State of the Evidence: A reflection on the gaps identified in Breakthrough RESEARCH’s Research and Learning Agendas for Advancing Provider Behavior Change Programming and Advancing Integrated Social and Behavior Change Programming

Breakthrough RESEARCH
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Background
At the start of Breakthrough RESEARCH in 2018, in collaboration with the United States Agency for International Development (USAID), the project took an intentional consensus-driven approach to develop global social and behavior change (SBC) research and learning agendas (RLAs). This included the engagement of over 190 stakeholders including researchers, implementing partners, service delivery organizations, and donors, who provided their expertise and experience to collectively identify how to continue to advance SBC programming. Building on existing literature and examples of innovative and effective ways to influence provider behavior and to integrate SBC programming, this process sought to identify priority evidence gaps and opportunities to expand the knowledge base for these two key areas of SBC programming.

Through this collaborative and consensus-driven process, Breakthrough RESEARCH developed two RLAs: one focused on provider behavior change (PBC) programming and one focused on integrated SBC programming. The RLAs identify cross-cutting SBC knowledge gaps and key research questions with broad applicability at global, regional, and local levels across health sectors (see Figures 1 and 2). The goal in developing these RLAs was to help guide SBC decision-making across sectors, foster collective learning, reduce duplication of efforts, and maximize the impact of research and programmatic investments.

There was clear recognition among those engaged in this process that to advance the RLAs, concerted and coordinated action was needed from a range of stakeholders including donors, SBC and service delivery organizations, health systems actors, governments and policymakers.

FIGURE 1 RLA FOR ADVANCING PBC PROGRAMMING RESEARCH AND LEARNING QUESTIONS

<table>
<thead>
<tr>
<th>Organizational Characteristics and Values</th>
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</thead>
<tbody>
<tr>
<td>• What norms (such as facility, profession/seniority, community) are most influential in shaping provider behavior in interpersonal communication with clients?</td>
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<tr>
<td>• How do these factors vary by client and provider profile?</td>
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<tr>
<td>• How do they vary across health areas and in different geographical contexts?</td>
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<tr>
<td>• How do facility-based clinical practices/standards shape provider behavior?</td>
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<td>• Which norms have the largest impact on how providers deliver quality counseling?</td>
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<tr>
<th>Effectiveness</th>
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<td>• Does improving the behaviors/practices of health providers influence the quality of care provided?</td>
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<tr>
<td>• What are the most effective SBC approaches to enable/motivate/facilitate (different cadres of) providers to provide respectful, client-centered care (such as staff recognition through incentives to provide postpartum family planning counseling)?</td>
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<tr>
<td>• What are the most effective non-communication-based SBC interventions to improve provider behaviors (for instance, a suitable waiting room)?</td>
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<tr>
<td>• How does addressing the factors that influence provider behavior (normative, structural, behavioral) lead to improved health outcomes?</td>
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<tr>
<th>Intervention Strategies</th>
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<td>• How does SBC programming affect the organizational culture of health facilities and systems to create an enabling environment for positive provider behaviors (for instance, improved attitudes, performance, shifts in norms)?</td>
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<tr>
<td>• What intervention designs are effective in addressing organizational/facility-level norms pertaining to provider behavior?</td>
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<tr>
<td>• Which intervention(s) or combinations of interventions are most important to improving the quality of provider counseling?</td>
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<tr>
<td>• How does the quality of provider counseling influence utilization of services among clients?</td>
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<tr>
<td>• How does the quality of provider counseling influence adoption of positive behaviors among clients?</td>
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<td>• Which interventions improve perceptions of service quality and provider accountability?</td>
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<th>Measurement</th>
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<td>• How can we best assess/measure the quality of client-provider interactions from client and provider perspectives?</td>
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<tr>
<td>• How can we best measure provider attitudes, norms, and biases that influence their performance and adherence to timely and respectful client-centered care practices?</td>
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and research institutions and universities. The RLAs were and continue to be intended to help maximize current and future investments to achieve the best possible health and development outcomes.

The starting point for the development of the RLAs was a desk review and a review of reviews focused on already synthesized evidence on SBC programmatic research or evaluations from low- and middle-income countries. This review was focused on USAID’s key global health SBC technical areas, reviewing documents from 2012 to 2018, tapping both peer-reviewed and programmatic literature. A total of 160 review documents were collected and research gaps identified based on where there were gaps in the literature. This was followed by a series of expert consultations focused on validating the desk review results and pinpointing and prioritizing cross-cutting themes, identifying SBC knowledge gaps, and generating research questions to enhance SBC programming in complex “real world” settings.

For more information on the RLA development process, see [here](#).

Five years later, in 2023, we reflect on the state of the evidence to understand progress made toward filling the identified evidence gaps in the RLAs and to renew the call for continued rigorous evidence generation to advance PBC and integrated SBC programming.

### A Scan of the Literature

To reflect on progress made, we scanned the literature for externally available resources produced from 1 January 2019 through 1 May 2023.

For the published and peer reviewed literature, the original search terms used during the development of the RLAs were used to identify progress made over the past five years to fill those evidence gaps. The Cochrane Library, PubMed, Google scholar, 3ie database, and USAID’s Development Experience Clearinghouse were searched using search terms related to “behavior change”, “social change”, and “health communication” in the following health areas: family planning/reproductive health, maternal health, child health, neonatal health, HIV, AIDS, malaria, and Zika.

We also purposively searched the websites of global implementing organizations known to be working on PBC and integrated SBC, including Breakthrough ACTION + RESEARCH, FHI 360, Pathfinder International, Population Services International, PATH, and the CORE group.

As part of the screening process, abstracts or executive summaries were reviewed to identify articles focused on...
PBC and on integrated SBC. Abstracts, and where needed, full text of an article or resource were used to align the focus of the article/resource with one of the identified evidence gaps in the RLAs. If the article/resource did not align with an identified evidence gap, it was not included. To note, that article/resource need not have specifically mentioned the RLAs or used the RLAs to be included.

This scan of the literature comes with limitations. It is very likely we have not identified all the evidence produced between 2019 and 2023 and that there are organizations not included in our search that have generated important and valuable evidence. Omissions are not a reflection of the value of these contributions.

This is also not meant to be a reflection on the strength or quality of the evidence or to make evidence-based conclusions around what works or does not work to advance PBC or integrated SBC programming. The objective of the scan of the literature was to provide an overall sense of progress made in focusing on closing these critical evidence gaps, where there remains work to be done, and where those working in integrated SBC and PBC can and should focus future evidence generation efforts.

State of the Evidence Gaps: Advancing PBC Programming

Of the nearly 2,600 articles screened through the search of databases, 76 resources published between 2019 and 2023 were identified as additions to the evidence base to advance PBC programming, including 19 resources (or 25%, overall) generated by Breakthrough RESEARCH, which used the RLAs to drive the project’s evidence generation focus.

The resulting 76 resources were mapped against the four categories of evidence gaps highlighted in the RLA and a color-coded evidence heat map below is used to highlight overall where relative progress has been made over the past five years, and where significant gaps in the published evidence persist. The evidence heat map represents the relative contribution of the identified resources mapped to the four evidence gaps, from greatest contribution (green) to least number of resources identified for the evidence gap (red).

Over the past five years, advancements have been made to better understand intervention strategies that address provider behavior—this evidence gap has seen the greatest progress since the development of the RLAs, with more than half of the 76 identified articles contributing evidence to fill this gap. There’s been some progress toward also studying the effectiveness of these intervention strategies—that is, whether PBC interventions lead to better health outcomes—though this gap remains, and more evidence is needed. Fairly good progress has also been made to fill the evidence gap around organizational characteristics—nearly a third of the identified articles aligned with this evidence gap—and values, but critically, there remains a stark evidence gap around measurement for PBC, which accounted for less than 10% of the identified articles.

In the recent literature related to provider behavior, there continues to be a focus on delivering client behavior change interventions through providers or on interventions aimed at clients that puts the onus on them to change the way they interact with the health system (e.g., health literacy) to improve provider-client interactions, rather than a focus on understanding and changing provider behavior itself.

State of the Evidence Gaps: Advancing Integrated SBC Programming

Of the nearly 2,600 articles screened through the search of databases, 33 resources published between 2019 and 2023 were identified that added to the evidence base to advance integrated SBC programming, including 17 resources (or just over half overall) generated by Breakthrough RESEARCH, which used the RLAs to drive the project’s evidence generation focus. Compared to PBC
programming, there were fewer published resources on identified gaps for integrated SBC programming.

The resulting resources were mapped against the four categories of evidence gaps in the RLA and a color-coded evidence heat map is used to highlight overall where relative progress has been made over the past five years, and where significant gaps in the published evidence persist. The evidence heat map represents the relative contribution of the identified resources mapped to the four evidence gaps, from greatest contribution (green) to least number of resources identified for the evidence gap (red).

In a similar pattern to the PBC-related evidence, progress has been made over the past five years to better understand intervention content and the programmatic models that advance integrated SBC programming, with roughly half of the identified 33 articles contributing to filling this evidence gap. In turn, advancements were also made to understand and measure the effectiveness of integrated SBC programming—roughly a third of resources were focused on this evidence gap. Importantly, while there has been fairly good progress in understanding the effectiveness of integrated SBC programming, none of the identified resources examined the effectiveness of integration relative to vertical programming (an important component of the identified evidence gap), but rather examined the effectiveness of the integrated program.

There remain persistent knowledge gaps around implementing in an enabling environment and around cost effectiveness. Evidence generated about the enabling environment for integrated SBC and on cost-effectiveness over the past five years has primarily been generated by Breakthrough RESEARCH.

Compared to PBC programming, where 76 resources have been identified, there has been slower progress towards producing resources that fill the identified integrated SBC programming, where only 33 resources were identified. It’s important to note that these color-coded gap maps consider the relative contributions of the resources produced within PBC and within integrated SBC—and so, for example, the ‘green’ evidence gap in integrated SBC programming is not comparable to the ‘green’ evidence gap in PBC programming, where considerably more progress has been made.

**Renewing and Reinforcing the RLA Calls to Action**

The RLAs are not intended to be static documents. Over the past five years, there has been good progress made and there are a lot of different stakeholders working to generate the evidence that is needed to continue to advance PBC and integrated SBC programming. This reflection provides an important opportunity to pause and take stock of progress that has been made, to identify what remains to be done, and to renew and reinforce the calls to action outlined in the RLAs. To do that:

**Donors:** Use these agendas to support and sustain evidence generation, particularly in the areas of measurement, the enabling environment for integrated SBC programming, and cost effectiveness. Engage with other donors for effective coordination and alignment of investments in evidence generation.

**SBC and service delivery organizations:** Continue to tailor and leverage routine data and evaluation systems to capture key information to help answer priority questions from the RLAs. Collaborate with research institutions and universities to share not only intervention content and strategies, but also their effectiveness and cost-effectiveness to guide future investments and decision-making.

**Governments and policymakers:** Foster and support an evidence-based programming environment to make use of emerging research to influence strategies and update relevant policies for PBC and integrated SBC programs.

**Research institutions and universities:** Develop and share innovative research designs and measurement tools—or develop and standardize new measurement tools—to
generate rigorous evidence on the priority questions from the RLAs. Synthesize the evidence (and quality of evidence) on PBC and integrated SBC to highlight program and policy implications. Examine the implementation and impact of local, national, and regional SBC approaches and programs.

Appendix: Resources Identified (2018–2023), by Evidence Gap Area

Provider behavior change

Organizational characteristics and values


Breakthrough RESEARCH. 2020. “Structural and behavior change interventions to improve experience of care for sick very young children (0 to 24 months of age) and their parents in hospital settings in Kenya.” https://knowledgecommons.popcouncil.org/cgi/viewcontent.cgi?article=1066&context=focus_sexual-health-repro_choice.


Intervention strategies


Intervention strategies


**Effectiveness**


**Measurement**


**Implementing in an enabling environment**


Integrated SBC

**Intervention content and programmatic model**


**Effectiveness of integrated SBC programming (relative to vertical SBC programming)**


Cost-effectiveness


Acknowledgments

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