CASE STUDY ON USING THE PROVIDER BEHAVIOR CHANGE TOOLKIT

Uganda

CONTEXT AND BACKGROUND

THE PROVIDER BEHAVIOR CHANGE TOOLKIT WITH A FAMILY PLANNING FOCUS is a four-step process developed by Breakthrough ACTION to help groups looking to effect provider behavior change (PBC). The process provides implementation teams a fuller understanding of providers and their clients to design impactful, scalable, and sustainable solutions (**Figure 1**). The toolkit recognizes that providers operate in complex systems, and factors, such as norms, health systems, client interactions, and individuals' own beliefs and attitudes, influence their behavior. In 2022, several organizations participated in two hands-on, virtual workshops that Breakthrough ACTION hosted to prepare them to implement the toolkit. This case study shares the implementation experience of one of these organizations, the Social and Behavior Change Activity (SBCA) Uganda,[1] to assist future toolkit users in their implementation process.

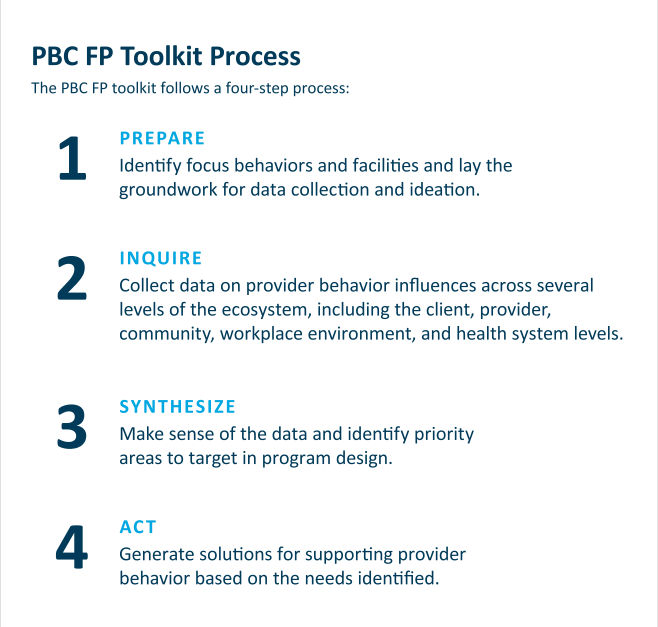

FIGURE 1: Four step process of the PBC Toolkit.

USAID/SBCA is an innovative social and behavior change (SBC) activity in Uganda, funded by the United States Agency for International Development (USAID), whose goal is to enable Uganda's SBC practitioners to create and implement their own programs based on their needs. A team with a focus on family planning (FP) from USAID/SBCA participated in one of Breakthrough ACTION's workshops in April 2022 that oriented them on the use of the toolkit with six other organizations. They participated with the hopes of learning how to identify and prioritize barriers and facilitators for providers to deliver quality FP services and improve health outcomes among clients.

[1] *Breakthrough ACTION would like to thank Fiona Amado, the USAID/SBCA Technical Specialist, FP/Maternal and Child Health, and Mabel Naibere, the USAID/SBCA Technical Specialist in Human-Centered Design, for their input into this case study.*

During the workshop, the USAID/SBCA team from Uganda put together a plan for implementing the PBC Toolkit post-workshop. Breakthrough ACTION facilitators provided them with implementation guidance post-workshop. USAID/SBCA also learned from the experiences of other attendees implementing the PBC Toolkit. Attending this orientation workshop as a team was very useful as it allowed multiple people to understand the toolkit, and they were able to draw from their different perspectives and understanding of how to use the tools to plan for success.

This case study follows the USAID/SBCA team in Uganda as they use the Prepare, Inquire, and Synthesize steps to identify barriers provides face in offering improved FP counseling. These initial steps took five months to complete, from June to October 2022, at eight facilities and eight district health offices. The team is currently working through the final step in the toolkit, Act, which will guide them in designing ways to solve for the problems they uncovered.

ADVICE FOR FUTURE TOOLKIT USERS

Work to ensure that more than one person on your staff becomes familiar with the entire toolkit before starting implementation. This team can support each other in using the tools to their full potential.

"The toolkit allows you to know the provider better and see the reality they work in vis-à-vis expectation. There is so much we expect providers to do, the toolkit helps you learn that the reality is much different than what you expect."

– FIONA AMADO, USAID/SBCA TECHNICAL SPECIALIST -FP/MCH

IMPLEMENTATION

Step 1: PREPARE

The first step in the toolkit, **PREPARE**, allows teams to recruit and orient their Core Implementation Teams (CIT), identify focus behaviors and participating facilities, and lay the groundwork for successful data collection and ideation. Preparing for implementation increases the likelihood of success by ensuring everything is in place for a smoother implementation.

ADVICE FOR FUTURE TOOLKIT USERS

USAID/SBCA found a benefit in having someone on the CIT who could further explore and work to fix structural issues—e.g., lack of opportunities for promotions or stockouts, that are uncovered during the Inquire step—so the SBC implementing partners are free to focus on social and behavioral issues. This could either be Ministry of Health staff or implementing partners focused on service delivery.

ASSEMBLING THE CITs

The CIT is a multi-disciplinary group that drives the preparation, inquiry, synthesis, and solution generation process. The USAID/SBCA team formed unique CITs for each of the seven districts they worked in, including different combinations of the following people:

- SBC-focused implementing partner: USAID/SBCA.
- Service delivery implementing partners who work in each district.
- Ministry of Health staff, such as the senior sociologist, secretary for health, district health Officers (DHOs), assistant DHOs, district health educators, district supply chain officers, the Health Management Information System focal person, biostatisticians, or district trainers.
- "Peer" health providers, such as midwifes, nurses, health assistants, facility persons in charge, medical officers, and/or mentor mothers.
- Candidates for bachelor's or master's degrees in Public Health from a local university to facilitate data collection.

As designed, members of the CITs had different roles and not all of them collected data; many instead provided their expertise in certain areas and liaised with the facilities to set up interviews. For USAID/SBCA, including DHOs on the CITs was useful for getting the districts on board, but most DHOs did not have time to go into the field to collect data.

CHOOSING FOCUS BEHAVIORS

With their CITs formed, the USAID/SBCA team then chose the same two behaviors for all seven districts to address. When they initially applied for the PBC Toolkit Workshop, the USAID/SBCA team sought to look at effective counseling for side effects. However, after using the Behavioral Mapping Tool (**Figure 2**), the CITs decided to expand the focus behavior to investigate client-centered FP counseling and service provider attitudes towards FP counseling.

ADVICE FOR FUTURE TOOLKIT USERS

CITs should work together to select the provider behaviors. Including all team members early in the process builds buy-in so everybody has the desire to do the necessary work to overcome whatever barriers are revealed through this process.

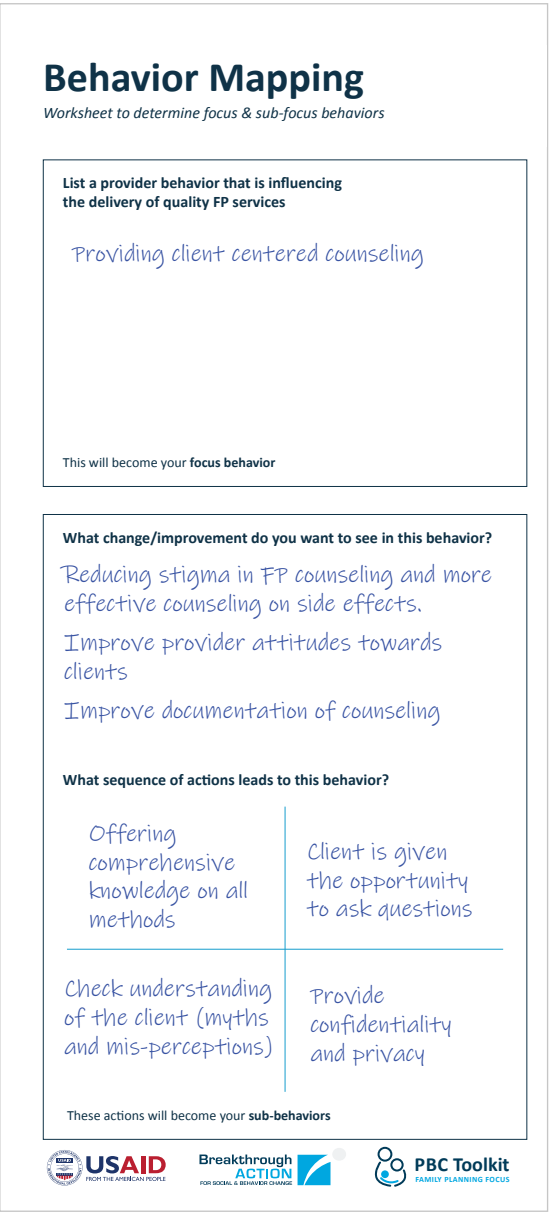

FIGURE 2: Filled in Behavioral Mapping Worksheet

SELECT SAMPLES FOR DATA COLLECTION AND CREATE A SCHEDULE

At each health facility, implementers spoke with health providers supporting FP and their clients. At the district health offices, they spoke with different district health team representatives. They started creating their schedule via an orientation meeting with the Ministry of Health and DHOs. The team found that meeting at the outset of the project helped orient people to all components of the toolkit and align on the provider behaviors to prioritize while using the toolkit.[2]

ADVICE FOR FUTURE TOOLKIT USERS

When going to the facilities, ensure you speak to the person in charge and be clear about how much time you will need. The timings described in the **instruction booklet** can help you know how much time to request. Also, make sure to select a time when providers are not busy seeing clients or when many providers are out due to training or time off.

[2] *Data collection for this work fell under the ethical approval from the Johns Hopkins Bloomberg School of Public Health Institutional Review Board (approval IRB00016476).*

Step 2: INQUIRE

The **INQUIRE** set of tools allows users to collect data on provider behavior influences across several levels of the ecosystem, including the client, provider, community, workplace environment, and health system levels. The USAID/SBCA team found the tools in this step to be particularly helpful in both starting conversations with providers and going deeper into those discussions to identify challenges the data collection team did not even know existed. For example, many midwives had marital issues because of working long hours and this impacted their work in unexpected ways.

ADVICE FOR FUTURE TOOLKIT USERS

Pilot the Inquire tools before implementing them in all your selected facilities. A pilot implementation in one facility will allow the CIT to learn and conduct an additional review of the toolkit together. After visiting one facility, consider conducting an after-action review to determine what changes need to be made for your context (e.g., do the tools need shortening, or do you want to use a different tool to get at different audience's perspectives?).

The USAID/SBCA team made good use of the **CLIENT VISUAL SCENARIO TOOL** (**Figure 3**), which invites clients to review images that depict service provision. Afterward, a CIT member spoke with clients about how each image compares to their recent service delivery experiences, their perceptions of the service experiences or provider behaviors, and their motivations for seeking the service. The team found that pictures of client-provider counseling sessions resonated with the clients, because the pictures depicted what happened in the clinics. This prompted clients to discuss more concretely their experiences of visiting the clinic and receiving FP counseling.

Initially, the USAID/SBCA team used the generic scenarios and pictures provided in the toolkit. They quickly learned that the toolkit's recommendation to re-write the scenarios to reflect more closely the local context and specific provider behavior during FP counseling helped them gather richer information during interviews.

ADVICE FOR FUTURE TOOLKIT USERS

The USAID/SBCA team experienced translation issues with clients, which necessitated bringing in more providers, created confidentiality issues, and placed more burden on providers. Teams should plan for translation needs during the Prepare phase, as suggested in the **instruction booklet**. It can also be useful to interview clients in the community, so they feel more comfortable sharing their honest opinions.

"The tools let us understand the health care provider better as a person. It helps you fully appreciate the environment that the provider is working in, which helps us work on facts and not just assumptions."

– MABEL NAIBERE, USAID/SBCA TECHNICAL SPECIALIST IN HUMAN-CENTERED DESIGN

FIGURE 3: CIT members using the Client Visual Scenario Tool

ADVICE FOR FUTURE TOOLKIT USERS

Plan to tailor the client scenarios and images to customize them for your context, and potentially for other health areas that the country needs. Think about the unique district needs in relation to providers' behaviors and make these scenarios specific to these needs and the context in your country.

The USAID/SBCA team found the **PROVIDER BEHAVIORAL BLUEPRINT** useful because it guided providers to reveal more issues that hindered client-centered FP counseling, compared to their previous inquiries. The **influencing factor cards** (**Figure 4**) helped providers consider funding, support systems, and the overall environment to better understand the providers' working conditions. When talking to providers, interviewers learned that engaging with the blueprint one-on-one allowed providers to express their concerns more openly, which they might not do in front of colleagues or their supervisor.

FIGURE 4: Influencing Factor Cards

ADVICE FOR FUTURE TOOLKIT USERS

Don't push the providers to speak with you when they are busy, instead wait for them and find pockets of time where they can give you their full attention.

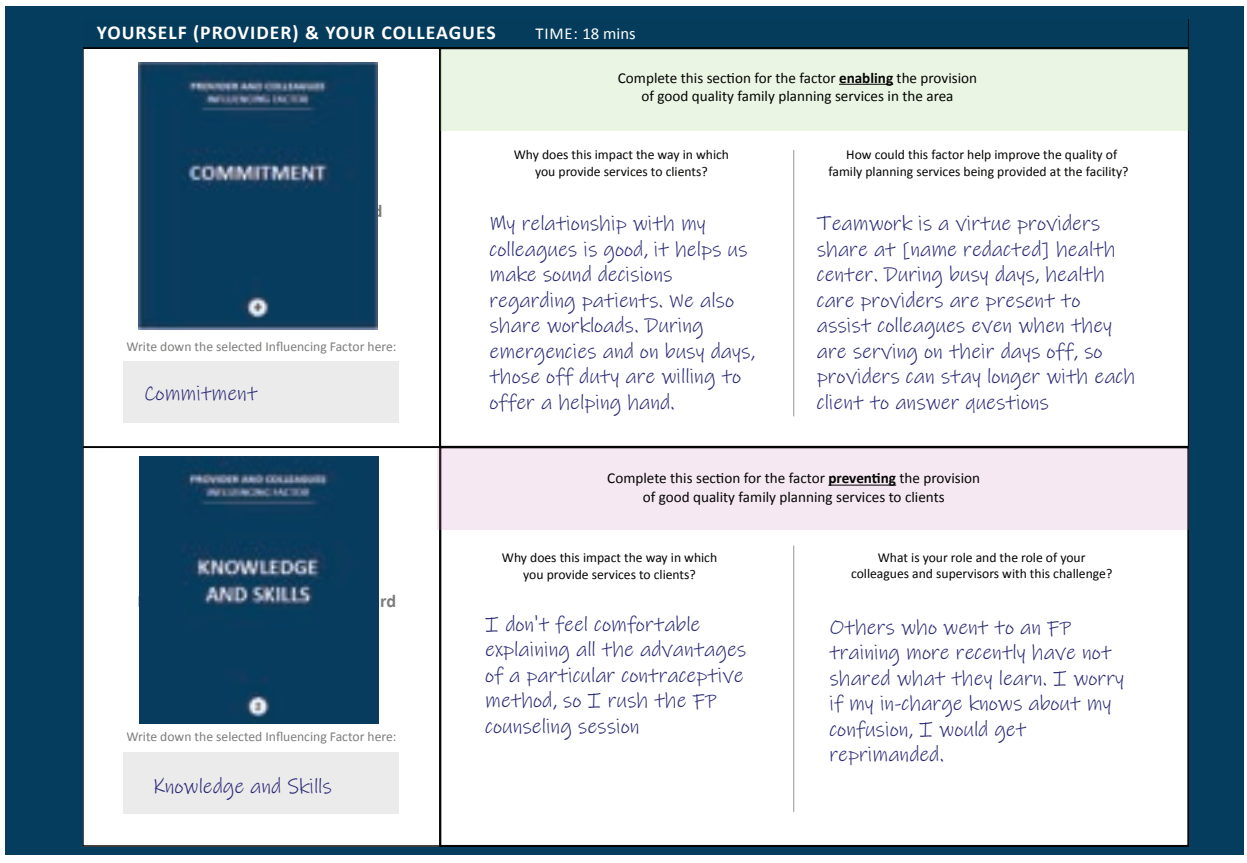

FIGURE 5: Filled in Provider Behavioral Blueprint

The team also learned that if they waited to speak with providers outside of a busy period, they gathered more useful information. If they pushed the providers to speak during a hectic time, the providers could not provide the interviewers their full attention. While using the **PROVIDER BEHAVIORAL BLUEPRINT TOOL** (**Figure 5** provides a filled-out example), the team observed that providers got distracted, as they were often in the process of attending to clients. The providers also got tired if the process went over two hours. To save time, some of the CIT members used focus group discussions instead of one-on-one interviews, bearing in mind to consider group composition to ensure providers feel free to share their issues. The Uganda team solicited written responses to protect anonymity, which also allowed for more critical responses to come out, not just compliments.

ADVICE FOR FUTURE TOOLKIT USERS

If providers do not have time to meet with you one on one, you can try to meet with them in groups. In this scenario, and especially if providers are not forthcoming with information during the group, facilitators will need to create space for providers to share private and anonymous reflections. Alternatively, you can make plans with the person in charge of the facility to speak with providers in the afternoons or times when the clinic is less busy.

The USAID/SBCA team engaged with the **DISTRICT BEHAVIORAL BLUEPRINT** (**Figure 6**), which involves a group discussion with key members of district health management teams to understand their support and what they see as influencers of provider behavior. The tool was useful in starting the conversation with the districts on what they thought impeded improvements to FP counseling or affected health workers' attitudes. The blueprint also helped the team orient providers to the intention of the project. However, implementers had to be diplomatic in using this tool, because some district staff perceived their work was under review, rather than seeing that they were engaging in a process to uncover areas where providers might need more support for positive change.

ADVICE FOR FUTURE TOOLKIT USERS

Ensure you understand the power dynamics in a room before asking people to share workplace information. One way to do this is by involving DHOs from your CIT. Ideally, district staff can assist by collecting data from clients or facilitate the DHO blueprint as providers might be uncomfortable sharing openly in front of people they perceive as their supervisors.

FIGURE 6: Behavioral Blueprint being used at a district health office

The **OBSERVATION GUIDE** (**Figure 7**) particularly helped the USAID/SBCA team, especially when they started work in a clinic to understand the environment in which providers offering counseling. This guide takes a member (or members) of the CIT through a facility tour, guided by the facility or department person in charge. A CIT member interviewed the person in charge while observing the activities and environment. Areas examined include the layout and client flow, staffing and hours, service provision process, behaviors of interest, and documentation. Observations of provider and client interactions were enlightening because they humanized the providers even further by providing context. For example, for one provider who had a reputation among supervisors of complaining about her job, observations showed she was very attentive to her clients and offered high quality counseling. Additionally, she was making sure her area was clean, including mopping the floor, even though this was not part of her job. Without this observation, that district's CIT may not have understood the provider's perspective and relied solely on the reputation they heard about.

ADVICE FOR FUTURE TOOLKIT USERS

1. Before conducting observations, work with the department persons in charge and providers to understand that your observations are not about assessing their work but about understanding their environment. If you are able to really include them in the process of applying the toolkit, the hope is they will act normally when observed.
2. When you start seeing the same results from a tool over and over, i.e., reach saturation, the tool has served its purpose and you do not need to keep using it.

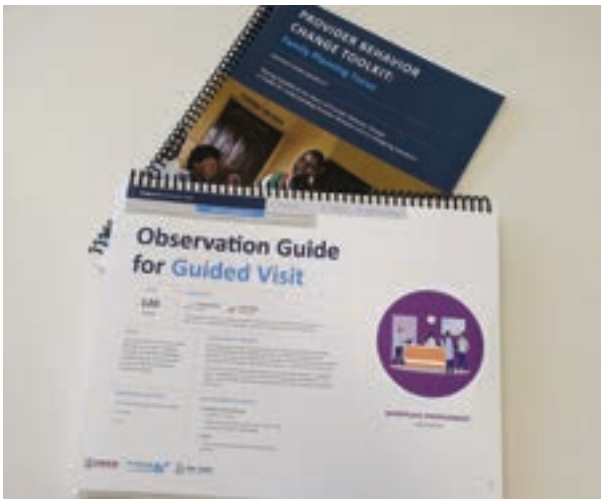

FIGURE 7: Instruction and toolkit booklets

Step 3: SYNTHESIZE

In this third step, the CIT worked to make sense of the data and identify priority areas to target in program design.

ADVICE FOR FUTURE TOOLKIT USERS

At this stage, ensure all outputs are presented anonymously. People on the CITs, especially DHOs or facility department persons in charge, might be implicated in the findings or be direct reports for some of the providers who were interviewed.

Due to fatigue after a long day of data collection, the USAID/SBCA team struggled to use the **DAILY SYNTHESIS TOOL** in its entirety. Instead, they took detailed notes to apply to the **GLOBAL SYNTHESIS TOOL.**

ADVICE FOR FUTURE TOOLKIT USERS

If you find that you cannot meet as a CIT at the end of each day of data collection, make sure to take detailed notes so you do not lose insights and fall back on your old assumptions about provider behavior.

The USAID/SBCA team used the **GLOBAL SYNTHESIS TOOL** to review all the data from the Inquire step, prioritize influencing factors, and reframe challenges as design questions. They also shared pain points and opportunities by categories and disseminated the results to the District Health Office and other implementing partners. These collaborators were well-placed to address structural issues, so the USAID/SBCA team could sustain focus on social and behavioral issues.

After using the synthesis tools, the USAID/SBCA team had several takeaways about FP counseling and provider attitudes. The team found that provider motivation is not only about pay but also is about how they are treated and what growth opportunities are available in their career. The team came to understand that what some termed "bad" provider behavior has deeper rooted causes than compensation or personality conflicts. Upon synthesizing their findings, the team found many ways in which the influencing factors providers face are interrelated, as described in the **Ecosystem Map**. For example, they found that when providers are satisfied with their relationships with their colleagues (a social component), this likely corresponds to an enabling work environment (a workplace component), due to improved teamwork and open communication channels between departments.

Overall, the toolkit "helped us work on facts and not just assumptions," as one CIT team member, Mabel Naibere, put it. While the team expected to get outcomes only related to specific provider behaviors, they actually found that many aspects of the system were not working, inspiring various members of the CITs to start making plans to address all the issues, structural, social, and behavioral.

ADVICE FOR FUTURE TOOLKIT USERS

The toolkit is designed to bring out all the issues that affect a provider's behavior. Even if you are not finding behavioral barriers, follow Uganda team member Fiona Amado's advice and "let it flow." Take in all the information you can with the Inquire tools and then synthesize it. Then you can rely on your CIT to determine who will address which types of issues (i.e., behavioral, social, structural, or systemic).

Step 4: ACT

This final step focuses on generating solutions for supporting provider behavior based on the needs identified. The USAID/SBCA team is still working on this phase. What follows are their plans to use the remaining tools in the PBC Toolkit.

The **IDEATION TOOL** will allow CITs to facilitate a brainstorming process with providers and community members to generate locally appropriate solutions for the prioritized influence factors. The USAID/SBCA team is now planning to work with a human-centered design consultant to work through the final tools in this toolkit (Ideation and Action Plan) to address the social and behavioral barriers they identified that are affecting client-centered FP counseling. They will reflect on what has already occurred in their context, brainstorm ideas, and then explore and prioritize SBC solutions that are locally appropriate.

Since the USAID/SBCA team has a mandate to focus solely on SBC interventions, they worked with members of their CITs to work on solutions for the more structural issues (**Figure 8**). Some of these solutions were quick fixes, like getting sugar for providers to use in their tea. Others took more effort but were the result of the DHO seeing challenges on the ground. For example, a DHO in one district saw that vaccines available at the district level were not reaching the health center, so they worked to streamline their communication systems and supply chain for those vaccines. Other issues, such as high workloads, lack of leave leading to burnout, or stockouts of FP commodities, will take longer to resolve, but the various DHOs and implementing partners from the CITs are now working to address them.

The **ACTION PLAN TOOL** provides a concrete template for the CIT to plan the prioritized solutions. As it continues its work, the team will outline proposed activities and identifies resources, staff, key audiences, and indicators of success. The USAID/SBCA team is now working with the districts to create a workplan which they will follow up with and discuss at joint review meetings. In the end, the CITs went into the application of this toolkit wanting to support solely with improving FP counseling but found that a myriad of issues impact provider behavior, so plans have evolved. The CITs will stay engaged to follow through on addressing the multitude of barriers they uncovered.

FIGURE 8: Work planning solutions at a district health office

CONCLUSION

The PBC Toolkit is designed to help uncover what gets in the way of providers practicing desired behaviors. The USAID/SBCA Uganda team's experience highlighted several best practices for engaging with the toolkit:

- CITS need to be open to uncovering structural as well as behavioral barriers to provider behavior, because these tools look at things from a systems lens.
- Partnerships are necessary for addressing the provider ecosystem more holistically.
- From the start, CITs should take care not to be overwhelmed by the number or length of the tools, as they are all valuable in building a full understanding of what influences provider behavior.

"As you work through the tools, they become easier and easier to use."

– FIONA AMADO,
USAID/SBCA TEAM MEMBER

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