BEHAVIORALLY FOCUSED APPLIED POLITICAL ECONOMY ANALYSIS

I. INTRODUCTION

Over the past generation, lower- and middle-income countries throughout the world have made significant progress in improving the health and well-being of communities and families. Neonatal mortality declined globally by half since 1990 and mortality for children under five declined by 63% during this same period.[1] Similarly, maternal deaths declined globally by 38% between 2000 and 2017.[2] These and other improvements in maternal and newborn health (MNH) outcomes have been complemented by and tied to progress in citizen empowerment, gender equity, and increased transparency and accountability in decision-making within national and local health systems.

However, despite significant investments, numerous challenges remain. These challenges are myriad and often seem intractable. Health systems often struggle with accountability, consistent financing, consistent implementation and use of global standards, protocols, tools and best practices along with adoption of new innovations often plague health systems. Additionally, many countries still experience significant barriers in sustaining gains once made and responding to new health challenges, especially in the absence of donor funds, resulting in ongoing global, regional, and intra-country disparities in MNH outcomes. As the United States government strengthens its commitment to supporting countries to become self-reliant in financing and managing their health systems, it is imperative that implementing agencies support national health partners with methodologies and tools that facilitate feasible, scalable, and appropriate responses to seemingly intractable issues that are stagnating progress.

The Behaviorally Focused Applied Political Economy Analysis (BF-APEA), developed by the U.S. Agency for International Development (USAID) flagship MOMENTUM Country and Global Leadership (MCGL) program, is one such methodology. The BF-APEA recognizes that development challenges are complex because people are complex. As such, tackling the toughest development challenges requires holistic approaches that make optimum use of limited resources. It requires starting by thinking first about why stubborn challenges persist in order to map their visible and invisible causes and only afterwards considering *what* interventions should be implemented, or of what we know to be "best practice.". Only by understanding the deep drivers of health system performance is it possible to shape effective solutions that yield sustainable health outcomes.

The BF-APEA supports countries to define and describe the complex behaviors of the many actors that comprise health systems, unpack and map the multiplicity of factors that influence those behaviors, and ultimately codesign sustainable, scalable interventions that respond to that complexity. This approach is not revolutionary, rather it offers a systematic way to bring the science of individual and collective behavior change, often focused on the health practices of individuals and communities, to bear on challenges often not considered behavioral in nature. The BF-APEA can be applied to any persistent challenge driven largely by systemic or institutional factors.

This brief provides an overview of the BF-APEA. It should be used by practitioners interested in understanding the approach and investing in its use. This includes stakeholders internal to the Momentum Country and Global Leadership program as well as donors, representatives from partner governments and other implementing partners. It will be refined over time to incorporate the experiences and lessons learned from the teams that first implement it, and to be clear about its value-add to the global development community. Ultimately, it is envisioned that this brief will be accompanied by capacity-building materials and

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[1] https://data.unicef.org/topic/maternal-health/newborn-care/
[2] https://data.unicef.org/topic/maternal-health/maternal-mortality/

additional resources to ensure countries are able to use the methodology to solve their own, biggest challenges into the future.

II. WHY FOCUS ON BEHAVIORS AND POLITICAL ECONOMY?

Institutions, and the complex systems in which they are imbedded, are defined in part by the **behaviors** of a diverse sets of actors and the interactions among them. These actors' behaviors may support positive health outcomes or could hinder them or lead to negative outcomes. Consider ANC, a requisite service for high-quality maternal and neonatal care. The World Health Organization's standards for ANC depend on the health-seeking behavior of pregnant women and their families, the behavior of health facility staff in extending effective ANC services, and the behavior of policymakers and managers in creating and facilitating an environment in which high-quality services can take place. In this context, it is possible to describe a series of "behavior chains" required by different actors to achieve a single outcome and, ultimately, impact maternal and newborn survival.

Numerous complex forces shape individual and institutional behaviors at many levels or spheres of influence. For example, a perception that multiple ANC visits have value may shape the health-seeking behavior of pregnant women. Similarly, adequate training, resources, and technology may influence the quality of care provided by health facility staff. Many development programs, therefore, focus on technical interventions that deploy the "right" evidence-based knowledge, skills, tools, and policies to achieve prioritized objectives. Although these technical factors are important, we know that the behavior of system actors is also influenced by interrelated incentives, interests, religious and gender norms, and values that help define the local **political economy**. For example, patriarchal relations within families may deter women from seeking ANC services. Similarly, the lack of administrative accountability within the health system or widespread misallocation of funds may reduce service quality, despite continued investment in staff training. Further adding to the complexity, these factors are often mutually reinforcing—the poorer the perceived quality or value of care, the less likely a woman is to seek it. These and other factors help explain why evidence-based interventions may not achieve anticipated results, or why progress is too often not sustained after a project ends.

> **Political economy** refers to the intersecting incentives, interests, and values that shape the operations of complex systems and the actions or decisions of key actors. The political economy can include highly visible, material interests alongside more invisible social or cultural norms. Factors related to the political economy have a direct bearing on the **behaviors** exhibited by individuals and institutions alike.

The BF-APEA is a fully integrated methodology for describing existing and desired behaviors and the complex forces that influence them. Because behavior is ultimately an expression of systemic factors, the BF-APEA provides a user-friendly way to logically and comprehensively understand systems that generate health outcomes and identify points for intervening within those systems.

III. ORIGINS OF THE METHODOLOGY

The BF-APEA methodology combines two established and complementary assessment and design approaches:

- The **Think | BIG** approach to behavioral integration[3] provides a process and tools for identifying key behavioral outcomes required for achieving and sustaining impact, analyzing the factors influencing those behaviors, and then creating pathways to address the factors that impede or motivate those priority behaviors.
- **Applied political economy analysis (APEA)**[4] describes the underlying interests and incentives that shape the decisions and behavior of local actors. APEA is used to map, and make visible, the often-hidden factors that influence the actions of individual and institutional actors within a given system.

Drawing upon these two approaches allows the MCGL team to strategically ask questions and analyze data to provide insights into persistent problems[5] that are rooted in norms, rules, interests, and incentives that influence behaviors. This integrated methodology will lead to collaboratively designed interventions and implementations that are politically aware and based on an understanding of the motivations and behaviors of key actors within the health system, including users of health services.

Examples of persistent problems that can be examined using BF-APEA:

- Ensure effective and consistent use of partographs
- Support medical staff retention of clinical skills
- Foster coherent lines of accountability within health system
- Ensure routine use of data to understand mortality causes and trends
- Fully integrate technical areas (nutrition, reproductive health, maternal health, etc.) into holistic primary health care
- Implement new global guidelines and polices, such as *Standards for Improving the Care of Small and Sick Newborns in Health Facilities* or the 2018 *Intrapartum Recommendations for a Positive Pregnancy*

IV. HOW CAN THE BF-APEA BE USED?

Although sound technical interventions are essential and should not be underprioritized, in any country context it is possible to identify stubborn problems that best practices have failed to adequately address. The BF-APEA methodology can be used to help advance any specific, well-defined objective identified by partners in a local or national health system. Therefore, as a starting point, MOMENTUM Country and Global Leadership will collaborate with local and national health partners to use this methodology to unpack and map behaviors and corresponding factors to address **persistent problems** that represent critical challenges that evidence-based technical interventions alone have failed to resolve.

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[3] Behavioral integration aims to center consideration of individual and group behavior in an understanding of complex development challenges and developing possible solutions. Developed by the Manoff Group, the Think | BIG methodology provides a user-friendly approach for mapping behavior chains and designing interventions that encourage optimal behaviors.

[4] Pact's APEA approach has been applied in more than 30 projects globally across sectors, including health, to identify and analyze key actors' interests and values that ultimately shape decision-making, resource allocation, and success and failure of initiatives.

[5] This guidance refers to "persistent problems" as issues or challenges that have persisted for years or generations, despite significant investment by national governments, donors, or other implementing partners.
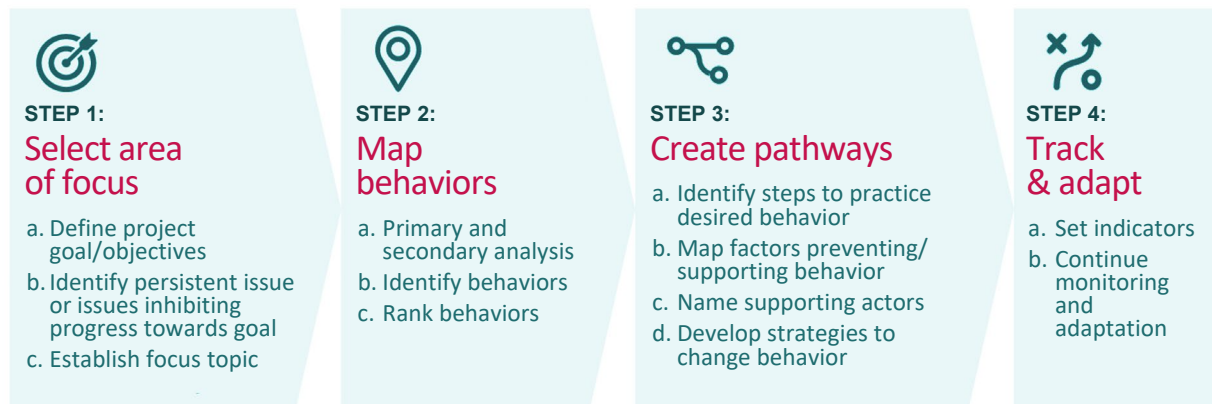
The challenge for development programs is not in understanding that behaviors are important, or even that social, political, and economic factors constrain or enable progress in achieving and sustaining results. The challenge is describing required behaviors and their drivers with enough specificity and depth to determine the most appropriate, responsive, and feasible interventions. The BF-APEA methodology aims to do this, thereby enabling actions that are grounded in an understanding of local incentives, encouraging constructive behavior change by all actors within a system, and introducing appropriate interventions to achieve prioritized outcomes.

V. HOW IS THE BF-APEA IMPLEMENTED?

The BF-APEA is designed to be a participatory and evidence-based analytical approach to inform the strategies and activities of projects, donors, and national health partners. To be successful, the BF-APEA process must be owned by local project teams and their stakeholders. This means ensuring that local partners set or vet key goals, objectives, and questions. It also means that project teams and partners should participate in and lead key elements of the research and analysis processes.

The BF-APEA is a truly **integrated** process, meaning that the **behavioral integration** and **political economy** aspects are not considered in isolation but rather provide unifying perspectives. The process consists of four steps, as illustrated in Figure 1.

FIGURE 1: BF-APEA IMPLEMENTATION STEPS

STEP 1:
Select area of focus
a. Define project goal/objectives
b. Identify persistent issue or issues inhibiting progress towards goal
c. Establish focus topic

STEP 2:
Map behaviors
a. Primary and secondary analysis
b. Identify behaviors
c. Rank behaviors

STEP 3:
Create pathways
a. Identify steps to practice desired behavior
b. Map factors preventing/supporting behavior
c. Name supporting actors
d. Develop strategies to change behavior

STEP 4:
Track & adapt
a. Set indicators
b. Continue monitoring and adaptation

Moving through these steps allows program managers, researchers, and other stakeholders to identify the behaviors that will help achieve prioritized goals and pinpoint the kinds of interventions and resources that will help to sustain those behaviors. This entails expanding our analysis of seemingly intractable obstacles to understand and map the interplay of actors and factors within a whole system and map the chain of outcomes and influences. Specifically, this entails prioritizing questions such as: what and whose behaviors contribute to or inhibit key goals? and, what behaviors are feasible to change? From there, the process builds pathways for change for each priority behavior by analyzing those systemic factors that inhibit or motivate it, including examining the underlying incentives that explain current behavior and considering why certain factors affecting stakeholder behavior exist in the first place. The process then identifies champions or spoilers in terms of promoting new behaviors and concludes with planning interventions that can and should be implemented. MCGL envisions working closely with local partners, stakeholders, and host-country governments to use the methodology, thereby creating capacity to address any subsequent or ongoing persistent issue. Note, as the process is

applied in the coming years to different entrenched obstacles, this document will be updated to reflect examples and lessons learned.

STEP 1: SELECT BF-APEA AREA OF FOCUS

This step is critical to delineate key domains in which program teams and other stakeholders can identify behavioral chains that support or hinder outcomes of interest. Health systems are complex, shaped by a multiplicity of actors designed to achieve diverse goals and objectives. For programs supporting change across many key domains of the health system related to, say, MNH, family planning, and infectious disease, the risk is selecting a focus area that is too general to provide the basis for targeted, **applied** analysis. Therefore, the BF-APEA process begins with teams **defining a narrow area of focus** that makes it possible to identify practical, concrete interventions.

Selecting the area of focus

Because selecting the area of focus frames the rest of the analysis and subsequent work, identifying the right area of focus is a critical starting point. The aim should be to craft the **narrowest possible statement of intent** around a prioritized issue of concern. Statements such as **improved health service delivery** or **strengthened implementation of health guidelines** are too broad to provide adequate focus and are not easily measurable.

In some cases, the project may have extensive research and understanding of the entrenched obstacles inhibiting progress toward the program goal (i.e., improved maternal health) that can be used to answer the questions below and ultimately determine the area of focus most in need of the BF-APEA. In other cases, a project might need to conduct a broader landscape analysis or rapid assessment to understand where key gaps in progress and understanding exist.

To determine the area of focus for the BF-APEA, consider the following questions:
1. **What change or progress (impact) does the project hope to see within the next five to 10 years?** Specify exactly what change the project wants to affect. This impact will often be predefined by existing strategic parameters such as government strategies, USAID's Country Development Cooperation Strategy, or others. For example:
   • Decrease in all-cause maternal mortality from X to Y; decrease proportion of maternal mortality due to indirect causes from X to Y
   • Reduce overall infant mortality from X to Y; decrease rate of mortality for small and sick newborns from X to Y; increase percentage of babies who are resuscitated at birth
   • Reduce persistent acute malnutrition from X to Y

2. **What is currently impeding that progress?** Use existing or new research to be as specific as possible in identification of the challenges. For example:
   • Lack of Respectful Maternity Care throughout the spectrum of care, from pre-pregnancy, through ANC to delivery and post-natal care.
   • Untimely referral of complicated deliveries from primary to tertiary facilities
   • Inadequate care for small and sick newborns in facilities and post-discharge
   • Professional culture driven by blame without opportunity for reflection or growth
   • Lack of adequate water-use management policy implementation and accountability

3. **What are the criteria for selecting the area of focus?** Consider the list of challenges created and prioritize the criteria in selecting the area of focus. The BF-APEA process will walk stakeholders through this decision-making process across a number of categories, including:
   • Relative importance of issues in achieving impact
   • Magnitude of problem
   • Level of intractability of issue or progress in recent years
   • How much we already know about the drivers of the issue
   • Potential influence of interwoven systemic and institutional factors
   • The extent to which a challenge is a higher priority for country-level partners, donors, or other key stakeholders

- The likelihood that a challenge may serve as a proxy for other important challenges

Ultimately, the choice of an area of focus is subjective, but it should be based on the answers to these questions. Although the BF-APEA could be applied to solving any number of challenges, it is helpful to start with one, as it keeps the analysis focused and grounded in measurable programmatic objectives. Further, learning uncovered in the analysis relating to one challenge will likely have a spillover effect and provide insight into others.

STEP 2: MAP BEHAVIOR TO AREA OF FOCUS

The prioritized set of **behaviors** that contributes to the intended outcome represents the practical focus of the BF-APEA inquiry. During Step 2, program teams are tasked with mapping behaviors that have bearing on the area of focus. Through the process, teams may map numerous behaviors that have some relationship to solving the issue in question. The behaviors that have the most bearing on that issue become the focus of the BF-APEA process.

The core of this step is answering the question: **to resolve this issue, who needs to do what?**

A desk review of epidemiology and subsequent discussion with expert stakeholders can help to generate an answer. In other cases, program teams and the broader health community may have less information with which to identify key behaviors. Where information is lacking, start by conducting research that answers these questions: What are the underlying incentives and interests that have constrained past efforts to address the issue? What key stakeholders have a role in addressing the issue, and what influences their relative support, opposition, or indifference? Answering these and related questions can involve multifaceted research, and a research plan may need to be developed that includes gathering epidemiological data (i.e., which behaviors impact a particular issue) and/or data about behaviors of key actors within the health system (i.e., funding decisions, policymaking, or administration of a ministry or department). Annex 1 provides a full set of the types of questions that should be answered.

What if behaviors cannot be readily identified?

In some cases, project teams or national counterparts may have a strong foundational understanding of the problem under consideration and be able to readily identify key associated behaviors. In other cases, the issue may be less well understood and teams may not know where to begin mapping key behaviors.

For issues that are less well understood, formative assessment may be critical. In addition to a desk review of key epidemiological and other relevant data, teams may need to probe the background context of the issue in question. This can mean taking an initial snapshot of the basic political economy to uncover key incentives, motivations, and other drivers of the local system. Even a rapid context analysis built around a limited set of focus group discussions and key informant interviews can provide project teams with a stronger understanding of the relevant actors and the constraints they face. Much of the information uncovered at this stage can be reused in Step 3.

The output of this step is a list of potential behaviors that might resolve the focus issue. Each behavior is written from the viewpoint of the primary actor for that behavior. The initial list generated from this exercise should be a representation of the ideal ecosystem, listing **all** ideal practices by **all** relevant primary actors required. This first list will likely be extensive. An example can be found in Table 1.

Table 1: Example initial mapping of behaviors

To resolve the issue of ineffective and incomplete antenatal care (ANC), extract a list of behaviors that answer the question: Who needs to do what? The list could be long and might include the following.	
Policymaker/manager level: • Managers ensure that all team members have clinical skills required to follow all routine care protocols during ANC. • Managers ensure respectful maternity care is part of the quality assurance and supervision provided at facilities. • Managers ensure that facilities are appropriately staffed, equipped, and stocked with supplies and medicines according to standards for that level of facility. • Managers identify and resolve transportation challenges to referrals. • Policymakers extend access to ANC for remote settings. • Policymakers review and revise service hours for ANC to better match community needs and higher patient volume. • Policymakers ensure adequate funding for eight visits.	**Family level:** • Couples use the voluntary family planning method of choice to delay first pregnancy and intentionally time and space subsequent pregnancies. • Couples seek the first ANC appointment as soon as the woman knows she is pregnant. • Couples continue to attend regular ANC appointments (at least four or eight, depending on country guidelines) throughout pregnancy. • Couples plan transportation and other resources required for each ANC visit. • Couples discuss danger signs in pregnancy and labor with primary care provider and a referral process, should it be necessary. • Couples decide what family planning method is appropriate for post-delivery and make plans. • Couples ask questions and express concerns or wishes with the provider freely. • Couples understand the value of, and support, quality, effective ANC for the health and well-being of the mother and fetus.
Primary provider level: • Providers consider a woman and her family as partners in care, rather than recipients of care. • Providers engage the family team in all aspects of ANC, including sharing exam findings, to demonstrate value. • Providers follow all protocols, including screening for gender-based violence and higher-risk delivery, at each visit. • Providers meet regularly to identify weaknesses or issues presenting challenges for the team as a means of ongoing quality-of-care improvements. • Providers debrief on challenging cases and identify opportunities for future improvement. • Providers clarify when and how referrals occur, including data feedback on cases once referred.	**Community support level:** • Community leaders serve as part of an active feedback loop between community members and the health facility staff, ensuring clear communication and understanding of community perceptions and needs for health services. • Community leaders resolve transportation issues for ANC and facility delivery (community moto-ambulances, waiting shelters, etc.). • Community leaders encourage delayed first pregnancy for all adolescents through use of a modern contraceptive method. • Community leaders empower families to actively plan fertility. • Peer groups actively support pregnant women to reduce their workload.

After generating the initial list, project teams must carefully consider the list of potential behaviors and identify those **most likely to have an impact** on the issue within the timeframe and with the resources available. All the behaviors on the initial list are likely not equal in their importance or proximity to the outcome. Further, although the behaviors were identified for their potential impact on the issue selected in Step 1, many might also contribute to other critical related issues, such as intrapartum care, postnatal care for the mother-baby dyad, postpartum family planning, and essential newborn care. To determine which behaviors to prioritize, a variety of objective and subjective criteria should be considered. Table 2 shows one way to organize the data. Often, quantitative data are not available on the potential behaviors, so consider scoring each behavior against each criterion on a five-point scale (1 = lowest, 5 = highest) to help think through relative priorities of possible behaviors.

1. Consider the current prevalence or uptake of the behavior: what percentage of the primary actor group is currently practicing the behavior? In many cases, quantitative data will not exist for all behaviors, so consider scoring each using the strength of evidence from all sources.

2. Consider the size of the gap between the current practice of the behavior and the ideal.

3. Consider the behavior's potential to impact the focus issue.

4. Estimate the feasibility of change, given the resources available as well as what is known about the participant group's willingness to practice the behavior. More profound and detailed insights will be generated on this question in the next step; at this stage, simply consider the relative feasibility of change of one behavior over another.

Teams should select the five to eight behaviors with the highest average score to target. As the team makes progress toward achieving these behaviors, they can add new behaviors.

Table 2: Example initial mapping of behaviors

Potential behaviors by primary actor	Behavior prevalence	Behavior gap	Potential to impact results	Feasibility of change	Average score across all columns

STEP 3: CREATE PATHWAYS

Using the list of prioritized behaviors selected in Step 2, create pathways to change behaviors. These pathways are established by creating a **behavior profile** for each priority behavior (Figure 2). A behavior profile takes the complexity of human behavior and identifies (a) the steps needed to practice the behavior, (b) factors inhibiting or supporting the behavior, (c) necessary supporting actors required to enable the behavior, and (d) strategies to achieve the change. Although the behavior profile provides a quick, user-friendly reference for program teams or policymakers, each category of information is underpinned by a more complete analysis. This analysis can be done at a high level for country-level strategies and planning or at a micro-level to create detailed implementation plans.

FIGURE 2: EXAMPLE BEHAVIORAL PROFILE

STEPS	FACTORS	SUPPORTING ACTORS	STRATEGIES
What steps are needed to practice this behavior?	*What prevents or supports practice of the behavior?*	*Who must support the practice of the behavior?*	*How might we best focus our actions?*
Behavior	**Structural**	**Institutional**	**Enabling Environment**
1. Step	Accessibility	Policymakers	Financing
2. Step	Opportunity	Managers	Institutional Capacity Building
3. Step	Incentives	Logistics Personnel	Partnerships and Networks
4. Step	Rules	Step Providers	Policies and Governance
	Service Provider Competencies	Employers	
	Service Experience		**Systems, Products and Services**
		Community	Infrastructure
	Social	Community Leaders	Products and Technology
	Peer and Community Support	Religious Leaders	Supply Chain
	Gender	Teachers	Quality Improvement
	Religious or Cultural Norms		
		Household	**Demand and Use**
	Internal	Family Members	Advocacy
	Emotions	Male Partners	Communication
	Aspirations		Collective Engagement
	Attitudes and Beliefs		Skills Building
	Self-Efficacy		
	Knowledge		
	Skills		

A) STEPS TO PRACTICE THE BEHAVIOR

The steps of the behavior are written from the primary actor's viewpoint. They help to define the behavior by identifying small actions that the primary actor needs to do to practice the behavior. Steps are not necessarily sequential. If the primary actor follows these steps, they have practiced the behavior.

B) FACTORS INHIBITING OR SUPPORTING THE BEHAVIOR

Factors refer to the features of the local system that have a positive or negative bearing on the desired behavior. Factors may be complex **norms**, **values**, **attitudes**, or **beliefs** that tend to change slowly over time, or may be more temporal and immediately subject to influence, such as **laws, policies, and regulations; service provider competencies;** and **organizational capacity and culture**. The factor categories (structural, social, internal) outlined here help users to systematically consider the kinds of factors that may impact a behavior and how they relate to each other. These factors are defined in Annex 2.

This step of the process helps users to unpack why certain factors are present, determine their influence on the behavior in question, and consider and weigh each factor's relative influence on the behavior and other factors. Appropriately leveraging the factors that impede or motivate practice of a priority behavior is the most critical driver of success. For example, the right **laws, policies, and regulations** may be in place but are not enforced, or service providers may have been trained in the right skills but are not practicing the skills regularly to ensure competency.

C) SUPPORTING ACTORS AND THEIR ACTIONS THAT ARE NECESSARY TO ENABLE THE BEHAVIOR

Often, the primary actor cannot practice the behavior without the support of others, including supporting actors at the institutional, community, and household levels. In cases where the project team and local stakeholders have a deep understanding of key actors, it may be relatively easy to map their current roles versus the role they need to play relative to the desired behaviors. However, in many cases, teams may lack sufficient understanding of the supporting actors. Research during Step 2 defines critical actors, allowing teams to better understand primary and secondary actors' interdependency. This research and additional

consultation during Step 3 will identify the extent to which different actors represent champions and spoilers (and those in between) of key primary actor behaviors, as well as their relative power and influence on the behavior. This analysis can inform teams' understanding of what actions supporting actors need to take (or actions they need to cease) to achieve the behavior.

Importantly, the strategies identified in the next step often involve the supporting actors as much as the primary actor. If the primary actor is, for example, a provider, but policy support is critical for that provider to carry out certain actions, a strategy would focus on engaging the relative policy-level supporting actor. The methodology recognizes the importance of and results in a process to ensure engagement with the ecosystem in which the primary actor lives, works, and makes decisions, considering actors at all levels and within all spheres of influence.

D) STRATEGIES TO ACHIEVE THE CHANGE

The final substep is determining appropriate strategies or activities to address the factors and engage the supporting actors. Strategies describe how to overcome a factor that inhibits practice of the behavior (barrier) or to leverage a factor that supports its practice (motivator). Strategies can incorporate a supporting actor's activity to address the factor or can address a supporting actor who must act before the primary actor can practice the behavior. Strategies complete the pathway to change, with each factor requiring a strategy designed explicitly to address it. Sometimes, one strategy might address more than one factor; other times, one factor might require a dedicated strategy.

Importantly, to change a specific behavior, multiple strategies are nearly always necessary, which might require different kinds of expertise. For example, to improve comprehensive delivery of quality ANC, strategies such as transportation vouchers, conditional cash transfer-based incentives, community support for childcare, performance accountability measures for providers, and community–facility feedback loops might all be required, depending on the factors uncovered (Figure 3). In addition, if a program has prioritized multiple behaviors (in Step 2), it will be important to look across the profiles created for each behavior to identify synergies and efficiencies, as well as opportunities to share accountability for outcomes among actors within the system. This effort can culminate in development of a results framework to guide implementation, or more simply, a set of recommendations on next steps.

FIGURE 3: EXAMPLE STRATEGIES TO ACHIEVE CHANGE FOR COMPREHENSIVE ANC DELIVERY

- Community–facility feedback loops
- Transportation vouchers
- Conditional cash transfer-based incentives
- Community support for childcare
- Performance accountability measures for providers

At this stage, teams should identify strategies that can be realistically implemented in the local context by analyzing the entrenchment of primary and secondary actors' interests and incentives for change versus the status quo, research undertaken in Step 2 and validated in Step 3. Regardless of how strategies are identified, however, it will always be critical to test or validate them to ensure that they are a best fit for the local context. At a minimum, program teams should review the behavioral profiles with focus groups or small workshops of key stakeholders to confirm their validity. Programs may also use a human-centered design (HCD) approach when working with local stakeholders to design concrete interventions to put strategies into action. Trials of improved practices, or similar approaches, provide effective methodologies for considering how key users (e.g., supporting actors) will likely apply strategies. This process may generate additional strategies that can be built into an intervention approach. Alternately, programs may carry out a more

formal HCD process to design scalable strategies, using the factor and supporting actor analysis to frame the design challenge.

STEP 4: TRACK AND ADAPT

Historically, most performance metrics used in a performance monitoring plan have quantified the efforts of projects rather than their influence on people, systems, and institutions. Using data to understand incremental progress and change for people, systems, and institutions is essential. The BF-APEA offers an opportunity to create (1) outcome indicators that measure true results and (2) a compelling set of intermediary indicators as measures of factors.

BEHAVIORAL OUTCOMES

Behavioral outcomes help monitor progress toward long-term, sustainable change in the conditions and behaviors of people, functionality of systems, and effectiveness of institutions. Examples of traditional performance metrics include: *number of community health workers trained using donor funding, number of books distributed in targeted districts, number of school meal programs established in the last 12 months.* These important output metrics help programs quantify their efforts and boost accountability for themselves, their beneficiaries, and donors. But they tell us little about the activities' effect and do not create accountability beyond implementation of a plan. In contrast, for each priority behavior identified, the BF-APEA supports programs to define a corresponding indicator to measure the change in that behavior, that is, the behavioral outcome.

FACTOR OUTCOMES

In addition, the BF-APEA supports programs to create a set of focused factor outcome indicators to measure progress along the pathway. This kind of data is critical for adaptive management, allowing teams to pinpoint where, along the pathway, progress is advancing or stagnating. Importantly, these kinds of indicators are often not captured through routine data gathering, so programs will need to consider which indicators to monitor and ensure appropriate resources to track them, including considering how to build them into routine monitoring and evaluation processes. Factor outcome indicators might include those listed in Table 3.

TABLE 3: EXAMPLES OF FACTOR OUTCOME INDICATORS

Sample factor outcome indicators	
Behavior: Pregnant women complete a full course of quality antenatal care (ANC)	
Factor	**Indicators**
Pregnant women cannot complete ANC due to the costs involved, such as transport to a clinic.	Among women delivering at facilities, the percentage who report not completing four ANC visits because of the costs involved
Pregnant women do not obtain quality ANC because providers do not effectively communicate relevant technical information.	Among pregnant women who obtained ANC services in the last 30 days, percentage who said they did not understand their service provider's guidance or feedback
Pregnant women do not seek ANC early or regularly because they do not understand the benefits of early or regular care.	Among women delivering at facilities, the percentage who report not completing four ANC visits because they do not understand the benefits

Note: This table is illustrative. Actual indicators should be based on the factors identified in each profile.

CONTEXT INDICATORS:

In addition to tracking behavioral and factor outcomes, programs may find it useful to monitor a set of basic, easy-to-track context indicators that signal changes in the overall operating environment that may affect desired outcomes. Context indicators may directly relate to the health sector, such as *leadership changes within the ministry of health and related health sector institutions* or *incidence of health sector labor disputes*. In more volatile environments, programs may use context indicators to highlight sociopolitical dynamics that may impact the ability of key actors to commit to new behaviors.

See Annex 3 for an example dashboard for monitoring changes in factor-level indicators.

Both quantitative and qualitative data should be used to measure these indicators, ensuring that the people and behavior-led approach laid out in the BF-APEA and used to develop the strategy are not forgotten in its monitoring. As strategies and interventions from the behavioral profile are carried out, program teams should continually validate the extent to which they are meeting with resistance, gaining traction, or contributing to unexpected outcomes. This process will be aided by careful selection of indicators, as described earlier, as well as regular contact and engagement with stakeholder groups to discuss externalities and participate in process reviews designed to facilitate broader discussion on the entire implementation. Cohort monitoring, digital surveys, feedback forms, and including stakeholders in quarterly review sessions of monitoring data are all opportunities to ensure this takes place.

VI. OPERATIONAL CONSIDERATIONS

Conducting a BF-APEA can be a short, focused effort to unpack and clarify specific issues related to clearly defined development objectives or a longer, more involved process to facilitate country stakeholders to articulate an entire strategy from vision to output. The need for varying levels of effort will depend entirely on where a country or group of stakeholders starts in terms of clarity on the area of focus, what is or is not already known about the topic area, and how much existing or new information they will need to gather. Cost inputs will also vary, but the approach should not be cost-prohibitive since the primary costs are for staff time. In addition, the process should always be conducted in partnership with country stakeholders to ensure that, in the future, they can replicate it to address additional challenges with no or minimal technical assistance. Annex 4 contains a more detailed breakdown of considerations for operationalizing each step of this process.

ANNEX 1: CONSIDERATIONS AND EXAMPLES FOR PRIMARY DATA COLLECTION

Although frequently a BF-APEA can be conducted through applying a different perspective and interpreting existing published and grey literature on a particular persistent issue, gaps can be encountered in existing literature. In particular, understanding the vision, motivations, incentives, and constraints from the perspective of policymakers or decision-makers within the health system are not widely documented. As such, targeted key informant interviews (KIIs) and focus group discussions (FGDs) may be necessary at multiple stages of the BF-APEA process to complement the desk-review process, including:

- Step 1, to develop a stronger foundational understanding of the overarching issue and select the area of focus for the activity
- Step 2, to begin identifying key information related to stakeholder and institutional behaviors
- Step 3, to identify pathways to desired behaviors and unpack the factors that serve as obstacles or motivators for the expression of the desired behavior

Interview guides can provide a basic structure for KIIs and FGDs. These guides should be tailored to the activity being conducted and the relevant step of the BF-APEA process. Thus, KIIs or FGDs during Step 1 may be broad in nature, oriented toward establishing a formative understanding of key issues. Interviews during Step 3 may focus on understanding one narrowly defined factor that is relevant to a desired behavior.

In most cases, KIIs and FGDs will be semi-structured. This means that the questions outlined in the interview guide provide scaffolding for and ensure a degree of continuity in the consultations. However, interviewers should feel free to ask follow-up questions or pursue lines of inquiry that arise over the course of the consultation.

Participating in (and conducting) KIIs and FGDs can be tiring. In developing interview guides, activity teams should ensure that the sessions are not too long. As a rule, teams should keep one-on-one KIIs to less than 60 minutes and FGDs to under 90 minutes. Depending on how open-ended the questions are, an interview guide may include anywhere from eight to 15 questions. **Teams should always seek informed consent before conducting interviews.**

Finally, diverse perspectives and experiences are valuable for any BF-APEA assessment team. Important perspectives may include individuals who are closely familiar with local community networks and issues and technical experts who understand the local health system. It can be helpful to have a behavioral scientist or someone expert in qualitative research or assessment supporting project teams to plan and execute data collection plans.

EXAMPLE QUESTIONS

The following represent questions that may be included in an interview guide focused on facilitating critical health care provider behavior change to improve the effectiveness of ANC. These and similar questions can be customized for different stakeholder groups or specific problem areas associated with ANC.

1. How long have you worked in this health center? Describe for me your role in the health center. 2. What is your role specifically in the provision (or oversight) of ANC or birth preparedness? 3. Have you worked at other health centers or in other parts of the health system? 4. How many patients per month receive ANC services?	*You may opt to begin with introductory questions focused on the individual respondent. These can build rapport and help you understand how the respondent relates to the subject.*

5. What policies and guidelines exist for guiding the provision of ANC? Have any new policies/guidelines been introduced in the past three years?
6. Have any recent policies/guidelines had a positive impact on the quality of ANC services at this health center?
   a. [**If yes:** Which policies/guidelines have had the greatest impact? Can you describe the impact?]
   b. [**If no:** Why do you believe recent policies/guidelines have not had a positive impact?]
7. What specific policies/guidelines have been the most difficult to implement in this health center? What has made these policies/guidelines difficult to carry out?
	You may want to probe into the formal rules (e.g., laws, policies, regulations, guidelines) and understand the extent to which they influence behaviors.

8. Where do you feel there has been the most improvement in the provision of ANC? What do you believe led to those improvements?
9. What aspects of ANC do you believe could be further improved? Please explain your answer.
10. Where have you seen health center staff struggle most with providing optimal ANC? *[Note: A version of this question could probe into specific aspects of ANC, such as screening for hypertension.]*
   a. Why do you believe health center staff struggle in these areas?
11. When health center staff have difficulty meeting ANC service requirements, do they receive any additional support?
   a. [**If yes:** What kind of support do they receive?]
   b. [**If no:** Why don't health center staff receive greater support for meeting ANC service requirements?]
12. From your experience, what would most help you provide effective ANC? Please explain your answer.
	You may want to combine open-ended questions that allow respondents to identify factors that explain key results or behaviors, while also probing into factors such as resource and administrative constraints. It is often most effective to depersonalize questions that could have a negative connotation, such as questions related to negative outcomes or "poor" behavior.

ANNEX 2: FACTOR DEFINITIONS

The table below presents a standard set of definitions for the kinds of factors that the BF-APEA considers. The breadth of these factors helps ensure that the analysis considers an actor's behavior from a comprehensive perspective, offering a lens which anyone—a behavioral scientist or not—can easily use to begin to unpack and map pathways to change. Each factor can be a motivating or inhibiting factor. Although this list is not exhaustive of the kinds of factors that might exist, it does provide a strong foundation for an analysis. These factors themselves are derived from a combination of different theories of behavior change, including the social-ecological model and others, but it is important to note that the theory and subsequent categorization of factors is less critical than simply approaching the exercise of a BF-APEA without pre-conceived ideas of what factors might be. These are meant to serve as a guide for analysis, not as a template or theory of change, as each human being and each behavior are different.

Factors to consider	Definition	Factor aspects
STRUCTURAL		
Accessibility	The primary actor's physical or logistical, usually external, constraints, or lack thereof, to practice the behavior	• Distance and transport • Availability of needed resources or inputs • Physical access
Opportunity	A set of circumstances, usually external, that impact the primary actor's practice of a behavior.	• Cost • Time • Opportunity Costs • Privacy
Incentives	Visible or invisible motivation for carrying out behavior	• Direct or indirect monetary payment • Social reward or social benefit • Personal growth or benefits • Punishments or reverse incentives
Rules	The formal or informal rules governing actors within a system	• Policy, law and regulation • Penalties or punishments for breaking rules • Informal, invisible rules and standards of practice
Service provider competencies	The primary actor's perception of the competency of those providing the service *(Note: This is only applicable if the primary actor uses a service. If the service provider [e.g., a health worker, government employee, or business] is the primary actor, their actual competencies should be considered under "skills.")*	• Communication • Clinical proficiency or skills • Effective soft skills such as communication and attitude toward client • Efficiency
Service experience	The primary actor's perception of their overall experience with structural aspects, such as infrastructure, equipment, and response time when receiving the service. For providers or systems actors, can also include levels of support for carrying out duties, needed supervision and openness to learning and growth.	• Equipment • Infrastructure • Waiting times • Service hours • Supportive policies • Perception of quality
SOCIAL		
Family, peer and/or community support	Proactive or passive help, encouragement, or attitudes toward a behavior by family members, peers, colleagues, or others in the community at large	• Monetary or material support • Moral support • Acceptance and approval • Task support • Collective action • Supporter knowledge

Factors to consider	Definition	Factor aspects
Gender	The specific influence of gender dynamics or relationships on the practice of a behavior	• Decision-making • Control of income • Status and value of girls and women
Religious and Cultural Norms	The acceptability and standards for practice of a behavior dictated by religious, cultural, or other social networks, including workplace norms	• Standard practice • Expected practices • Sanctions and enforcement
INTERNAL		
Emotions	The primary actors subconscious, habitual, intuitive or emotional response to practice of a behavior	•
Aspirations	The primary actors hopes, dreams and ambitions that influence practice of a behavior	•
Attitudes and beliefs	The primary actor's personal judgment, feeling, or emotion toward a behavior	• Perceived value of the behavior • Perceived threat, fear, or consequences of the behavior • Perceived convenience • Perceived identity with the behavior • Emotional response to the behavior
Self-efficacy	The primary actor's personal confidence in their ability to exert control over successfully practicing a behavior *(Note: This factor may not be applicable in many cases beyond health.)*	• Confidence in ability
Knowledge	The required information the primary actor has to complete a set of actions or practice a behavior completely and competently	• Awareness • Understanding • Information
Skills	The primary actor's ability to completely and competently perform a set of tasks	• Learned ability

ANNEX 3: SAMPLE BEHAVIORAL OUTCOMES DASHBOARD

This dashboard depicts the kinds of indicators that might be measured after conducting a BF-APEA. The actual indicators will depend on the behaviors prioritized and factors identified as critical to enabling those behaviors.

Think | BIG Indicator Tracking Table																	
Indicators	**Desired Direction of Change**	**Baseline**		**Year 1**			**Year 2**			**Year 3**			**Year 4**			**Year 5**		
	(+ or -)	Date	Actual	Target	Actual	Change	Target	Actual	Change	Target	Actual	Change	Target	Actual	Change	Target	Actual	Change
GOAL: Reduce Maternal Mortality by 50% in 5 years																		
IMPACT INDICATOR																		
Number of maternal deaths per 100,000 live births (MMR)	-	2020	512													256		
BEHAVIORAL OUTCOME INDICATOR 1—PREGNANT WOMEN COMPLETE A FULL COURSE OF QUALITY ANTENATAL CARE (ANC)																		
Percentage of women who have had a live birth in the three years preceding the survey who received full, quality ANC (4+ visits, quality counseling, all necessary services, tests and engagement)	+	2020	57%							60%						75%		
FACTOR-LEVEL INDICATORS—REFLECTING WHY WOMEN CURRENTLY DO NOT ALWAYS COMPLETE A FULL COURSE OF QUALITY ANC																		
Among women delivering at facilities, % who report understanding the benefit of complete ANC, starting in the first trimester	+	11/20	28%	35%			40%			45%			55%			65%		
Among women delivering at facilities, % who report being able to complete 4 ANC visits because they are free or affordable	+	11/20	60%	65%			70%			75%			80%			85%		
% public facilities with consistent supply of commodities and technologies required to offer all components of ANC to all women	+	11/20	40%	45%			60%			70%			80%			90%		
Among providers providing ANC, % who report accurate knowledge of protocols for management of pregnancy-related hypertension	+	11/20	31%	40%			50%			55%			60%			70%		
BEHAVIORAL OUTCOME INDICATOR 2—PREGNANT WOMEN DELIVERY IN A FACILITY WITH AN EQUIPPED, QUALIFIED PROVIDER																		
Percentage of births in the three years preceding the survey attended by a qualified provider in a health facility	+	2020	39%							50%						60%		

Think | BIG Indicator Tracking Table																			
Indicators	**Desired Direction of Change**	**Baseline**		**Year 1**			**Year 2**			**Year 3**			**Year 4**			**Year 5**		
	(+ or -)	Date	Actual	Target	Actual	Change	Target	Actual	Change	Target	Actual	Change	Target	Actual	Change	Target	Actual	Change
FACTOR-LEVEL INDICATOR—REFLECTING WHY WOMEN CURRENTLY DO NOT ALWAYS COMPLETE A FULL COURSE OF QUALITY ANC																		
% public sector health facilities that provide free maternity care to all pregnant women, per national policy	+	11/20	75%	80%			85%			90%			95%			99%		
Among women who gave birth in the previous three years, % who complete a birth plan prior to birth that identifies transportation plan and child care plan for other children	+	11/20	10%	15%			20%			30%			50%			60%		
Among women who gave birth in the previous three years, % who believe that a facility birth with a trained provider is safer than a birth attended by a traditional attendant at home	+	11/20	40%	45%			50%			60%			70%			80%		
Among providers facilitating safe deliveries, % who believe the woman and her family should be actively involved in aspects labor and delivery (cord clamping, catching baby, etc.)	+	11/20	2%	10%			20%			30%			40%			50%		
% public sector health facilities that permit women to labor in different positions and facilitate client's adherence to traditional post-birth practices (such as burial of placenta)	+	11/20	4%	10%			20%			30%			40%			50%		

ANNEX 4: OPERATIONAL CONSIDERATIONS FOR IMPLEMENTATION OF THE BF-APEA

This table is a snapshot of the level of effort and time required for each step of the BF-APEA. It includes an in-depth exercise as well as a rapid version. The choice of in-depth versus rapid (or somewhere in between) can be made based on resource availability and time pressure. The issue's complexity and the breadth of involved actors should also be considered. For both, it is critical to note that the timelines and illustrative activities are just estimates and much of the process will be influenced by the topic area, the degree of prior understanding, and available information on the topic area that can be assessed, organized, and structured within the BF-APEA framework.

Step	In-depth BF-APEA exercise		Rapid BF-APEA exercise	
	Timeline	Illustrative activities/inputs	Timeline/resources	Illustrative activities/inputs
Step 1: Select area of focus	**1–3 weeks**, depending on the preexisting clarity around project goals, key issues, and research topic	• Define and articulate goal/objectives and identify persistent issues and research topic. • When dealing with a complex topic with minimal prior understanding, more significant primary or secondary research could be required. • Workshop or focus group discussions (FGDs) are often required to develop, confirm, and socialize understanding of the selected focus. *3–15 days level of effort (LOE), workshop costs, travel and associate resources for any additional primary research activities*	**A few days;** teams should typically have existing clarity around the activity topic for rapid exercises	• Staff meet to define and articulate project goal/objectives and identify persistent issues and research topic. • A workshop or FGD may be required to validate and socialize focus topic. *2–5 days LOE, workshop/FGD costs (if required)*
Step 2: Map the behavior	**1–4 weeks**, depending of the complexity of mapping key behaviors	• Conduct secondary and primary research aimed at identifying key behavioral issues. *(Note: Depending on the extent of secondary literature available, more or less primary research may be necessary at this stage.)* • Identify and rank behaviors, often in participatory workshop(s). *7–20 days LOE, workshop costs, travel and associated costs for primary research activities*	**A few to 10 days**	• Conduct secondary and primary research aimed at identifying key behavioral issues • Identify and rank behaviors, often in participatory workshop(s) *3–10 days LOE; workshop costs; travel and associated costs for primary research activities*
Step 3: Create pathways	**1–4 weeks**, depending on the complexity of pathways and the extent of research required for understanding key factors	• Conduct workshop(s)/FGDs to identify steps to desired behavior, as well as key factors and supporting actors. • As required, conduct primary and secondary research to understand the drivers of key factors. • Conduct workshop(s) to develop strategies to change behavior. *7–20 days LOE, workshop costs, travel and associated costs for primary research activities*	**A few to 10 days**	• Conduct combined workshop(s) focused on identifying steps to desired behavior, key factors/actors, and strategies. • As required, conduct targeted primary/secondary research to understand drivers of key factors. *3–10 days LOE, workshop costs, travel and associated costs for primary research activities*
Step 4: Track and adapt	**2–4 weeks to duration of implementation**	• Based on identified behavioral outcomes and factors as part of pathways, craft or identify indicators for each behavior and at least two or three critical factors. Base indicator selection on a survey of existing data and globally accepted standards of measurement, when feasible. Craft new indicators along with corresponding reference sheets when necessary. • Support creative opportunities for data monitoring, including cohort monitoring, digital feedback surveys, peer monitoring, and other low-intensity options. • Provide periodic support (quarterly or annually as required) to analyze and discuss monitoring data and adapt implementation as necessary.	**2–4 weeks**	• Based on identified behavioral outcomes and factors as part of pathways, craft or identify indicators for each behavior and at least two or three critical factors. Base indicator selection on a survey of existing data and globally accepted standards of measurement when feasible. Craft new indicators along with corresponding reference sheets when necessary.

ANNEX 5: EXAMPLE APPLICATION OF BEHAVIORALLY FOCUSED APPLIED POLITICAL ECONOMY ANALYSIS

Note: This annex will be completed once the BF-APEA is applied in MCGL Project Year 2.