality antenatal care (ANC)

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<tr>
<td>1. Recognize signs and symptoms of pregnancy</td>
<td><strong>Structural</strong>&lt;br&gt;Accessibility: Pregnant women cannot access health facilities because they are too far</td>
<td>Institutional&lt;br&gt;Policymakers: Ensure antenatal care is accessible via insurance schemes, conditional cash transfers (CCTs) or other financing</td>
<td><strong>Enabling Environment</strong>&lt;br&gt;Financing: Expand free or low-cost access to products and services through vouchers or fee exceptions to ensure access to ANC</td>
</tr>
<tr>
<td>2. Decide to seek ANC early - by the end of the first trimester</td>
<td>Accessibility: Pregnant women do not attend multiple ANC visits because they struggle to afford the costs that come in addition to on-going essential expenditures</td>
<td>Policymakers: Ensure pregnant adolescents can still attend school</td>
<td>Financing: Finance task-shifting and explore community-based service delivery such as iron and folic acid supplements</td>
</tr>
<tr>
<td>3. Plan transport, resources, and logistics</td>
<td>Service Provider Competencies: Pregnant women cannot obtain quality ANC because providers neither respect them nor effectively communicate relevant technical information or explain the benefits of the different services, tests, and medications given during ANC</td>
<td>Providers: Offer counseling and support to pregnant women during ANC visits, including thorough explanations of services provided as well as the importance of multiple visits and adherence to supplements or medications given</td>
<td>Policies and Governance: Adopt and enforce policies to permit pregnant adolescents to attend school</td>
</tr>
<tr>
<td>4. Attend all recommended ANC visits</td>
<td>Service Experience: Pregnant women do not go for ANC because the health facilities often lack the tests, medications, or supplements that women need, or payment is required when services and products should be free</td>
<td>Logistics Personnel: Monitor and properly forecast stock of essential tests, medicines, and supplements</td>
<td>Policies and Governance: Establish a policy for areas with poor health facility access to have the most basic ANC services, such as iron and folic acid supplement resupply resupplied managed at the community level</td>
</tr>
<tr>
<td>5. Obtain all required services from qualified provider at each visit</td>
<td><strong>Social</strong>&lt;br&gt;Family and Community Support: Many pregnant adolescents and unmarried women are reluctant to seek early care because of stigma or the risk that they will be asked to leave school or quit their job</td>
<td>Managers: Provide effective supervision and on-site support to ensure quality ANC services</td>
<td><strong>Systems, Products and Services</strong>&lt;br&gt;Supply Chain: Strengthen supply chains for essential drugs, supplements, and preventative medicines for ANC</td>
</tr>
<tr>
<td>6. Adhere to provider instructions during and following each visit, including when to return for the next visit</td>
<td><strong>Internal</strong>&lt;br&gt;Attitudes and Beliefs: Pregnant women do not always perceive a value to multiple ANC visits if they have already had one or more healthy pregnancies</td>
<td></td>
<td>Quality Improvement: Train and support providers to emphasize value of completing all ANC visits as well as active birth planning</td>
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**POSSIBLE PROGRAM STRATEGIES**

- **Institutional**
- **Community**
- **Household**
- **Community Health Workers / Peer Educators**
- **System, Products and Services**
- **Demand and Use**
- **Communication**

*Improve maternal and child survival*

Pregnant women complete a full course of quality antenatal care (ANC)

- Percentage of women who had a live birth in the three years preceding the survey who had 4+ antenatal care visits
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<thead>
<tr>
<th><strong>Attitudes and Beliefs:</strong> Pregnant women do not always comply with provider’s instructions particularly related to medications, supplements, or foods because of beliefs about the adverse effects of the medication or foods on their fetus</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Knowledge:</strong> Most pregnant women attend at least one ANC visit because they understand its benefits</td>
</tr>
<tr>
<td><strong>Collective Engagement:</strong> Train and use traditional leaders and traditional birth attendants to encourage women to seek early and multiple ANC visits</td>
</tr>
</tbody>
</table>
## DELIVERY IN HEALTH FACILITY

**HEALTH GOAL:** Improve maternal and child survival

Pregnant women deliver in a health facility with an equipped, qualified provider

*Percentage of live births in the three years preceding the survey delivered at a health facility*

### BEHAVIOR ANALYSIS

<table>
<thead>
<tr>
<th>STEPS</th>
<th>FACTORS</th>
<th>SUPPORTING ACTORS AND ACTIONS</th>
<th>STRATEGY</th>
</tr>
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<tbody>
<tr>
<td>What steps are needed to practice this behavior?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Identify appropriate health facility for delivery</td>
<td></td>
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<tr>
<td>2. Plan transport, resources and logistics required for delivery in health facility</td>
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<tr>
<td>3. Obtain all required services before, during and after delivery from qualified provider</td>
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<tr>
<td>4. Adhere to provider instructions during and following birth of infant</td>
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</table>

### BEHAVIOR ANALYSIS

**STEPS**

What steps are needed to practice this behavior? These should be analyzed for each country context.

1. Identify appropriate health facility for delivery
2. Plan transport, resources and logistics required for delivery in health facility
3. Obtain all required services before, during and after delivery from qualified provider
4. Adhere to provider instructions during and following birth of infant

**FACTORS**

- **INTERNAL**
  - **Attitudes and Beliefs:** Women want a healthy baby
  - **Attitudes and Beliefs:** Many women perceive the quality of care they receive from a clinic as no better than that which they receive at home from a traditional birth attendant

- **STRUCTURAL**
  - **Accessibility:** Clinics are frequently far from households and transport is hard to find, especially in an emergency
  - **Accessibility:** Maternity care is not always free
  - **Service Provider Competencies:** Women want to avoid negative provider attitudes and treatment
  - **Service Experience:** Not all clinics are open or staffed 24 hours

- **SOCIAL**
  - **Gender:** Men are not often involved in pregnancy or childbirth due to tradition, lack of information or lack of accommodation and inclusion of men in the maternal health system
  - **Norms:** Traditional birthing practices and preferences differ from women’s experiences in clinics

- **COMMUNITY**
  - **Community Leaders:** Support women with transport costs and logistics, including facilitation of community solutions like building maternity waiting shelters

- **HOUSEHOLD**
  - **Male Partners:** Actively participate in childbirth related decisions and encourage partners to deliver in a facility

**SUPPORTING ACTORS AND ACTIONS**

- **INSTITUTIONAL**
  - **Policymakers:** Review staffing policy to ensure maternity care is accessible 24 hours
  - **Policymakers:** Ensure affordability of care for most vulnerable via insurance schemes, CCTs, or other financing
  - **Managers:** Explore ways to offer more of what women want for their delivery in clinic setting
  - **Providers:** Actively engage men in pregnancy and delivery decisions
  - **Providers:** Offer respectful care to clients

- **COMMUNITY**
  - **Community Leaders:** Support women with transport costs and logistics, including facilitation of community solutions like building maternity waiting shelters

- **HOUSEHOLD**
  - **Male Partners:** Actively participate in childbirth related decisions and encourage partners to deliver in a facility

### POSSIBLE PROGRAM STRATEGIES

**ENABLE ENVIRONMENT**

- **Financing:** Create national insurance schemes, use conditional cash transfers (CCTs) or establish community savings schemes to ensure all are able to access maternity services
- **Partnerships and Networks:** Expand delivery of labor and delivery as well as EmONC services beyond formal system via avenues like social franchising
- **Policies and Governance:** Strengthen human resources allocation to ensure 24 hour coverage at all EmONC sites and referral systems

**SYSTEMS, PRODUCTS AND SERVICES**

- **Infrastructure:** Explore creation of waiting shelters for mothers
- **Quality Improvement:** Ensure providers are well-trained in and offer respectful maternity care

**DEMAND AND USE**

- **Communication:** Leverage traditional birth attendants for counseling, referrals and support to women and families in planning for and delivering in a facility, including distribution of birthing kits
- **Communication:** Use targeted media, including SMS where possible, to promote the improved quality of care and tailor reminders and tips for pregnant women and their families, self-created locally appropriate or picture-based birth plans
- **Collective Engagement:** Engage community leaders and men to diffuse responsibility for women’s health care
### BEHAVIOR ANALYSIS

**Steps**

1. Learn the components of essential newborn care
2. Obtain essential newborn care supplies for cord cutting and care, drying and wrapping, and resuscitation
3. Make sure provider follows essential newborn care
4. Adhere to provider instructions

**Factors**

- **Structural**
  - Accessibility: For babies born at home, families may lack key supplies including antiseptic for cord cleansing
  - Service Provider Competencies: Providers do not always know or follow protocol for essential newborn care

- **Social**
  - Family and Community Support: For babies born at home, supporting family members or birth attendants do not know the essential newborn care actions they should be taking
  - Norms: Many cultures have specific rituals or beliefs dictating care of newborns including separation of mother from baby and immediate cleansing using herbs or other agents on or around the umbilical cord

- **Internal**
  - Attitudes and Beliefs: Families want a healthy baby
  - Knowledge: Many babies are not born in facilities and new mothers do not always know what essential newborn care is
  - Knowledge: Many providers and families are unaware that many babies born not breathing can be easily resuscitated

**Supporting Actors and Actions**

- **Institutional**
  - Policymakers: Create, disseminate and enforce national guidelines for newborn care
  - Policymakers: Ensure availability and distribution of clean birthing kits to mothers during antenatal care visits
  - Providers: Follow protocols for newborn care practices
  - Family Members: Learn newborn care practices and support new mothers in implementing them

### STRATEGY

**Possible Program Strategies**

- How might we focus our efforts based on this analysis?

<table>
<thead>
<tr>
<th>Enabling Environment</th>
<th>Systems, Products and Services</th>
<th>Demand and Use</th>
</tr>
</thead>
<tbody>
<tr>
<td>Policies and Governance: Clarify and enforce clear newborn care guidelines in health facilities</td>
<td>Products and Technology: Provide clean delivery and newborn care kits to mothers during ANC visits (including antiseptic)</td>
<td>Communication: Create pregnancy and newborn care information for new mothers and their families on newborn care steps</td>
</tr>
<tr>
<td>Policies and Governance: Ensure community health agents and Traditional Birth Attendants (TBAs) are included in awareness raising on newborn care practices</td>
<td>Quality Improvement: Ensure health providers understand and follow national guidelines for newborn care including newborn resuscitation and counseling new mothers on take-home actions</td>
<td>Skills Building: Offer training to pregnant women and their families on newborn care steps</td>
</tr>
<tr>
<td>Policies and Governance: Ensure availability and distribution of clean birthing kits to mothers during antenatal care visits</td>
<td>Policies and Governance: Ensure community health agents and Traditional Birth Attendants (TBAs) are included in awareness raising on newborn care practices</td>
<td>Policies and Governance: Ensure availability and distribution of clean birthing kits to mothers during antenatal care visits</td>
</tr>
<tr>
<td>Providers: Follow protocols for newborn care practices</td>
<td>Providers: Offer counseling on newborn care practices to pregnant women during antenatal care visits and to new mothers before discharge and during postpartum visits</td>
<td></td>
</tr>
</tbody>
</table>
Caregivers seek prompt and appropriate care for signs and symptoms of newborn illness

Percentage of last births in the two years preceding the survey who had their first postnatal checkup in the first two days after birth. The proxy indicator is based on the assumption that caregivers who attend a postnatal checkup within the first two days are more likely to know the danger signs of newborn illness and take action, and are also accessing care during a child’s most vulnerable days.

**BEHAVIOR ANALYSIS**

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<td>How might we focus our efforts based on this analysis?</td>
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<tr>
<td>1. Recognize signs and symptoms of newborn illness</td>
<td><strong>STRUCTURAL</strong></td>
<td><strong>INSTITUTIONAL</strong></td>
<td><strong>ENABLING ENVIRONMENT</strong></td>
</tr>
<tr>
<td>2. Mobilize transport, resources and logistics to get to a qualified provider</td>
<td>Accessibility: Households are far from facilities, especially those which can provide care at all hours</td>
<td>Policymakers: Ensure clear linkages between maternal and newborn care and establish protocols for community-based postpartum and newborn home visits</td>
<td>Policies and Governance: Ensure linkages between newborn health and postpartum care for mothers including community-based care options and home visits</td>
</tr>
<tr>
<td>3. Obtain care from a qualified provider</td>
<td>Accessibility: Many women deliver at home and therefore miss critical signs of distress in first hours of newborn's life</td>
<td>Providers: Offer counseling and support to pregnant women on newborn care and care-seeking at all touch points during pregnancy, delivery and in the first month of life</td>
<td>Quality Improvement: Ensure clinics and providers adhere to rigorous quality standards including provision of counseling on drug side-effects and adherence</td>
</tr>
<tr>
<td>4. Adhere to full course of prescribed treatment</td>
<td>Service Provider Competencies: Lack of continuum of care between antenatal care, delivery, postpartum and newborn periods reduces attention paid to child</td>
<td>Family Members: Learn signs and symptoms of newborn illnesses and encourage new mothers to feel comfortable in seeking skilled care for their infants</td>
<td><strong>SYSTEMS, PRODUCTS AND SERVICES</strong></td>
</tr>
<tr>
<td>5. Continue breastfeeding</td>
<td>Service Provider Competencies: Some caregivers have a low perception of the quality of care they will receive at the clinic and prefer traditional medicine options</td>
<td>Male Partners: Actively participate in ANC and support partner in learning about newborn care and care seeking including planning for transport when and if it is required</td>
<td>Communication: Provide education for caregivers during antenatal and postpartum visits on newborn illness and danger signs, including plans for emergencies</td>
</tr>
</tbody>
</table>

**INTERNAL**

- **Attitudes and Beliefs**: Some medications (antibiotics) cause side effects that are not well-understood by and are worrisome to caregivers
- **Attitudes and Beliefs**: Families want a healthy baby
- **Knowledge**: Caregivers do not always understand how quickly small problems can become major issues in a newborn and they do not always recognize the early signs and symptoms of serious newborn illnesses

**SYSTEMS, PRODUCTS AND SERVICES**

- **Communication**: Explore use of mobile phones and other innovative reminder materials to check in with new mothers in the first days post partum
- **Collective Engagement**: Engage husbands and family members in outreach and education during pregnancy to plan support for the new mother and baby
- **Skills Building**: Train TBAs or CHWs to conduct home visits with new mothers on day 1 and 3 of a baby’s life to monitor the health of both mother and baby and provide referrals and counseling
# Early Initiation of Breastfeeding

**Health Goal:** Improve maternal and child survival

Mothers initiate breastfeeding within one hour after delivery

Among last-born children born in the two years preceding the survey the percentage who started breastfeeding within 1 hour of birth

## Behavior Analysis

<table>
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<th>Possible Program Strategies</th>
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</thead>
<tbody>
<tr>
<td>Step 1: Place newborn on breast immediately (within first hour) after birth</td>
<td>Accessibility: There is a lack of enforcement or existence of policies banning distribution of breast milk substitutes in health facilities</td>
<td><strong>Institutional</strong>&lt;br&gt;Policymakers: Institutionalize baby-friendly hospital initiatives within the health system</td>
<td><strong>Enabling Environment</strong>&lt;br&gt;Policies and Governance: Create structured policy frameworks (e.g. Baby Friendly Hospitals) that keep mother and baby together</td>
</tr>
<tr>
<td></td>
<td>Accessibility: Environment is crowded with promotion and presence of breast milk substitutes</td>
<td>Policymakers: Pass and enforce the international code preventing marketing of the Breast Milk Substitutes (BMS)</td>
<td>Policies and Governance: Enact regulations to ensure adherence to BMS Code</td>
</tr>
<tr>
<td></td>
<td>Service Provider Competencies: Providers lack skills required to counsel on importance of and techniques for early initiation</td>
<td>Providers: Train mothers on techniques of early initiation and the need to avoid any other prelacteal feeding</td>
<td><strong>Systems, Products and Services</strong>&lt;br&gt;Quality Improvement: Ensure health facilities have a provider trained in lactation</td>
</tr>
<tr>
<td>Step 2: Allow newborn to suckle immediately (no prelacteal feeding) even if milk does not appear to be present</td>
<td>Service Provider Competencies: Babies are often separated from mother immediately to be cleaned or wrapped and often kept separated</td>
<td>Providers: Support the need to keep mother and baby together immediately after birth</td>
<td><strong>Demand and Use</strong>&lt;br&gt;Communication: Add early initiation to the full range of counseling materials used during antenatal care visits and pregnancy support groups and organize community dialogues and home visits before pregnancy to discuss and prepare with family members</td>
</tr>
<tr>
<td></td>
<td>Service Provider Competencies: Babies are often separated from mother immediately to be cleaned or wrapped and often kept separated</td>
<td>Providers: Counsel on early initiation of breastfeeding during antenatal care visits</td>
<td>Skills Building: Work with traditional birth attendants on the importance of supporting women with immediate breastfeeding</td>
</tr>
</tbody>
</table>

## Institutional Strategies

**Policymakers:**
- Institutionalize baby-friendly hospital initiatives within the health system.
- Pass and enforce the international code preventing marketing of Breast Milk Substitutes (BMS).

**Service Providers:**
- Train mothers on techniques of early initiation and the need to avoid any other prelacteal feeding.
- Support the need to keep mother and baby together immediately after birth.
- Counsel on early initiation of breastfeeding during antenatal care visits.

**Family and Community Support:**
- Extended families do not always support new mothers with immediate breastfeeding, especially if the baby is born at home.

**Norms:**
- Babies are often immediately given other fluid, food, or substance based on cultural practices.

**Attitudes and Beliefs:**
- Many mothers do not understand the benefit of early breastfeeding and colostrum.

**Self-Efficacy:**
- Mothers feel they might not have enough or any milk.
**What steps are needed to practice this behavior?**

1. **Decide to exclusively breastfeed**
2. **Plan with family members and other supporting actors** for ways to work through breastfeeding concerns and challenges (i.e. feed the baby breastmilk if away from the baby)
3. **Do not give any other substance before initiating breastfeeding**
4. **Make sure baby latches properly**
5. **Feed only breastmilk day and night** when the baby is hungry or when it is time (8-12 times per 24 hour period)
6. **Do not give or allow others to give** the child water, other liquids, substances, or foods
7. **Allow time to feed, feeding until the first breast offered feels soft, and then offering the second breast**
8. **Seek care for breast or breastfeeding problems**

**What factors may prevent or support practice of this behavior? These should be analyzed for each country context.**

<table>
<thead>
<tr>
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<th>SUPPORTING ACTORS AND ACTIONS</th>
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</tr>
</thead>
</table>
| 1. Decide to exclusively breastfeed | **INTERNAL**<br>Attitudes and Beliefs: Most women believe that breastfeeding is good for their children<br><br>Self-Efficacy: Women are not confident that they have sufficient milk supply or quality | **INSTITUTIONAL**<br>Policymakers: Pass and enforce the Code to the Marketing of Breast Milk Substitutes (BMS)<br>Policymakers: Update maternity leave policies<br>Policymakers: Enact and enforce Baby-Friendly standards in hospitals, maternity homes, and health centers<br>Providers: Counsel mothers on ease and benefits of exclusive breastfeeding first, then on how to succeed at exclusive breastfeeding (breastfeeding techniques)<br>Employers: Offer breastfeeding areas or pumping breaks at work, if it is feasible for women to bring their infants to work | **How might we focus our efforts based on this analysis?**

| 2. Plan with family members and other supporting actors | **STRUCTURAL**<br>Accessibility: Women often have to return to school or work before the baby is 6 months old, leaving the baby during the day usually without breast milk<br><br>Accessibility: Environment is crowded with promotion and presence of breast milk substitutes<br><br>Accessibility: Women lack access to assistance on the proper techniques to breastfeed or how to resolve problems when they occur | **ENABLING ENVIRONMENT**<br>Partnerships and Networks: Make alliances with pediatric associations, social welfare, and environmental groups to promote exclusive breastfeeding<br>Policies and Governance: Create structured policy framework supportive of exclusive breastfeeding, Baby-Friendly hospitals, maternity leave regulations, and the enactment and enforcement of the BMS Code | **STRATEGY**

| 3. Do not give any other substance before initiating breastfeeding | **SOCIAL**<br>Family and Community Support: Family members do not support exclusive breastfeeding due to time, value, worry of illness or appropriateness<br><br>Norms: Completely exclusive breastfeeding until 6 months is not always common | **SYSTEMS, PRODUCTS AND SERVICES**<br>Quality Improvement: Train clinic or community-based providers in lactation management<br>**DEMAND AND USE**<br>Communication: As part of new mother support groups, offer proactive tips for successful breastfeeding and discuss importance of exclusivity until age 6 months, similar to the La Leche League in the US | **Identify ways to engage men and extended family members in supporting women to exclusively breastfeed**

| 4. Make sure baby latches properly to the breast | **HOUSEHOLD**<br>Family Members: Especially fathers and grandmothers, encourage and support mothers to exclusively breastfeed (do not offer the infant water or foods, help with chores as needed and ensure a nutritious diet for the mother) |  |  |
## BEHAVIOR ANALYSIS

### WHAT STEPS ARE NEEDED TO PRACTICE THIS BEHAVIOR?

1. Obtain animal source foods and other nutrient-rich fruits and vegetables for daily meals.
2. Prepare and offer food of appropriate consistency based on age.
3. Prepare and feed required number of meals based on age.
4. Prepare and feed meals of adequate amounts based on age.
5. Prepare and feed meals hygienically.

### WHAT FACTORS MAY PREVENT OR SUPPORT PRACTICE OF THIS BEHAVIOR? THESE SHOULD BE ANALYZED FOR EACH COUNTRY CONTEXT.

#### STRUCTURAL

**Accessibility:** Many households lack sufficient quantity and diversity of foods to feed the required meals.

**Service Provider Competencies:** Providers lack the information and skills needed to effectively counsel caregivers on complementary feeding.

#### SOCIAL

**Family and Community Support:** Heads of household and other family members often do not see the need to prepare "special" food for infant child.

**Gender:** Often certain foods are reserved for men or heads of household.

**Norms:** Some cultural and traditional practices promote a hands-off attitude toward feeding the young child.

#### INTERNAL

**Knowledge:** Link between optimum feeding practices and children’s healthy growth and development are not well understood.

**Knowledge:** Many caregivers have insufficient information on when to initiate, what and how much food to give, and how to feed.

### WHO MUST SUPPORT THE PRACTICE OF THIS BEHAVIOR?

#### INSTITUTIONAL

**Policymakers:** Create national nutrition policy that integrates complementary feeding into training and supervision of health workers on child health.

**Policymakers:** Create nutrition safety net programs or conditional cash transfer programs in food insecure areas.

**Policymakers:** Leverage and collaborate with private sector to expand access to a variety of options for nutrient rich foods.

**Providers:** Counsel caregivers and household members on when, how, and how much to feed the infant children, including demonstrations.

#### COMMUNITY

**Community Leaders:** Promote a variety of farming practices and prioritization of the young child’s diet to ensure availability of adequate and nutritious foods for infant children.

#### HOUSEHOLD

**Family Members:** Support prioritization of food and active feeding style of infant or young child.

### POSSIBLE PROGRAM STRATEGIES

**How might we focus our efforts based on this analysis?**

#### ENABLING ENVIRONMENT

**Policies and Governance:** Create multi-sectoral National Nutrition Policies that emphasize nutritious agricultural production and practices.

**Policies and Governance:** Enact food security programs that include Conditional Cash Transfers or Vouchers or Nutrition Safety Net programs.

#### SYSTEMS, PRODUCTS AND SERVICES

**Quality Improvement:** Train and provide refresher training on complementary feeding practices among community and facility-based providers.

**Communication:** Conduct community nutrition education programs to promote the “cost-benefits” of complementary feeding.

**Collective Engagement:** Facilitate family and community dialogue including reflection on fatherhood, to address inequitable food division in the household.

**Skills Building:** Offer cooking classes at a variety of venues frequented by mothers of young children (e.g., essential food markets, community events, etc.)
### ADOLESCENT FIRST BIRTH

**Health Goal:** Improve maternal and child survival

Sexually active adolescents use a modern contraceptive method to delay first birth until after age 18

Percentage of sexually active unmarried women age 15-19 currently using any modern method of contraception

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#### Behavior Analysis

<table>
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</tr>
<tr>
<td>1. Decide to use a modern contraceptive method</td>
<td>Accessibility: Hours and locations of services are not convenient for adolescents</td>
<td>INSTITUTIONAL</td>
<td></td>
</tr>
<tr>
<td>2. Obtain family planning counseling from a qualified provider</td>
<td>Service Experience: Policies around adolescent sexual and reproductive health are not always clear, including clinic guidelines on parental permission, rights to privacy, and requirement for physical exams</td>
<td>Policymakers: Create and enforce clear policies establishing adolescents’ rights to access a wide variety of modern contraception methods without judgement and with the expectation of privacy</td>
<td></td>
</tr>
<tr>
<td>3. Select appropriate modern contraceptive method</td>
<td>Service Provider Competencies: Clinics do not always maintain privacy for adolescents and providers often deny care or judge adolescents who do seek family planning</td>
<td>Providers: Offer adolescent-friendly contraception services, including assurance of privacy and acceptance, counseling on appropriate methods and continuous care</td>
<td></td>
</tr>
<tr>
<td>4. Obtain chosen method</td>
<td>Social</td>
<td>COMMUNITY</td>
<td></td>
</tr>
<tr>
<td>5. Use chosen method as instructed</td>
<td>Social</td>
<td>COMMUNITY</td>
<td></td>
</tr>
</tbody>
</table>

**Factors**

- **Structural**
  - Accessibility: Hours and locations of services are not convenient for adolescents

- **Service Experience:** Policies around adolescent sexual and reproductive health are not always clear, including clinic guidelines on parental permission, rights to privacy, and requirement for physical exams

- **Social**
  - Family and Community Support: Adolescents, especially girls, often have no social support for accessing family planning and suffer stigma and social exclusion if they do

- **Gender:** Traditional concepts of masculinity drive sexual decision making

- **Norms:** Adolescent sexuality is often highly moralized in communities and can be especially taboo for girls

- **Internal**
  - Self-Efficacy: Many adolescents, especially girls, do not feel confident to discuss family planning with sexual partners or to seek it from a provider

- **Knowledge:** Adolescents have limited information on sexuality, reproduction and contraceptive methods

---

**Possible Program Strategies**

- **Enabling Environment**
  - Financing: Ensure sexual reproductive health services are provided to adolescents at no-cost or highly subsidized (via vouchers, social franchising, etc.)

- **Partnerships and Networks:** Use variety of service delivery mechanisms (outreach, posts, social franchising, etc.) and innovative partners to reach a wide range of adolescents and create confidence in accessing services

- **Policies and Governance:** Ensure and enforce clear policy around adolescents’ right to access contraception services confidentially, respectfully and without a physical exam

- **Systems, Products and Services**
  - **Products and Technology:** Offer a full range of contraceptive options to adolescents including long-acting reversible contraceptives

- **Quality Improvement:** Train providers to offer adolescent-friendly services including providing confidential, nonjudgmental information and services, accurate information on medical eligibility criteria for adolescent contraceptive use, etc.

- **Demand and Use**
  - Communication: Use adolescent-appropriate media to reinforce messages and normalize both adolescent access and use of modern contraception, and create opportunities for community-wide reflection on gender norms, and other issues and concerns

- **Skills Building:** Ensure schools adopt comprehensive sexual and reproductive health curriculum covering family planning options and deliver it by age rather than grade
**Health Goal:**
Improve maternal and child survival

**Accelerator:**
After a live birth, women or their partners use a modern contraceptive method to avoid pregnancy for at least 24 months

- Percentage of currently married or in union women using family planning for spacing

<table>
<thead>
<tr>
<th>Behavior Analysis</th>
<th>Strategy</th>
</tr>
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**Structural:**
- **Accessibility:** Commodity supply is irregular or sporadic, especially for certain methods
- **Service Provider Competencies:** Some providers do not emphasize the importance of birth spacing in discussing family planning
- **Service Provider Competencies:** Providers are sometimes rude, judgemental or do not maintain confidentiality

**Social:**
- **Norms:** Large families are often the norm and the risks of children spaced closely together are not well-understood or accepted
- **Family and Community Support:** Community and religious leaders often resist family planning on moral grounds, though less so the notion of birth spacing
- **Gender:** Men often see large families or a frequently pregnant partner as sign of virility and strength

**Internal:**
- **Attitudes and Beliefs:** Many women and men fear side effects of contraception
- **Knowledge:** Couples do not always understand benefits of birth spacing for their families

**Institutional:**
- **Logistics Personnel:** Plan and manage contraceptive supplies to ensure consistent supply of stocked commodities
- **Providers:** Offer respectful care and comprehensive counseling on the benefits of birth spacing and other specific birth spacing messages

**Community:**
- **Community Leaders:** Publicly support birth spacing and seek out spaces to discuss with men and women both on the importance of healthy birth spacing

**Household:**
- **Male Partners:** Actively support wives to select and implement appropriate birth spacing method

**Enabling Environment:**
- **Partnerships and Networks:** Extend commodity supply outlets via social franchising or community based distribution networks

**Systems, Products and Services:**
- **Supply Chain:** Enhance use of Logistics Management Information Systems to better estimate contraceptive needs
- **Quality Improvement:** Expand birth spacing entry points into Integrated Management of Childhood Illness clinics, postnatal care, etc.
- **Quality Improvement:** Integrate specific birth spacing messages and communication skills into pre-service health worker curricula

**Demand and Use:**
- **Advocacy:** Develop birth spacing and Family Planning Advocacy Toolkit to garner support from different levels of leadership
- **Communication:** Use community open forums (with materials produced above) to discuss birth spacing services
- **Communication:** Produce and disseminate birth spacing materials to families that position birth spacing as the healthiest option for a family
**Handwashing with Soap**

**Health Goal**: Improve maternal and child survival

Family members wash hands with soap under running water at 4 critical times [after defecation, after changing diapers, before food preparation and before eating].

Among households where place for handwashing was observed, percentage of households with soap and water. Soap includes soap or detergent in bar, liquid, powder or paste form.

### Behavior Analysis

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<td></td>
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<tr>
<td>1. Construct or purchase handwashing station</td>
<td><strong>Structural</strong>&lt;br&gt;Accessibility: Often, families lack readily available water and secured soap for handwashing</td>
<td><strong>Institutional</strong>&lt;br&gt;Policymakers: Establish financing schemes for soap and handwashing stations</td>
<td>How might we focus our efforts based on this analysis?</td>
</tr>
<tr>
<td>2. Obtain soap and water</td>
<td><strong>Social</strong>&lt;br&gt;Family and Community Support: Extended family members do not reinforce handwashing, especially among younger children</td>
<td><strong>Community</strong>&lt;br&gt;Community Leaders: Promote hand washing at community events and public locations like schools, maintain a handwashing station in own household, and find ways to create reminders for handwashing at home or in the community</td>
<td><strong>Enabling Environment</strong>&lt;br&gt;Policies and Governance: Monitor and ensure availability of low-cost soap and handwashing stations for the most vulnerable</td>
</tr>
<tr>
<td>3. Maintain handwashing station with soap and water at all times</td>
<td><strong>Internal</strong>&lt;br&gt;Norms: Handwashing at all critical times is not regularly practiced or reinforced by community members</td>
<td><strong>Household</strong>&lt;br&gt;Family Members: Encourage and assist children to wash their hands as a way of avoiding ingestion of feces</td>
<td><strong>Systems, Products and Services</strong>&lt;br&gt;Products and Technology: Develop locally appropriate handwashing stations and train families how to construct stations themselves</td>
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### Supporting Actors and Actions

| **Institutional**<br>Policymakers: Establish financing schemes for soap and handwashing stations |
| **Community**<br>Community Leaders: Promote hand washing at community events and public locations like schools, maintain a handwashing station in own household, and find ways to create reminders for handwashing at home or in the community |
| **Household**<br>Family Members: Encourage and assist children to wash their hands as a way of avoiding ingestion of feces |

### Possible Program Strategies

| **Enabling Environment**<br>Policies and Governance: Monitor and ensure availability of low-cost soap and handwashing stations for the most vulnerable |
| **Systems, Products and Services**<br>Products and Technology: Develop locally appropriate handwashing stations and train families how to construct stations themselves |
| **Quality Improvement**<br>Train providers to promote handwashing with caregivers |
| **Demand and Use**<br>Advocacy: Support community leaders with tools to make handwashing behavior public, including installation of HW stations in public locations and publicly tracking the behavior |
| **Communication**<br>Create context disruptions and visual cues in the community and household to provide reminders for handwashing |

### Factors

- **Structural** Accessibility: Often, families lack readily available water and secured soap for handwashing.
- **Social** Family and Community Support: Extended family members do not reinforce handwashing, especially among younger children.
- **Internal** Norms: Handwashing at all critical times is not regularly practiced or reinforced by community members.
- **Attitudes and Beliefs** Many family members believe that it is disgusting not to wash hands after defecation or before handling food.
- **Knowledge** Many are unaware of the diseases transmitted by hands.
- **Knowledge** Family members forget to wash hands at the critical moments.
**SAFE DISPOSAL OF HUMAN FECES**

**HEALTH GOAL**
Improve maternal and child survival

**ACCELERATOR BEHAVIOR**
Family members safely dispose of human feces

**ACCELERATOR**
Percentage of households with improved and non-shared toilet facilities

### BEHAVIOR ANALYSIS

<table>
<thead>
<tr>
<th>STEPS</th>
<th>FACTORS</th>
<th>SUPPORTING ACTORS AND ACTIONS</th>
<th>POSSIBLE PROGRAM STRATEGIES</th>
</tr>
</thead>
<tbody>
<tr>
<td>What steps are needed to practice this behavior?</td>
<td></td>
<td></td>
<td>How might we focus our efforts based on this analysis?</td>
</tr>
<tr>
<td>1. Decide to build or access a latrine</td>
<td></td>
<td></td>
<td>ENABLING ENVIRONMENT</td>
</tr>
<tr>
<td>2. Build or access an improved latrine</td>
<td></td>
<td></td>
<td>Financing: Offer financing or credit mechanisms for household sanitation improvements and sanitation businesses</td>
</tr>
<tr>
<td>3. Always use the latrine for human feces, including feces from babies</td>
<td></td>
<td></td>
<td>Partnerships and Networks: Form surveillance cadres (government, international and local NGOs) to track ODF communities</td>
</tr>
<tr>
<td>4. Cover the latrine hole</td>
<td></td>
<td></td>
<td>SYSTEMS, PRODUCTS AND SERVICES</td>
</tr>
<tr>
<td>5. Maintain latrine and surroundings</td>
<td></td>
<td></td>
<td>Products and Technology: Investigate new sanitation technologies for geographically constrained situations</td>
</tr>
</tbody>
</table>

### STRATEGY

**STRATEGIC PRIORITIES**

**FACTORS**

<table>
<thead>
<tr>
<th>STRUCTURAL</th>
<th>ACCESSIBILITY: Products needed to build an improved latrine are unavailable locally or in small quantities</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACCESSIBILITY: Physical constraints (e.g., height of ground water, hardness of ground) make building a latrine difficult</td>
<td></td>
</tr>
<tr>
<td>ACCESSIBILITY: Families have insufficient resources to build a latrine</td>
<td></td>
</tr>
<tr>
<td>SOCIAL</td>
<td>NORMS: No neighbors have a latrine, so families do not understand why they need one</td>
</tr>
<tr>
<td>INTERNAL</td>
<td>ATTITUDES AND BELIEFS: Families do not believe baby feces is dirty and do not throw it into the latrine</td>
</tr>
<tr>
<td></td>
<td>ATTITUDES AND BELIEFS: Families prefer to use the outdoors where the air is fresh</td>
</tr>
<tr>
<td></td>
<td>ATTITUDES AND BELIEFS: People feel proud and prestigious when they think they can have their own household latrine</td>
</tr>
<tr>
<td></td>
<td>KNOWLEDGE: Families do not know how to build an improved latrine</td>
</tr>
</tbody>
</table>

**SUPPORTING ACTORS AND ACTIONS**

<table>
<thead>
<tr>
<th>INSTITUTIONAL</th>
<th>Policy makers: Adopt open defecation free (ODF) policy and sanitation regulations for the country</th>
</tr>
</thead>
<tbody>
<tr>
<td>COMMUNITY</td>
<td>Community Leaders: Support local sanitation marketing efforts and construction training to improve accessibility</td>
</tr>
<tr>
<td></td>
<td>Community Leaders: Build institutional latrines (schools, clinics)</td>
</tr>
<tr>
<td>HOUSEHOLD</td>
<td>Family Members: Save a portion of available income for sanitation needs</td>
</tr>
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**POSSIBLE PROGRAM STRATEGIES**

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<thead>
<tr>
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<th>Financing: Offer financing or credit mechanisms for household sanitation improvements and sanitation businesses</th>
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<tr>
<td></td>
<td>Quality Improvement: Facilitate improved private-sector markets to increase access to latrine options and construction, small-scale supplies, or delivery options</td>
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<table>
<thead>
<tr>
<th>DEMAND AND USE</th>
<th>Communication: Use regular community forums to share data and progress on ODF status and discuss challenges</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Skills Building: Train local cadres of masons and builders</td>
</tr>
</tbody>
</table>

---

**NOTES TO THE FRAMEWORK: SAFE DISPOSAL OF HUMAN FECES**

1. **Behavior Analysis:** The table outlines the steps needed to practice the behavior of safe disposal of human feces, along with the factors that may prevent or support this practice. The analysis is organized into structural, social, and internal factors, which help identify who must support the practice and possible program strategies.

2. **Strategy:** The strategy section provides potential program strategies for improving maternal and child survival by promoting the safe disposal of human feces. These strategies are categorized under enabling environment, systems, products and services, and demand and use, highlighting key areas for intervention.
**HEALTH GOAL**
Improve maternal and child survival

**ACCELERATOR**
Family members drink safe water

- Percentage of households whose main source of drinking water is an improved source

---

### BEHAVIOR ANALYSIS

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<td>1. Collect water from an improved source in a clean container</td>
<td><strong>STRUCTURAL</strong>&lt;br&gt;Accessibility: It can be difficult to find water treatment products in local market or health centers</td>
<td><strong>INSTITUTIONAL</strong>&lt;br&gt;Policymakers: Prioritize water and sanitation development projects for rural communities</td>
<td><strong>ENABLING ENVIRONMENT</strong>&lt;br&gt;Financing: Support market-based approaches including micro-credit and loans</td>
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<tr>
<td>2. Transport water in a clean, covered container</td>
<td>Accessibility: It is usually expensive or time consuming to collect from improved water sources or to treat water</td>
<td><strong>COMMUNITY</strong>&lt;br&gt;Community Leaders: Model healthy behaviors by adhering to safe water handling and treatment behaviors</td>
<td>Policies and Governance: Support regulatory reforms that increase and improve the quality of water treatment and storage options available in the market</td>
</tr>
<tr>
<td>3. When necessary, treat water by boiling, solar water disinfection (SODIS), chlorination or filtration</td>
<td><strong>SOCIAL</strong>&lt;br&gt;Norms: Households believe that others in community have adopted safe water behaviors</td>
<td></td>
<td><strong>SYSTEMS, PRODUCTS AND SERVICES</strong>&lt;br&gt;Infrastructure: Support national planning to improve water systems development</td>
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<td>4. Store water in a clean, covered container out of reach of children</td>
<td><strong>INTERNAL</strong>&lt;br&gt;Attitudes and Beliefs: Many family members do not like the taste of chemically-treated water</td>
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<td>Quality Improvement: Train and equip health care personnel to conduct interpersonal communication with clients on the importance of correct water handling and treatment at all times to prevent disease</td>
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<tr>
<td>5. Retrieve water using a clean long-handed implement</td>
<td>Attitudes and Beliefs: Often family members believe that drinking treated water is only required during illness</td>
<td><strong>DEMAND AND USE</strong>&lt;br&gt;Collective Engagement: Train and equip community leaders to promote the benefits of correct water handling and treatment within households</td>
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<tr>
<td>6. Provide water to children with clean cup</td>
<td>Attitudes and Beliefs: Many are willing to change water collection, treatment, and storage behaviors to improve their health</td>
<td>Skills Building: Develop point-of-use and education interventions at the household-level to train families on correct water handling, treatment options and equipment</td>
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<td>Knowledge: Most are not aware of the link between unsafe water and diarrheal episodes</td>
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<td></td>
<td>Skills: Many are unable to correctly use treatment options or equipment</td>
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**SAFE DRINKING WATER**

---

**HEALTH GOAL**
Improve maternal and child survival

**ACCELERATOR**
Family members drink safe water

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