**Country: Togo**

**Title of Action Research Project:** Action Research Study on the Behavioral Determinants to Bed Net Usage to Inform the 2017 National Bed Net Distribution in Togo

**Action Research Team Members:**

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The action research taskforce was formed in November 2016 and includes members of the PC Togo Malaria Action Committee (MAC) and the PC Togo M&E Committee.

**Introduction:**

Malaria continues to be the number one cause of mortality among children under 5 in Togo. In contrast, malaria is only the third cause of death following pneumonia and diarrhea on the African continent. In fact, only 22% of African countries have malaria as their leading cause of childhood death (*UNCIEF, 2015*). Even in West Africa, the average cause of U5 death is pneumonia (20.6%) followed by malaria (18.8%) and diarrhea (14.1%) (*UNICEF, 2015*). Non-fatal malaria cases in Togo are widespread as well. Malaria prevalence among children aged 6-59 months is 36% with more of a burden in rural areas (47%) compared to urban (15%) *(DHS, 2013-2014*). The skewed burden of malaria on Togo has created a mandate for the development community to work together to decrease all cases of malaria, both fatal and nonfatal. Using an insecticide-treated mosquito net (ITN) has been proven as one of the accelerated behaviors for improving malaria health outcomes (*USAID, 2016*).

The Togolese Ministry of Health's National Program for the Fight Against Malaria (in French- PNLP) and its partners are planning a national bed net distribution in 2017. Peace Corps (PC) Togo has historically played a noteworthy role in these campaigns, mostly through Peace Corps volunteers helping at the village distribution level. Even though bed net coverage is extensive (according to the DHS 2013-2014 study, 63% of households have at least one ITN), especially after national bed net campaigns, usage remains low even among priority groups. Only 61.2% of mosquito nets available are used (*DHS 2013-2014*). Just following the 2011 distribution, this percentage went as high as 71.4% (*Peace Corps, 2013*). However, according to the DHS, only 34% of the population (on average) reported that they had slept under a mosquito net the night before. 43% of children under 5 slept under a mosquito net the night before the data collection interview (*DHS 2013-2014*). This data clearly demonstrates the gap between availability and usage. Just because people have mosquito nets does not guarantee usage and a subsequent causal decrease in malaria cases. National bed net distributions are extremely costly and require many resources and manpower; thus, it is critical that we focus on behavior change. Otherwise, all of these resources, time, and money will have been wasted.

Before this study, no formal research had taken place to quantitatively determine barriers to the target behavior of repetitive bed net usage. Peace Corps Togo, with over 90 Peace Corps Volunteers (PCVs) in the field who are integrated into their communities, has a unique strategic position to be able to provide the PNLP and its partners with behavioral data. From November 2016 to May 2017, the action research team in Togo implemented a national study on the determinants to bed net behavior change. PC Togo then hopes, by working with the PNLP and Catholic Relief Services, to use this data to inform distribution communications as well as to develop messaging and campaign materials for Community Health Workers (CHWs) and other community health agents (e.g. health talk guides, posters, etc.). This way, we will potentially see not just an increase in access, but also in usage and positive health outcomes, derived from the 2017 bed net distribution.

**Methodology:**

This study uses the Designing for Behavior Change (DBC) Framework (*CORE Group 2008)* and identifies determinants using a barrier analysis (BA). DBC Framework is a project design tool that provides targeted activities and interventions based on formal research of the barriers to a specific target behavior. It takes the guesswork out of project development through a step-by-step and research-focused approach. Barrier Analysis is a qualitative rapid assessment tool originally created by Feed the Children that identifies the most important obstacles to behavior change. This methodology is widely used in behavior change projects among international development agencies. To align itself with this international push towards sustainable behavior change and data-driven interventions, Peace Corps, as an agency, has made a fundamental programmatic shift towards the DBC Framework globally. The shift was prompted by an agreement signed in 2015 between Peace Corps and USAID's Ending Preventable Child and Maternal Deaths (EPCMD) initiative, which encourages target and non-target countries to adopt the DBC methodology.

**Summary:**

This research projects plays upon the accelerated behavior of insecticide treated net use. The target behavior is as follows: mothers of children U5 put their children U5 underneath an insecticide treated mosquito net every night.

Researchers executed five barrier analysis studies throughout Togo, one per region, covering all five regions of Togo except for Lomé and its surrounding suburbs. Each regional study has the same target behavior. Due to the vast cultural and climatic diversity in Togo, researchers hypothesized that barriers and motivations to sleeping under a bed net differ per region. Data was collected mostly in rural zones, in which there is an elevated prevalence of malaria, and on populations that received mosquito nets during the last national bed net distribution in 2014. PCVs collected data in their own villages and in surrounding non-PC villages to get a roughly 50/50 PC/Non-PC sample. Respondents were mothers over the age of 15 who have at least one child under the age of 5 (with the exception of 5 surveys that were conducted with male caregivers with at least one child U5). Two categories of interviews exist: doers (users of mosquito nets) and non-doers (non users of mosquito nets). It is the statistically significant differences between these two groups that supply relevant behavioral information. Categorization of an interviewee as doer or non-doer occurred before the actual survey and was determined by specific criteria detailed in Section A of the survey. Doers, at a minimum, must have a functioning mosquito net (confirmed by direct observation) and put their youngest child under a mosquito net at least most nights (even if it is just during the rainy season). Most all doers also had put their child under a mosquito net the night before. Exceptions to this rule were in the Maritime region where the interviews took place during the hot season, and the climate is hotter than in other regions. Consequently, several mothers deviated from their normal behavior and did not put the child under the net the night before due to the heat. These mothers were still classified as doers as long as they answered all other questions in Section A as doers. Each PCV data collector threw out the first two surveys conducted for quality control purposes (exception- because of two surveys with missing information in the Central Region, two initial surveys were used in the analysis).

A total of 442 surveys were collected nationally. Breakdown per region can be found in Chart 2. Normally, the recommended total number of surveys for each BA study is 90 (45 doers and 45 non-doers). However, for the one study below the 90 survey total goal (Maritime Region), significant conclusions (p value <0.05) can still be reached. Six doer and five non-doer surveys from the Maritime region were stolen during a house robbery. These surveys are currently being redone. The Maritime region study still presented significant information, even with only 79 total surveys. Each PCV data collector conducted each interview with a Togolese counterpart, who assisted with translation from French into local language(s) and back into French. Each PCV then wrote responses in English. The Maritime Region had 3 data collection pairs (PCV-counterpart); Plateau Region had 2 pairs; Central Region had 4 pairs; Kara Region had 2 pairs; and Savanna Region had 2 pairs (refer to Chart 1).

Chart 1. Number of surveys collected per PCV data collector and per region.

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| --- | --- | --- | --- | --- |
| PCV  Data Collector | #Doer  Households | #Non-doers  Households | # Counterparts | Totals per region |
| Maritime #1 | 17 | 17 | 1 | 39 Doers  40 Non-doers  3 counterparts |
| Maritime #2 | 5 | 5 | 1 |
| Maritime #3 | 17 | 18 | 1 |
| Plateau #1 | 23 | 22 | 1 | 46 Doers  44 Non-doers  2 counterparts |
| Plateau #2 | 23 | 22 | 1 |
| Central #1 | 20 | 23 | 1 | 45 Doers  45 Non-doers  4 counterparts |
| Central #2 | 13 | 10 | 1 |
| Central #3 | 6 | 5 | 1 |
| Central #4 | 6 | 7 | 1 |
| Kara #1 | 22 | 23 | 1 | 45 Doers  45 Non-doers  2 counterparts |
| Kara #2 | 23 | 22 | 1 |
| Savanna #1 | 23 | 25 | 1 | 45 Doers  48 Non-doers  3 counterparts |
| Savanna #2 | 22 | 23 | 2 |

Each PCV data collector used one Togolese counterpart for all their surveys, with the exception of the 2nd data collector in the Savanna region, who used two different counterparts. Doers and non-doers were evenly split among each data collector per region as much as possible (Refer to Appendix). Participating households were selected using the "pen toss" randomization method.[[1]](#footnote-1) (Exception: for one village in the Kara region, interviews were conducted at every house in the direction indicated by the pen toss due to the dispersed layout of the village). PCVs were instructed to not do health talks during or after the surveys, even if questions were answered incorrectly. Data collectors started with Section A to distinguish if the participant was a doer or non-doer. If the data collector had enough of one group already, he/she continued using the randomization method until finding someone from the opposite group. Data collectors then continued onto Section B, which includes 15 questions addressing all 12 determinants.

Chart 2. Breakdown of surveyed sample (combined all 5 studies). n=442.

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| --- | --- | --- |
|  | Count | Percentage of total (n=442) |
| Sex  *Female*  *Male* | 437  5 | 98.87  1.13 |
| Age  *15-19*  *20-24*  *25+*  *NR* | 22  102  297  21 | 4.98  23.08  67.19  4.75 |
| Ethnicity  *Moba*  *Kabye*  *Watchi*  *Akebou*  *Lamba*  *Larni*  *Kotikoli*  *Bassar*  *Logba*  *Losso*  *Ewe*  *Other[[2]](#footnote-2)* | 96  88  76  40  36  22  22  17  6  6  6  29 | 21.04  19.91  17.19  9.05  8.14  4.98  4.98  3.85  1.36  1.36  1.36  6.56 |
| Religion  *Christian*  *Muslim*  *Animist*  *No Response*  *None* | 222  94  93  21  12 | 50.23  21.27  21.04  4.75  2.71 |
| Highest Education Level  *Elem. School*  *None*  *Middle School*  *High School*  *BPC*  *BAC*  *University*  *No response* | 174  157  83  4  3  3  2  16 | 39.37  35.52  18.78  0.90  0.68  0.68  0.45  3.62 |
| Participant attended PC training  *No*  *Yes*  *Doesn't Know*  *No response* | 375  53  3  11 | 84.84  11.99  0.68  2.49 |

**Trainings:**

**Summary of Trainings**

* *Pre-service Training; Aug. 2016; Cohort 2016-18; Yoonhee Ryder; technical deep-dives in early care-seeking for pneumonia, diarrhea, and malaria, hand-washing, and newborn health.*
* *Mid-service Training, Cohort 2015-17; Yoonhee Ryder and Ismael Morou; DBC Framework, Barrier Analysis, Malaria BA project.*
* *Inter-service Training; Nov. 2016; Cohort 2016-18 and their Togolese counterparts; Yoonhee Ryder, Samantha Cardwell, and Ismael Morou; DBC Framework, Barrier Analysis, Malaria BA project.*
* *PDM; Feb. 2017; Cohort 2016-18 and their Togolese counterparts; Yoonhee Ryder, Samantha Cardwell, and Ismael Morou; project logistics and local language translations.*
* *Pre-service Training; June 2017; Cohort 2017-19; Yoonhee Ryder and Ismael Morou; DBC Framework and Barrier Analysis.*

Yoonhee Ryder conducted a total of five trainings, in collaboration with several others, since return from the EPCMD Conference in Kigali, Rwanda, in June 2016. This includes an "EPCMD bootcamp" with the 2016-18 volunteer cohort CHAMP volunteers during their PST in August 2016. This bootcamp involved "deep dives" into early-care seeking for diarrhea, malaria, and pneumonia, hand washing, and newborn health. In September 2016, Yoonhee Ryder trained the 2015-17 on DBC Framework, the BA, and this specific project. In November 2016, Yoonhee Ryder and Malaria PCVL Samantha Cardwell trained the entire 2016-18 cohort and their counterparts on DBC Framework, the BA, and this specific project in two separate trainings. In February 2017, Yoonhee Ryder and Samantha Cardwell did a logistics translation with the data collectors and their counterparts. Local language recordings were also secured at this time. In June 2017, Yoonhee Ryder led a DBC framework and BA training with the 2017-19 volunteer cohort at their PST.

During the Nov. 2016 and Feb. 2017 trainings, counterparts were trained on how to successfully interview mothers. This included separating mothers from other family members during the interview, creating a non-judgmental and inviting space for open discussion, not asking leading questions, not giving away answers, translating word-for-word into local language and back into French, and always asking "what else." All PCV data collectors were also required to lead this training on-on-one with their counterpart to reinforce the instructions and make sure that all counterparts (including those that could not make it to the national training) were trained.

**Designing the Questionnaire:**

The Barrier Analysis being used for this project has been adapted to the Togolese context through input from the EPCMD team in Washington, PC M&E specialists, and the PNLP. Bonnie Kiddle, Matthew McLaughlin, and Danny Brown (PC Togo M&E Specialist) offered special assistance. The survey was finalized in March 2017 and follows the standard Barrier Analysis format.

The questionnaire was originally designed from the sample online. Yoonhee Ryder and Ismael Morou then translated it into French. The original version was tested on KONDI Nikabou, the nurse at the Kpassouade clinic. Dr. Bonnie Kiddle then sent a new version of the survey in both English and French, which was used to modify the original version. This final version was finalized in March 2017. Unfortunately, the original version's French was easier to understand in the Togolese context than the finalized version. But, for consistency, all PCVs used the March 2017 version except for one volunteer in the Savanna region (Savanna #2) who used the old survey. The old and new versions contained the same information; the only difference between them is a slight change in French phrasing.

In order to ensure standardization of local language translations, researchers made recordings of the surveys in five different common local languages- Ewe, Akposso, Kabye, Kotikoli, and Moba during the PDM Feb. 2017 training. 25 different ethnic groups are represented in the data sample, most of which have a distinct local language. Since the written forms of local languages have just been developed and few people, besides those specifically trained in it, know how to read in local language, recordings were done instead. Yoonhee Ryder and several other members of the team worked with Togolese counterparts to back-translate the recordings. Due to time constraints and difficulties in back translations, only the Kabye, Kotikoli, and Ewe translations were officially back-translated. Three volunteers were able to use these translations in the field. Mostly, volunteers would play the recordings to their counterparts during the initial training/meeting and whenever needed afterward if confusion arose.

**Coding, Tabulation, and Analysis of Results:**

All PCV data collectors (except for Maritime #3) came together to code the data at the "Coding Summit," the 23-24 May, 2017, in Sokode, Togo. Coders electronically input data from paper surveys. Each regional team individually coded open response questions (No. 1,2,3,4,6,7) in the most detailed way possible. Then each regional team came together as a national group to discuss in an open forum format which codes to keep or consolidate to ensure standardization across the country. Yoonhee Ryder then analyzed each of the studies, coded them based on what was discussed from the coding session (consolidating or changing names of codes as needed), and formulated the significant responses.

**Significant Findings from the Barrier Analysis Study:**

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| **MARITIME** | | | | |
| **Code** | **Doer Non-doer Percent Difference *(Significant if >15%). If negative, then #ND>#D.*** | **p-value**  **(Significant if p<0.05)** |  | **Bridge to activity** |
| *1. This behavior is easy…*  Perceived self-efficacy | | | | |
| … because the net prevents malaria. | 18.2 | .037 | **D**oers are 2.9 times more likely to give this response than NonDoers. | Increase the perception that a mosquito net can prevent malaria. |
| … if it's not hot. | -20.0 | .003 |  | Decrease the perception that mosquito nets can only be used at cooler times. |
| *2. This behavior is difficult…*  Perceived self-efficacy | | | | |
| …nothing. It is not difficult. | 30.8 | .000 | Doers are 8.5 times more likely to give this response than NonDoers. | Increase the perception that there is nothing difficult about doing this behavior. |
| … there is no net. | -32.5 | .000 |  | Increase the availability of mosquito nets. OR Increase the perception that nets are easy to obtain. |
| *9. How difficult is it to get the necessary materials to hang the net?*  *Access* | | | | |
| Not difficult at all. | 14.7 | .007 |  | Increase the perception that it is not difficult to hang the net. |
| *11. How likely will your child get malaria in the next six months?*  Perceived risk | | | | |
| Very likely | -44.8 | .000 | NonDoers are 11.1 more likely to give this response than Doers. | Use the perception that it is very likely that your child will get malaria to increase target behavior. |
| Somewhat likely | 33.8 | .002 | Doers are 4 times more likely to give this response than NonDoers. | Use the perception that it is very likely that your child will get malaria to increase target behavior. |
| *13. Will doing the behavior actually reduce malaria?*  *Perceived action-efficacy* | | | | |
| Somewhat likely | 21.3 | .045 | Doers are 2.2 times more likely to give this response thanNonDoers. | Increase the perception that bed nets are effective against malaria. |
| Not likely at all | -29.4 | .007 | NonDoers are 3.1 more likely to give this response than Doers. | Increase the perception that bed nets are effective against malaria. |

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| **PLATEAU** | | | | |
| **Code** | **Doer Non-doer Percent Difference *(Significant if >15%). If negative, then #ND>#D.*** | **p-value**  **(Significant if p<0.05)** |  | **Bridge to activity** |
| *1. This behavior is easy…*  Perceived self-efficacy | | | | |
| … because the net prevents mosquito bites. | 18.2 | .059 |  | Increase the perception that the net prevents mosquito bites. |
| …if you have a net. | -13.6 | .011 |  | Increase the availability of mosquito nets. OR Increase the perception that nets are easy to obtain. |
| … if it's not hot. | -11.4 | .025 |  | Decrease the perception that mosquito nets can only be used at cooler times. |
| *2. This behavior is difficult…*  Perceived self-efficacy | | | | |
| …nothing. It is not difficult. | 37.6 | .000 | Doers are 4.2 times more likely to give this response than NonDoers. | Increase the perception that there is nothing difficult about doing this behavior. |
| …because it's hot. | -28.5 | .005 | NonDoers are 3 more likely to give this response than Doers. | Decrease the perception that mosquito nets make you hot. |
| …there is no working net. | -11.7 | .025 |  | Increase the availability of mosquito nets. OR Increase the perception that nets are easy to obtain and/or easy to repair. |
| *7. Who disapproves of this behavior?*  Perceived social norms | | | | |
| No one. | -20.7 | .033 | NonDoers are 2.3 more likely to give this response thanDoers. | Increase the importance of social acceptance (?) |
| *10. Is it difficult to remember to do this behavior?*  Cues for action / reminders | | | | |
| Not difficult at all. | 18.4 | .011 | Doers are 5.8 times more likely to give this response than NonDoers. | Increase the perception that it is not difficult to remember to place child under the net every night. |
| *11. How likely will your child get malaria in the next six months?*  Perceived risk | | | | |
| Very likely | -34.2 |  | NonDoers are 12 more likely to give this response than Doers. | Use the perception that it is very likely that your child will get malaria to increase target behavior. |
| Not likely at all | 46.6 |  | Doers are 6 times more likely to give this response than NonDoers. | Increase the perception that your child is not likely to get malaria if they practice the target behavior. |
| *14. Is it God's will when your child gets malaria?*  Perceived divine will | | | | |
| Yes | -13.8 | .038 | NonDoers are 4.4 more likely to give this response than Doers. | Decrease the perception that it is God's unchangeable will that your child will get malaria. |
| No | 13.8 | .038 | Doers are 4.4 times more likely to give this response than NonDoers. | Increase the perception that community members themselves have the ability to reduce malaria. |

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| **CENTRALE** | | | | |
| **Code** | **Doer Non-doer Percent Difference *(Significant if >15%). If negative, then #ND>#D.*** | **p-value**  **(Significant if p<0.05)** |  | **Bridge to activity** |
| *1. This behavior is easy…*  Perceived self-efficacy | | | | |
| …because the net blocks mosquitos. | 24.4 | .007 | Doers are 3.2 times more likely to give this response than NonDoers. | Increase the perception that the mosquito net blocks mosquitos from biting you. |
| …if you have a net. | -51.1 | .000 | NonDoers are 41 more likely to give this response than Doers. | Increase the availability of mosquito nets. OR Increase the perception that nets are easy to obtain. |
| … because the net prevents malaria. | 26.7 | .003 | Doers are 3.8 times more likely to give this response than NonDoers. | Increase the perception that a mosquito net can prevent malaria. |
| *2. This behavior is difficult…*  Perceived self-efficacy | | | | |
| …because there is no net. | -26.7 | 0.000 |  | Increase the availability of mosquito nets. OR Increase the perception that nets are easy to obtain. |
| …because it's hot. | 20.0 | 0.043 | Doers are 2.1 times more likely to give this response than NonDoers. | Decrease the perception that mosquito nets make you hot. |
| *6. The people who approve this behavior are…*  Perceived social norms | | | | |
| … my family. | 17.8 | .067 |  | Increase the perception that one's family approves of this behavior. |
| *8. How difficult is it to get a mosquito net?*  Access | | | | |
| Very difficult. | -22.2 | .029 | NonDoers are 2.3 more likely to give this response than Doers. | Decrease the perception that mosquito nets are very difficult to get. |
| Not difficult at all. | 20.0 | .022 | Doers are 2.8 times more likely to give this response than NonDoers. | Increase the perception that mosquito nets are not difficult at all to get. |
| *11. How likely is it that your child will get malaria in the next six months?*  Perceived risk | | | | |
| Very likely | -15.6 | .067 |  | Use the perception that it is very likely that your child will get malaria to increase target behavior. |
| Somewhat likely | -17.8 | .067 |  | Use the perception that it is likely that your child will get malaria to increase target behavior. |
| Not likely at all | 33.3 | .001 | Doers are 3.9 times more likely to give this response than NonDoers. | Increase the perception that your child is not likely to get malaria if they practice the target behavior. |
| *14. Is it God's will when your child gets malaria?*  Perceived divine will | | | | |
| No | 20 | .045 | Doers are 2.1 times more likely to give this response than NonDoers. | Decrease the perception that it is God's unchangeable will that your child will get malaria. |

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| **KARA** | | | | |
| **Code** | **Doer Non-doer Percent Difference *(Significant if >15%). If negative, then #ND>#D.*** | **p-value**  **(Significant if p<0.05)** |  | **Bridge to activity** |
| *1. This behavior is easy…*  Perceived self-efficacy | | | | |
| … because it keeps my child healthy. | 20.0 | .018 | Doers are 3 times more likely to give this response than NonDoers. | Increase the perception that this behavior will keep your child healthy. |
| ... because the net prevents malaria. | 15.6 | .073 |  | Increase the perception that a mosquito net can prevent malaria. |
| *2. This behavior is difficult…*  Perceived self-efficacy | | | | |
| … nothing. It is not difficult. | 15.6 | .06 |  | Increase the perception that there is nothing difficult about doing this behavior. |
| *5. Do most people approve of this behavior?*  Perceived social norms | | | | |
| Yes | 15.6 | .006 |  | Increase the perception that most people approve of this behavior. |
| Maybe | -13.3 | .013 |  | Decrease the perception that people may not approve of this behavior. |
| *8. How difficult is it to get a mosquito net?*  Access | | | | |
| Not difficult at all. | 17.8 | .047 | Doers are 2.4 times more likely to give this response than NonDoers. | Increase the perception that mosquito nets are not difficult at all to get. |
| *9. How difficult is it to get the necessary materials to hang the net?*  Access | | | | |
| Very difficult. | -11.1 | .028 |  | Decrease the perception that it is very difficult to obtain the materials needed to hang up the net. |
| *10. Is it difficult to remember to do this behavior?*  Cues for action / reminders | | | | |
| Not difficult at all. | 15.5 | .025 | Doers are 4.9 times more likely to give this response than NonDoers. | Increase the perception that it is not difficult to remember to place child under the net every night. |

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| **SAVANNA** | | | | |
| **Code** | **Doer Non-doer Percent Difference *(Significant if >15%). If negative, then #ND>#D.*** | **p-value**  **(Significant if p<0.05)** |  | **Bridge to activity** |
| *2. This behavior is difficult…*  Perceived self-efficacy | | | | |
| … there is no net. | -12.5 | .016 |  | Increase the availability of mosquito nets. OR Increase the perception that nets are easy to obtain. |
| *8. How difficult is it to get a mosquito net?*  Access | | | | |
| Very difficult | -21.1 | .031 | NonDoers are 2.3 more likely to give this response than Doers. | Decrease the perception that mosquito nets are very difficult to get. |
| Not difficult at all | 18.6 | .026 | Doers are 2.7 times more likely to give this response than NonDoers. | Increase the perception that mosquito nets are not difficult at all to get. |
| *11. How likely will your child get malaria in the next six months?*  Perceived risk | | | | |
| Very likely | -14.2 | .046 | NonDoers are 3.4 more likely to give this response than Doers. | Use the perception that it is very likely that your child will get malaria to increase target behavior. |

**Behavior Change Activity Descriptions:**

Activities have not yet been conducted. The action research team has shared this data with the 2017-19 cohort. Each CHAMP volunteer (of all cohorts present in country during the distribution) will be required to do a targeted activity based on their region's data during the actual distribution.

**Funding:**

World Connect awarded 431,693 CFA for this project. Counterparts received a 10,000 CFA per diem for every 45 surveys completed. Per diems were distributed to PCV data collectors at PDM Feb. 2017 in Pagala.

The World Connect Grant requires community contribution. PCVs tracked their counterparts' food and transportation costs during survey implementation and turned in receipts with their surveys.

**Key Successes and Best Practices:**

* This study was the first Barrier Analysis study using the DBC Framework attempted in Togo. The team learned that this type of study is useful and valuable to both Peace Corps Volunteers in the field and Peace Corp's partners.
* In the effort to use this data for the upcoming 2017 national mosquito net distribution, PC Staff and Yoonhee Ryder have been solidifying relationships with development partners, most notably the Catholic Relief Services (CRS). Catholic Relief Services won the bid to collect all M&E for the 2017 distribution. Thus, we have been working closely with them to see how we can use the data, and how PCVs can be more involved with the distribution follow-up.
* The Togo Malaria Action Committee (MAC), led by PCVL Samantha Cardwell, included this BA study as one of the MAC initiatives this year. We were able to involve STOMP alumni and MAC members into the project.
* Yoonhee Ryder developed a standard, somewhat simple way to enter in and count codes in Excel (refer to raw data sheets in the appendix).
* In addition to the five Barrier Analysis studies, this project has influenced a strategic shift in PC Togo's programming and training. Upon return from Rwanda, Yoonhee Ryder and Ismael Morou have trained three different PCV cohorts. With support from Jane O'Sullivan (P&T) and Victor Luboyeski (Togo CD), we have been able to incorporate DBC and the BA into the habitual programming and are requiring this year for all 2017-19 PCVs to conduct one BA during their first 3 months at site, and follow through with targeted activities.

**Key Challenges and Limitations:**

* The local language translations were particularly challenging for several reasons. First, just considering the nature of local languages in Togo, it is hard to get direct translations for qualitative surveys like the BA. Back-translating is difficult because oftentimes, translators cannot agree on exact phrasing. Some of the local language translations involved doing over three different translations and back translations. Second, the audio format is hard to share with volunteers in the field. Audio files are large and require extensive bandwidth to download and store. They are not easily portable as most PCVs can only download them on their laptops*.*
* The survey design itself was challenging. It was difficult consolidating everyone's opinion on how specific questions should be worded into a final version. Additionally, many of the French versions online are not correct. The French version of this particular survey uses French that most Togolese people do not understand, which caused some confusion. Also, some of the wording on surveys (available through various resources) is not consistent. For example, on some surveys, it states, "Are there any cultural rituals or taboos that make it *more likely* you with do this behavior?" While other surveys say "*less likely*." Many people are confused by the former phrasing because the definition of taboo normally indicates something that makes one less likely to do something. The survey kept getting updated, and some PCVs found the delays frustrating.
* As with any national project involving PCVs, it is hard to motivate them to keep deadlines. We dealt with this by changing our original project format from using all PCVs to a select few who were more motivated.
* Ismael Morou has had challenges connecting with the PNLP. The representatives involved in this project were constantly travelling and never available for discussion. Most correspondence has taken place over email. However, we are hoping that our relationship with Catholic Relief Services will serve as a bridge to the PNLP.

**Summary of Resources** (manuals, training sessions, tools)

* Designing for Behavior Change Curriculum, CORE Group
* EPCMD Overview powerpoint (on EPCMD USB)
* Deep-dive powerpoints (on EPCMD USB)
* A Practical Guide to Conducting a Barrier Analysis Guide, B. Kiddle, CORE Group
* Make Me a Change Agent, CORE Group
* French and English BA surveys available online through the Food Security Network
* Barrier Analysis Excel Tabulation Sheet, available online
* Developed: more Togo-specific case studies for DBC Framework trainings
* Developed: excel coding document for analyzing raw data

**Next Steps:**

The national bed net distribution is planned for late July or early August, 2017. Until then, Yoonhee Ryder and Ismael Morou are working closely with Catholic Relief Services (and hopefully the PNLP) to incorporate our data into the distribution preparation and/or follow-up. Each community health worker must visit each household in their catchment area one week following the destruction to make sure that the nets are properly "aired out" and hung. Usually, the PNLP sends out "talking guides" in the form of powerpoint slides for these CHWs to use in the field. Ideally, we will be able to add a couple slides on key talking points to address per region based on the BA data.

Additionally, I. Morou and Y. Ryder will be having a meeting with CRS next week to discuss, in addition to the data inclusion, how PCVs can be involved in the distribution M&E. CRS has previously discussed with us that they would like for PCVs to hold focus groups either 3 to 6 months post-distribution. Details pending.

PC Togo is adding a Girls' Education Barrier Analysis (see appendix) to this year's "On the Job II Training." The "On the Job II Training" includes mandatory surveys that the new PCVs (2017-19) must complete within their first three months at site. Surveys are due during Inter-Service training in November 2017. From there, each 2017-19 PCV will then implement targeted activities based on their DBC Frameworks.

During the current PST, cross-cultural and language facilitators are in the process of translating BA question "stems" into written local languages. This way, future BA studies will simply have to translate the target behavior and add it to each question stem.

Select PCVs in the central region will be conducting a BA on family planning. The goal is to see if religion plays a significant role in family planning. We plan to have approx. half Muslim and half non-Muslim respondents. This data will inform Islamic family planning trainings in October 2017. At this conference, religious leaders from the area will train imams and Muslim health care professionals on how to use the Qur'an to support and encourage family planning.

Yoonhee Ryder is working closely with the PC Togo M&E taskforce to make sure that the knowledge of how to fully implement a BA/DBC project from beginning to end is passed on. She will be attending the national M&E summit in Sokode in Aug. 2017.

**Anticipated Support:**

If possible, it would be great to have at least a couple of Android phones to be able to use Compcare. Entering in data manually is extremely time-consuming. Also, Compcare would allow us to embed local language recordings directly into the survey.

**Appendix- Further documentation:**

* *Division of doers and non-doers*
* *Togo case studies DBC Framework trainings (including village descriptions and BA data sheets)*
* *Copy of World Connect grant funding and budget*
* *Final BA Mosquito net usage children U5 (French)*
* *Excel document detailing finalized results per region*
* *Raw data- Maritime Region*
* *Raw data- Plateau Region*
* *Raw data- Central Region*
* *Raw data- Kara Region*
* *Raw data- Savanna Region*
* *BA Girls Education (French)*
* *BA "how to guide"*
* *MSC presentation notes (2 files)*
* *Final concept note (English)*
* *EPCMD boot camp pre and posttest results*

1. The pen toss method: the researcher starts at the chief's house and throws a pen in the air. The direction that the pen points to indicates the direction that the researcher must do surveys. He/she will then follow this direction and do every third house until not being able to go any further. At this point, the researcher will throw the pen again to find a new direction vector to follow. [↑](#footnote-ref-1)
2. Four or less surveys per ethnic group [↑](#footnote-ref-2)