The Only People Who Like Change Are Babies with Dirty Diapers:

Useful considerations about fostering behavior change in your health programs (and the rest of your life)

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Global Health Mini-University, Washington, D.C., October 8th, 2010

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Our challenge

"It is not the strongest of the species that survives, nor the most intelligent, but the one most responsive to change."

—Charles Darwin, ~1860

"The art of progress is to preserve order amid change and to preserve change amid order."

—Alfred North Whitehead, ~1910

"Mastering the generation of good changes is not the same as mastering the use of good changes."…

— Berwick, JAMA, 2003

"Whatever it is, I'm against it!"

— Groucho Marx , Horse Feathers, 1932

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Why concern ourselves with change?

- We are all “change agents”
  - It’s what we do when we “do development”
- Most public health interventions require behavior change
- Comes with “hardware” (tool) and “software” (new knowledge)
- Scientific / empirical / proven findings about nature and dynamics of change, across time, place, sector
  - I.e., change has predictable dynamics and phases
- Applicable to most contexts, “developed” and “developing”
- Can lead to better, more strategic programming practices, realistic timeframes and expectations

Yet, what often happens:

- Researchers publish new findings

  Implicit in “rational” paradigm of science:

  generate new finding / new knowledge, “best practice,”put it out there, and inevitably (and soon), it will lead to appropriate new behavior …

  i.e., “Build it and they will come.”

  But not how it usually works [as shown by how hard R-to-P is]

- Experts devise new guidelines
- Policymakers issue new policies
- Programs introduce improved services

… And nothing much changes

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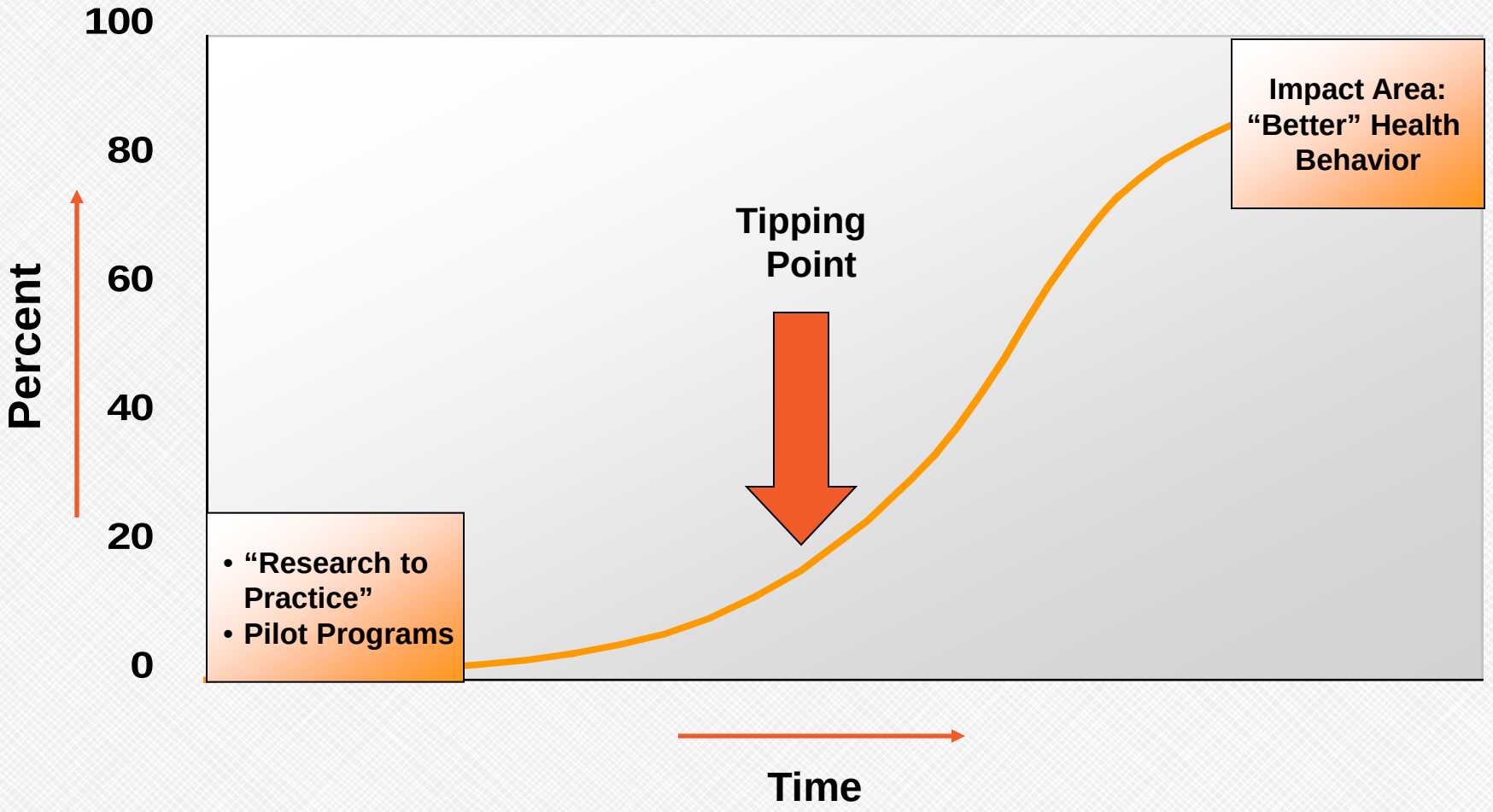
As this talk proceeds, think about …

- What new technology or new PH practice spread quickly in the countries and programs where you work?
- What has spread slowly in your country?
- What factors helped it to spread quickly?
- What factors impeded spread?

What we are trying to accomplish:
Dynamics of adoption of successful change



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Four key aspects of adoption of new behavior / health practice

I. "What": Objective characteristics of the proposed new behavior, plus potential adopters' perceptions of it
e.g., Active Mgmt 3rd Stage of Labor, DOTS, VCT, ART, FP use

II. "Who": Characteristics of the potential adopters
(providers, clients, communities, health facilities, org. units)

III. "How": Contextual factors that facilitate or impede spread
e.g., health system structures & characteristics, leadership, management, supervision, communication

IV. "Where": Locus of provision/receipt of new behavior / practice
(in this talk) medical settings

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Key subjective aspects of the "what"
(the proposed intervention or new PH behavior)

- **Perceived benefit**
- **Perceived compatibility** (e.g., with medical system's norms, standards, practices; &/or with sociocultural norms)
- **Perceived simplicity** of new behavior
- Also, its perceived **observability** & "**trialability**"
- As these variables increase, **rate, strength and extent of adoption go up**
- Together: **49-87% of rate & extent of change**

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Perceived benefit: most important single variable

- **Perceived benefit**: "What's in it for me?"
- The greater the perceived benefit & **relative advantage**, the more rapid the rate of adoption of the new behavior & the more sustained (less likely to discontinue)
- Aspects of perceived benefit:
  - Degree of economic profitability
  - Low initial cost
  - Decrease in discomfort
  - Increase in social prestige
  - Savings in time and effort
  - Immediacy of the reward**

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Perceived compatibility & simplicity

- Perceived compatibility
  - Importance of pre-testing
    - > *(Copper-T; Chevy No-va; level of language)*
  - Importance of knowing cultural beliefs
    - > *e.g., menstruation vis-à-vis FP*
  - Modern methods of FP have traditional analogues
  - "Yes, but may not be true for our women"
- Perceived simplicity
  - "easy to do" more likely & quickly adopted than "complex"
    - > *Thus impulse to adapt [and to simplify]*
    - > *Local adaptation is nearly universal & inevitable*
    - > *Successful adaptations: not "spread" but "reinvention"*

Perceived trialability & observability

- Perceived trialability (*"pilot testability"*)
  - Innovations tried on "installment plan" adopted more quickly
  - Agriculture / Why we have O.R.
  - Represents less uncertainty/risk to potential adopter
  - Also, individual can learn by doing
  - But, e.g., can't have "trial" vasectomy (one reason it's use is low)
- Perceived observability
  - Preventive innovations inherently less observable than curative
  - Applies to problems as well as solutions
    - > e.g., one reason MM so high: largely an "unseen" event (which happens to rural poor women not urban wealthy men)

Perceived: It's in the eye of the "changee" (not us)

Avoid the “empty vessel syndrome”

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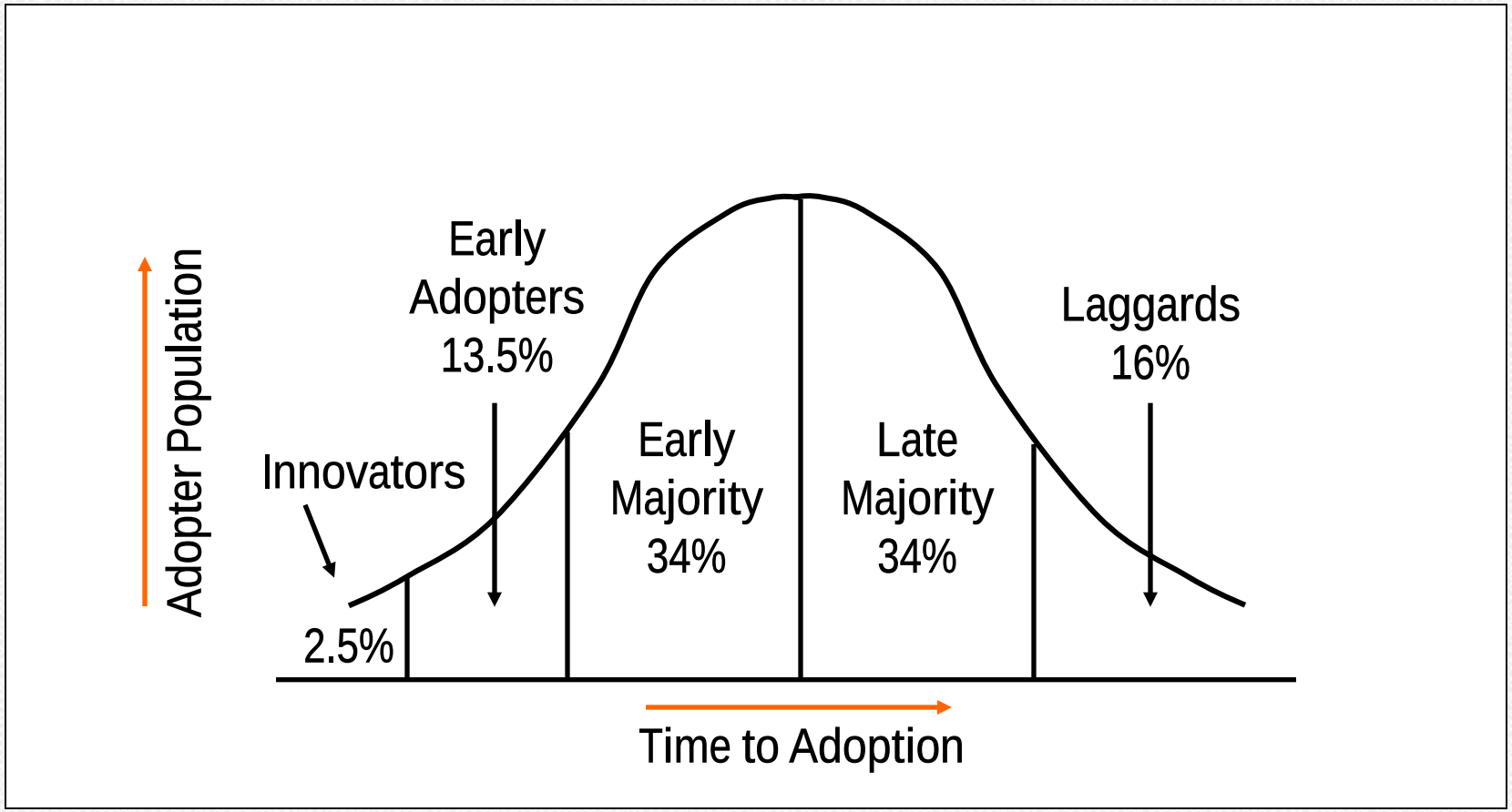
Distribution of adopters (the "who")



Considerations about "the who"

- Early adopters are programmatically key:
  - Receptive to change
  - Opinion leaders / locally well-connected, well-respected
  - Resources & risk tolerance & willingness to try new things
  - Often chosen as leaders & representatives
  - Most closely watched by others (thus crucial to dynamics of spread)
- "Innovativeness-Needs Paradox":
  - Individuals or system units that most need benefits of a new idea (the less educated, less wealthy, etc.) generally the last to adopt it
  - Innovations meant to improve situations actually widen SE gaps (not inevitable but needs attention)
  - Later adopters of an innovation more likely to discontinue

Considerations about the "how"

- Environmental/system factors support or impede change
  - Communication patterns
  - Structure of work / job incentives
  - Leadership / management / supervision
- Several styles of leadership-induced spread:
  - Spectrum from "authoritative" to "collective"
  - No one best; context-specific
- Here where CAs work, because can most influence here, but lesser influence than the "what" or the "who"

The nature of medical settings (a "where")

- Hierarchical & 'conserve-ative'
- Well-established policies, routine practices
- Provider as gatekeeper
- Provider often lacks motivation to change (no perceived benefit)
- PH / prev. med. lower priority & status than curative medicine
- Great fear of iatrogenic disease: *Primum non nocere*
  - Harm of doing vs. harm of not-doing
  - Not thinking about relative risk
- Low felt (perceived) need for change (value stability/homeostasis)

Slow pace of change in medical settings

- "Then" and "there"
  - Scurvy
  - Semmelweis
  - Countries where we work
- "Here" and "now":
  - 500,000 unnecessary C-sections in U.S., every year!
  - 80,000 unnecessary hysterectomies annually
  - 11-year lag until 51% correct treatment of heart attacks in U.S. …

    by cardiologists! (despite threat of suits and plethora of information)

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How have you experienced resistance to change in your programs?

- “We’ve never done it that way.”
- “It’s contrary to our policy.”
- “We don’t have the money.”
- “This needs committee study.”
- “That may have worked in Peru (or Vanuatu or Timbuktu), but it won’t work here, because _____”)

So, What to Do?: Eight and a half strategies for fostering change in medical settings

Strategy #1: Factor in the 'what,' 'who,' 'how,' & 'where' of behavior change

Strategy #2: Promote "evidence-based" and "data-driven" health practices ("science" is necessary, just not sufficient)

Strategy #3: Understand how all actors see the innovation … and intervene accordingly

- Avoid the "empty vessel syndrome"
- "We must walk in their shoes, or else we will fail"

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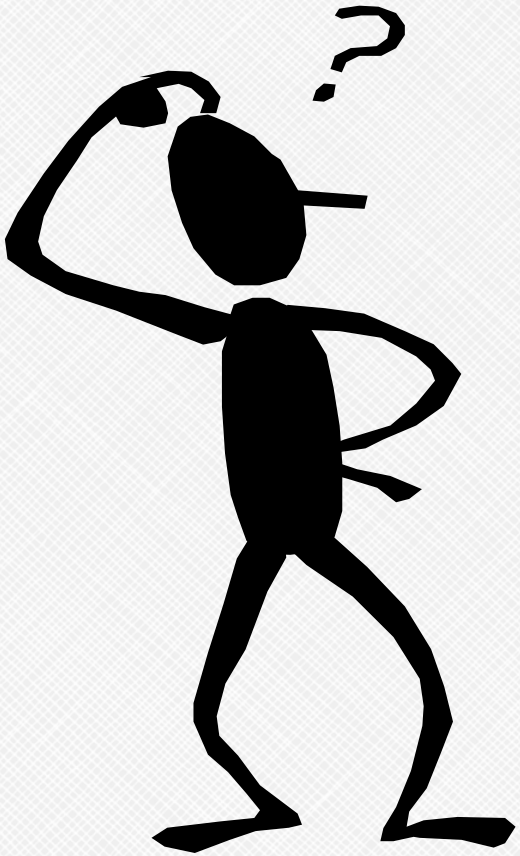
Strategy # 4: Take a "provider perspective"



- Reflect on providers as human beings, with same needs, motives, aspirations, and limitations all humans have
- Imagine yourself as a provider of FP/RH services in busy clinic, low resource setting
- Align interventions with providers' situations and with how they evaluate an innovation (Is proposed new behavior / new intervention simply more work?)
- Focus program effort on benefit to providers as well as to clients (providers' rights)
- And measure and reward it: "What gets measured—and rewarded—gets done"

Strategy # 5: Find, support & nurture champions

- Show an “activity bias”
- Find them among the early adopters
  - At all levels
    (policy, program, facility, provider, client)
- Make their activity visible / promote their face-to-face activities / support their local networks / “reward” them
- Sustain your engagement (“nurture” means not a one-time or brief encounter)

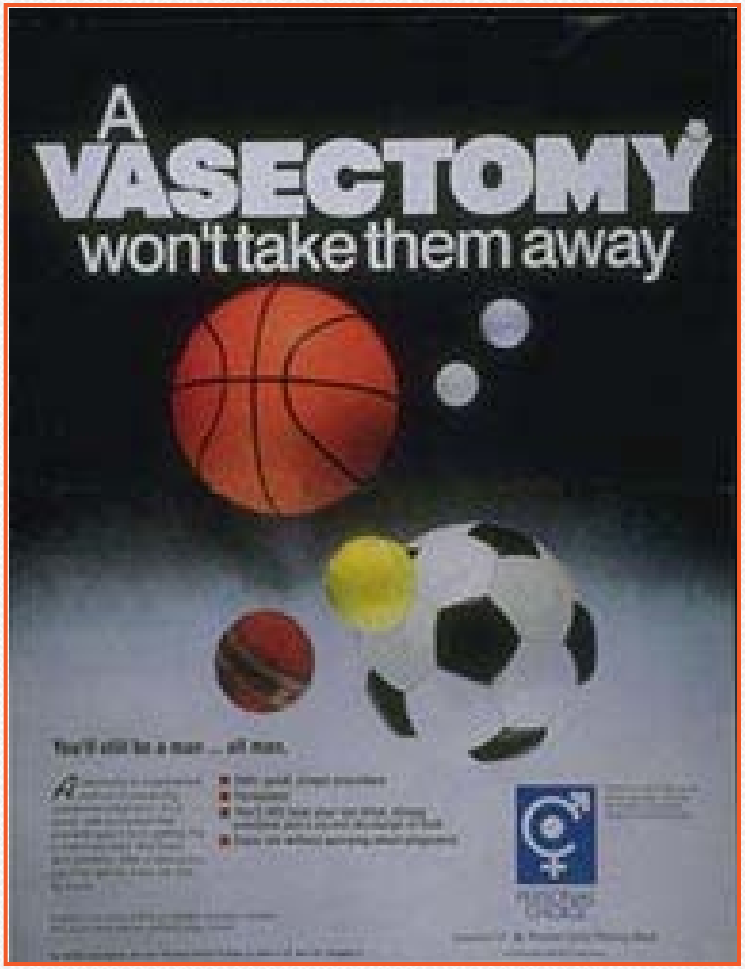
Strategy # 6: Follow rules of good pilots

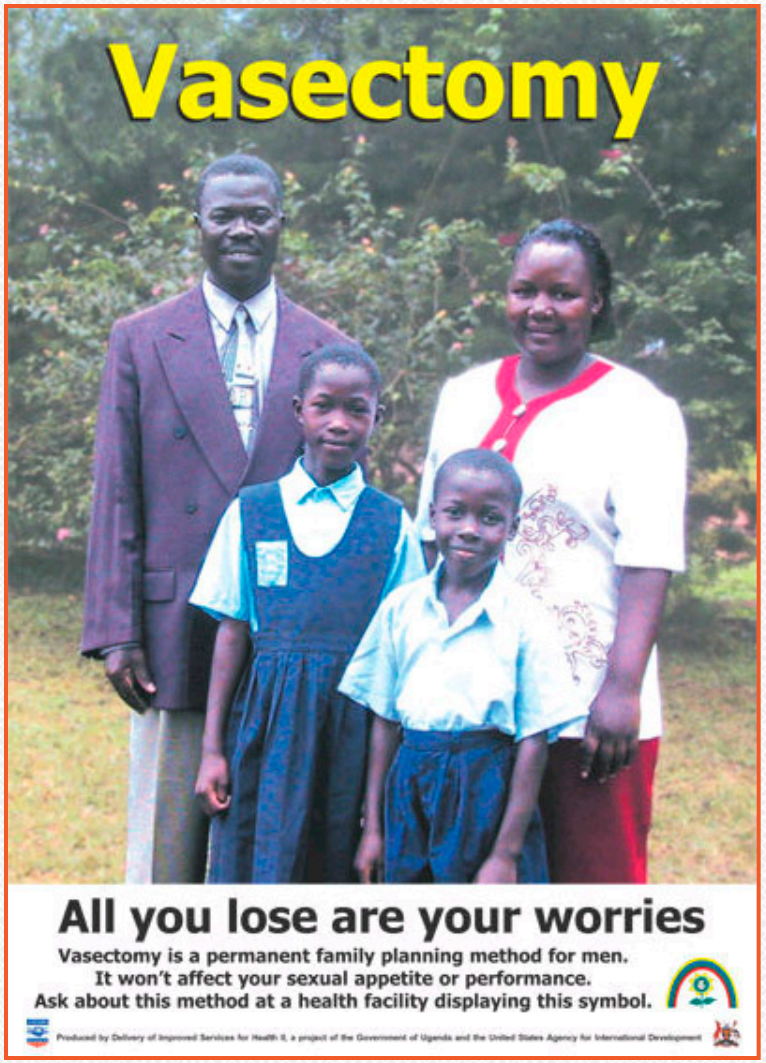
- "Until proven otherwise, what you are working on is a pilot"
- So follow rules of good pilots
  - "Who's interested? / "Who cares about results?"
  - "Why do they care?" How do you know?
  - "How are they involved?"
    - > *Need to / good opportunity to include policymakers, decisionmakers, future implementers, & convert them to champions*
  - "How is your [pilot] activity being made visible?"
    - > *"Demonstration project"*
    - > *Capital city? President's wife? Youssou NDour? Madonna?*
  - How will it be replicated? / How will it be scaled-up?
    - > *"Rollout" or "scale-up" IS diffusion (so dynamics of diffusion apply)*

Strategy # 7: Address audiences' truths

- At center of process of diffusion of innovation / adoption of new behavior is communication & modeling
- Language conveying innovation is crucial
  - "Copper-T" in Korea
  - "Nova T" (and Chevy No-va) in Latin America
- Human communication fraught with misunderstanding
- Messages & interventions need to address audiences' 'truths,' in simple, understandable/understood language

Use messages relevant to known concerns





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IUD campaign messages in Kenya:
strength, engagement, support

Fahamu ukweli wa mambo
"Now you know the truth"

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Strategy 8: Repeat messages & interventions

- Repetition is the key to adult learning and behavior change:
  - "Be like Coke"
- As stand-alone, limited value to one-off "knowledge transfer" activities, e.g., CTU, training event, "policy dialogue" – even a MAQ talk!

Strategy 8 &1/2: Be realistic and be patient

- Program incrementally (with "scale-up" in mind—& plans!—from the start)
  - Change will likely be slow, incremental
  - "Change takes (a lot) of time" –- but it WILL occur …
  - and it can be sped up by heeding principles and dynamics of change

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