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BEHAVIOUR CENTERED PROGRAMMING: An Approach to Effective Behaviour Change



empower

inform dreams

act

change desire

challenges

enable inspiration

learn create

teamwork own

behaviour courage

educate goals

honor

believe motivation

opportunity

strength support

trust share

people

success

achieve

TRAINER'S MANUAL



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FROM THE AMERICAN PEOPLE

SEPTEMBER 2011

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BEHAVIOUR CENTERED PROGRAMMING: An Approach to Effective Behaviour Change

TRAINER'S MANUAL

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This toolkit was written, pre-tested and launched as part of the USAID-funded Communications Support for Health (CSH) project in Zambia. The project is implemented by Chemonics, Inc in partnership with The Manoff Group and ICF Macro. It was primarily authored by Elizabeth Younger, Senior Behaviour Change Communication (BCC) Advisor and Christina Wakefield, BCC Specialist from The Manoff Group with extensive input from CSH staff and Zambia Ministry of Health counterparts. Special acknowledgement is extended to Florence Mulenga, Capacity Building Director for CSH, Josephine Nyambe and Answell Chipukuma, BCC Advisors for CSH, and George Sikazwe, Chief of Health Promotion, Zambia MOH.

The content of this manual was primarily adapted from The Manoff Group's Behaviour Centered Programming approach to developing behaviour change communication strategies and tools.

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Letter to the Trainer

The Government of the Republic of Zambia (GRZ), with the support of the USAID-funded Communication Support for Health (CSH) Project, has compiled this training manual to train individuals to:

- Differentiate between behaviour change communication (BCC) and traditional IEC
- Explain communication's strategic role in behaviour change and understand and identify the role that communications plays in achieving behaviour change
- Identify best practices in behaviour change programming
- Apply a strategic framework to development of campaigns (including identification of key behaviours, conducting a behaviour analysis and clearly defining a responsive strategy and program
- Competently manage the entire process of behaviour change communications interventions, including: project planning and strategy development, formative research, materials development, pre-testing, partnership development, and activities/communications development.

The training will be designed as a multi-level toolkit, where different modules will be used with different levels of participants, and it is anticipated that a cascade model training program will be implemented using this material. As such, the national level participants course will include modules on how to be a trainer as well as all of the technical information. At the provincial and district levels, more streamlined modules will be focused on execution and monitoring of interventions. Suggestions for which modules to use with specific participants (national, provincial, and district level staff) are presented in the table below.

The GRZ and CSH project developed these materials by first conducting a thorough review of existing behavior change communication and campaign development curricula. The best elements of these materials were used to inspire this training package, which was pretested with representatives of the Ministry of Health and its partners in a training in May 2011.

Preparing for the Training

There are a number of steps that you, the trainer, should take to prepare for the training.

1. You should familiarize yourself with both this training guide, as well as with the accompanying PowerPoint slides/presentations for each Unit. This will give you a clear idea about roles, responsibilities, and scope of the training. You should also familiarise yourself with the other pieces of the training, including:
 - handouts and facilitators resource sheets found at the back of each relevant session to use during training
 - the participants' reference materials which provide additional information beyond the scope of the training
 - the Quick Guide to Behaviour Centred Programming which presents a snapshot view of the strategic process that the training covers.
2. Designate someone to handle the logistical aspects of the training: selecting the participants, arranging the lodging for the participants, selecting the venue, making arrangements for meals, etc.
3. One of the most important decisions you need to make is which sessions you will offer to your

Letter to the Trainer (Continued)

workshop participants. In general, it is advisable to cover all of the sessions for all training workshops, at national, provincial, AND district levels. This recommendation is because the training presents a strategic process that works from start to finish. Although not everyone will be responsible for implementing all pieces of the process, it is imperative that anyone working with any one piece is able to understand how and where their piece fits in with the whole.

The only exception to this recommendation is the train-the-trainer unit which will not need to be delivered to those individuals who will not be training others.

Supporting the Participants

It is recommended that you, the program manager, take the following steps to support the participants while the training program is in progress:

1. Welcome the participants to the training program and tell them that they have the organization's approval and support. Explain how their new skills and tasks will help meet organizational goals and objectives by improving the quality and effectiveness of behaviour change communication efforts.
2. Monitor the progress of the workshop to see that participants understand the technical content, that the training conditions are favorable for learning, and that the participants are motivated to undertake their new roles. If it is logistically feasible, an effective way to train the participants is to have them spend time in the workshop learning one set of skills, then return to their departments/organizations to try out their newly acquired skills, and then return to the classroom to discuss what they learned and receive more training in preparation for their next step in the strategic communications development process.

Supporting Your Participants in the Field

There are steps you should take to assist the participants after the training is complete:

1. Make every effort to put the participants' newly acquired skills and knowledge into practice as soon as possible. The longer they wait, the more they'll forget what was learned in the training. Take advantage of their enthusiasm and motivation.
2. Make sure they have the resources they need, such as access to funding to hire a contractor to conduct formative research that may be necessary.
3. Provide supportive supervision, particularly in the first months following training, since this framework for developing evidence based communications is likely to be new to them.
4. Conduct debriefing sessions where the participants can compare notes, think about lessons learned, and develop new ways and practices for their work.

Letter to the Trainer (Continued)

Finally, an introductory word or two to share with the trainer(s):

1. Preparing to implement any workshop takes a lot of time. The general rule is two days of preparation for every day of workshop. The preparation will involve reviewing and practicing delivery of each session as well as gathering materials such as newsprint, markers, tape, etc., and photocopying forms and tools for participants. These tasks are in addition to the logistical and administrative tasks involved in staging a workshop.
2. The training guide has been written purposefully in a “recipe” style, so that someone whose primary duties are not related to training will be able to implement the workshop. Experienced trainers may find the training directions too detailed and should treat them accordingly. Also, please feel free to have experienced trainers “upgrade” the training methodologies based on their level of comfort with training and the content.
3. The timing for the various activities is generous. You may find that you are able to complete an activity well within the suggested timeframe. For example, an experienced trainer may be able to complete the introductory activities in a relatively short period of time on the first morning. **Please remember timing suggestions are illustrative.**
4. Finally, the session objectives have been written in terms of what the participants should be able to do. They are learner-focused. They guide the content of the session and help both trainer and participant to assess the acquisition of new knowledge and skills.

Good luck!

Introduction to the Manual, Workshop, and Materials

The purpose of this guide is to support the training of program designers and managers for Behaviour Change and Behaviour Change Communication from the Government of the Republic of Zambia (GRZ). This training package is applicable to staff at the national, provincial, and district level and for individuals from the Ministry of Health (MOH), the National AIDS Council (NAC), the National Malaria Control Center (NMCC), and NGO, PVO, and USAID partners.

The training package covers a systematic process for applying an evidence-based behaviour change centred framework for developing communications interventions for health programs. After participating in the workshop, participants should be able to use the knowledge and skills acquired to develop well-informed, audience-driven messages and communications activities, such as national campaigns.

Workshop Objectives

This manual is intended to enable users to organize a workshop that prepares workers to:

- Differentiate between behaviour change communication (BCC) and traditional IEC
- Explain communication's strategic role in behaviour change and understand and identify the role that communications plays in achieving behaviour change
- Identify best practices in behaviour change programming
- Apply a strategic framework to development of campaigns (including identification of key behaviours, conducting a behaviour analysis, and clearly defining a responsive strategy and program)
- Competently manage the entire process of behaviour change communications interventions, including: project planning and strategy development, formative research, materials development, pre-testing, partnership development, and activities/communications development.

Workshop Methodology

The workshop:

- Uses structured learning activities: presentations, group discussions, group work, role plays, practical exercises, etc.
- Engages the participants through active involvement in exercises and small groups
- Enables participants to experience the same activities they will be carrying out when they are applying the behaviour change framework to develop a communication plan.

Training Structure

The training guide is organized by units, modules and sessions. Each session has:

- A title page with session objectives
- A “session-at-a-glance” table with activities, times, and needed materials
- Detailed training instructions for the trainer
- Accompanying Training Handouts to distribute during applicable sessions (not all sessions have handouts). These handouts are found at the back of each relevant session.
- A few sessions have additional instructions for the trainer, such as how to set up a game board or conduct a role-play. These sheets are labelled “facilitator’s resource sheets” and are also found at the back of each relevant session.

Introduction to the Manual, Workshop, and Materials (Continued)

How to Use This Manual and the Handouts

The Manual

This manual provides easy-to-follow instructions to the trainer on how to conduct the sessions. Before beginning a workshop, the trainer(s) should become familiar with the manual and its contents. The level of detail provided is for those who are less experienced in the field of training. More experienced trainers should feel free to modify recommended training techniques.

The sponsoring organization should make decisions on which modules, sessions, and activities to include or exclude based on who is participating in the training (national, provincial, district, etc. level staff. The training manual is structured in a module and session format so that the training can be tailored to the participants' needs, existing knowledge, and capabilities by selecting the appropriate modules to implement. It is recommended that all sessions be given to all participant groups with the exception of the train-the-trainer unit.

The trainer's manual is accompanied by a set of powerpoints. Directions for when to show each powerpoint are included in the manual.

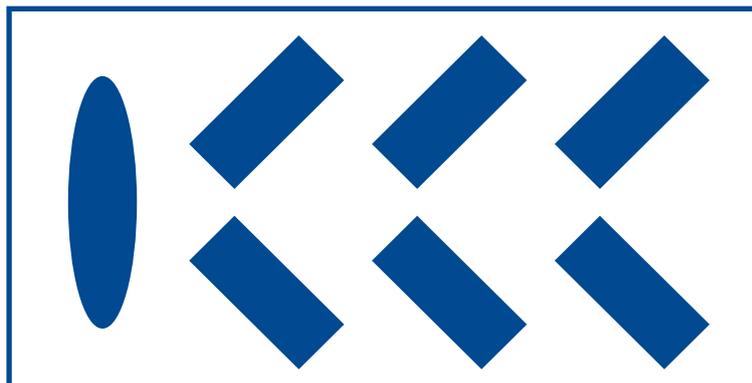
Participants Materials

The participants receive a set of booklets that should be used during the training. The appropriate time to use each is noted in the trainer's manual. The booklets are: 1) Training Handouts which contains all the various handouts used during the training; 2) Participants Reference Materials which contains additional information for the participants to use after the training; 3) Quick Guide to Behavior Centered Programming which explains the process being taught in the training and will be used in Unit 2 as the key handout. It will serve as a key reference for the participants after the training and 4) print outs of all the powerpoint slides for the participants to take notes on.

Logistics for the Workshop

Carefully select the venue for the workshop so that participants will be comfortable and ready to learn.

If possible, have the participants sit at a table (five or six per table) in such a way that they can all see the trainer as well as have face-to-face discussions at their tables during the small group work. The following diagram illustrates the recommended placement of tables.



Workshop Materials

(Quantity based on 15 workshop participants)

| Materials | Quantity |
|--|------------|
| Name tents/tags | 15 |
| Welcome sign | 1 |
| Flip charts | 2-3 |
| Markers | 2 packages |
| Printer | 1 |
| Projector | 1 |
| Computer for use with projector | 1 |
| Copies of training agenda | 15 |
| Copies of all training handouts hole-punched | 15 sets |
| Copies of all PowerPoints in handout form, hole-punched | 15 sets |
| Copies of the Quick Guide to Behaviour Centred Programming | 15 sets |
| Participant Reference Material binders with dividers for each unit | 15 sets |
| UNICEF's Facts for Life booklet | 15 |
| Blank note-pads | 15 |
| Pens | 15 |
| Copies of pre and post-test | 15 |
| Copies of daily evaluations | 15 |

Possible Energizers

THE STAGES OF CHANGE THEORY

Listed below are some possible icebreakers to do with the group when you sense that the energy is lagging in the room—this can be after a particularly intense work session or after breaks or lunch. These have been used in trainings in Zambia before, but they are just suggestions. Feel free to use ones you know from experience as well.

1. **Mrs. Clecher:**

Have one person start. They turn to the person next to them and say, with a clenched jaw and not showing their teeth:

Excuse me; is this Mrs. Clecher's house?

Their person responds "I don't know, let me ask my neighbour" and then repeats "Excuse me, is this Mrs. Clecher's house?" to the person sitting to their other side.

This continues around the entire group or until someone laughs or shows his/her teeth.

2. **Hi, Hi, Hi:** Have the facilitator chant "hi, hi, hi" over and over again as the participants run/skip/hop in a circle. When the leader stops chanting, the participants must group themselves into pairs. Those who cannot find a mate immediately/are the odd person out must sit down. The game keeps going until everyone is out.
3. **Dance your first name:** Have the participants stand in a circle and write their first name in capital letters using their body. First have them try with their left foot, then the right foot, then the waist.
4. **Counting to 50 without 7s:** Have the participants stand up in a circle. Start with one participant and go clockwise around the circle, counting to 50 out loud. Each time the number 7, a multiple of 7 (7, 14, 21, 28, 35, 42, 49), or a number that has 7 in it (7, 17, 27, 37, 47) comes up, the participant whose turn it is must clap instead of saying the number. If someone messes up, the whole exercise starts again.

Preliminary Activities (PA)

Session 1: Opening Ceremony; Introductions and Expectations 14

Session I: Welcome, Introductions and Skills, and Knowledge Pre-assessment

| | |
|----------------------------|--|
| Time | 60 minutes |
| Learning Objectives | <ul style="list-style-type: none"> • Understand the purpose and structure of the training • Get to know their fellow participants • Determine baseline knowledge/skills |
| Preparation | <ul style="list-style-type: none"> • Read the session carefully • Review accompanying PowerPoint slides • Photocopy training handout P-I Pre-Assessment • Find 15 pictures from magazines and tear in half |
| Materials | <ul style="list-style-type: none"> • Flipchart, markers • 15 pictures from magazines torn in half • Training Handout P-I: Pre-Assessment |

Activity 1: Opening remarks & workshop objectives (15 minutes)

- Welcome participants to the workshop. If possible, ask a respected official (government or otherwise) to give a welcome address and to officially open the workshop.
- Present slide titled: “Learning Objectives” of the Preliminary Activities Accompanying Slideshow. Let the participants know that this session is just an introductory one, but that they should start to get comfortable with talking, practicing, and asking questions.
- Present slide titled: “Workshop Objectives.” Tell the group that this list of objectives represents what the participants will hopefully be able to do by the end of the training. Have a volunteer read the list aloud to the rest of the group.

By the end of the workshop participants will be able to:

- Differentiate between behaviour change communication (BCC) and traditional IEC
- Explain communication’s strategic role in behaviour change and understand and identify the role that communications plays in achieving behaviour change
- Identify best practices in behaviour change programming
- Apply a strategic framework to development of campaigns (including identification of key behaviours, conducting a behaviour analysis and clearly defining a responsive strategy and program
- Competently manage the entire process of behaviour change communications interventions, including: project planning and strategy development, formative research, materials development, pre-testing, partnership development and activities/communications development.
- Present Slide titled: “Workshop Structure.” Tell the group that they each have a binder that includes a workshop agenda. That agenda shows the various units and sessions they will be going through over the next 5 days. Tell them that you will keep to the agenda as much as is possible, but if some times vary a little you will let them know where things stand.
- Tell them that in their binder’s they also have all of the PowerPoint slides that will be used in the training printed out and organized by unit and session so they can follow along and take notes.
- They will also note that they have a reference guide in the binders—this contains a lot of information. Some will be used/referred to during the training, some will be for extra reading.

Session I: Welcome, Introductions and Skills, and Knowledge Pre-assessment

- They also have in front of them a copy of the Quick Guide for Behaviour Centred Programming and a copy of UNICEF's Facts for Life. These will be used at various points in the training.
- Lastly, make sure they know that they will be receiving a lot of handouts as the training unfolds that will serve as references to take away.

Activity 2: Participants' introduction (20 minutes)

- Now announce that it is time to get to know each other a bit better.
- Give every participant half a picture from those you have torn from the magazine.
- Explain that participants should walk around the room and look for their partner, the person with the other half of the picture. Each pair will get 5 minutes to get to know each other; asking the other their names, one fun fact about themselves, one expectation for the workshop, and one or two specific behaviour change-related tasks they do as part of their job.
- Start the exercise.
- After 5 minutes, show slide titled "Health education and IEC" with instructions. Ask each participant to present his or her partner using about a minute, giving the partner's name, the fun fact about them, two expectations for the workshop and two behaviour change related tasks that are part of their job.
- As the participants are presented, write their expectations on a flipchart.
- After all participants have been presented, ask the group if they heard anything that was mentioned as an expectation that was not part of the workshop objectives. If so, ask the group how they might address such additional pieces of information. If it is something that can be done through group discussion (such as getting to know other people working in the field better), then make a plan to accomplish that during lunches/breaks or evenings. If it is something technical that will just not be covered, tell the group that the desire for more information on the topic will be noted and try to point the person to additional resources or trainings.
- Thank the group.

Activity 3: Ground Rules (5 minutes)

- Now ask the group to think about the ground rules they would like to see established for the training. Write down the rules on a piece of flip-chart paper as mentioned. A sample list can include:
 - Respect for each other
 - No whispering
 - Good listening
 - Actively participate in all activities
 - Talk one by one
 - Come on time
 - Cell-phones on silent mode
 - Minimize unnecessary movements
 - No newspapers
- Post the list of rules on a wall where it will remain throughout the training. Ask the group to please remember and respect them.

Session I: Welcome, Introductions and Skills, and Knowledge Pre-assessment

- Post a blank flipchart paper with the heading “Parking Lot” on the wall. Tell the participants that they are welcome to ask questions and discuss issues or topics at any time, but if something comes up that is unanswerable in that moment or is more appropriately discussed at a later date, it can go in the parking lot.

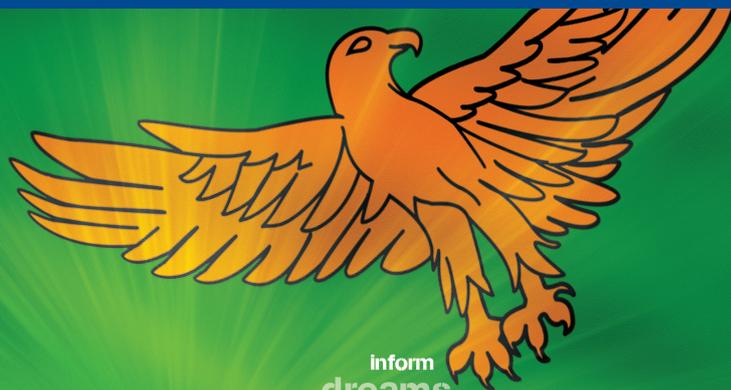
Activity 4: Pre-Assessment of Skills and Knowledge (20 minutes)

- Now pass out the pre-assessment forms (Training Handout P-1).
- Ask participants to answer the questions the best that they can, but remind them that this is a pre-assessment. If they knew all the answers without even having to think about them, the training would not likely be very interesting to them!

Pre-Assessment

Trainer's Manual

UNIT I



empower

act

honor

people

inspiration

teamwork

educate

strength

trust

believe

motivation

support

share

achieve

inform dreams

enable

learn

create

behaviour

courage

own

opportunity

goals

challenges

change

desire

success

UNIT I: Introduction to Behaviour Change

Session 1: What is Behaviour Change 19
Session 2: Case Studies of Successful Programs 27

Session I: What is Behaviour Change?

| | |
|----------------------------|---|
| Time | 60 minutes |
| Learning Objectives | <ul style="list-style-type: none"> • Establish common understanding of key terms: health promotion, behaviour change, behaviour change communication and IEC/health education • Recognize the difference between BCC and IEC • Identify scenarios where BCC vs. IEC is appropriate |
| Preparation | <ul style="list-style-type: none"> • Read the session carefully • Read through the session and familiarise yourself with the process and activities • Review Unit I, Session I PowerPoint slides • Prepare the twister board and “turn” slips of paper for drawing during the game (see Facilitator Resource Module I, Session I, Activity 2) |
| Materials | <ul style="list-style-type: none"> • Photocopies of Training Handout I-1 Definition of Health Promotion |
| Methodologies | <ul style="list-style-type: none"> • Large group discussion • Brainstorm • Exploratory game playing |

Activity 1: Group work: Establishing a common language (30 mins)

- Show slide titled “Learning Objectives” in Unit 1 accompanying PowerPoints. Read them aloud.
- Tell the group that one challenge in working to create behaviour change is that there are many different terms and definitions.
- Show Slide titled “Establishing a Common Vocabulary”
(slide says:
 - o Behaviour Change means...
 - o The difference between Behaviour Change Communication (BCC) and Information Education Communication (IEC) is...)
- Lead the participants in a brainstorm to complete the first phrase, Behaviour Change means.... Take notes on a flipchart paper.
- Now show slide titled “Definition of Behaviour Change” and ask the group to refer to Participants Reference Material # 1-1, “Definition of Behaviour Change”). Ask for a volunteer to read the definition aloud. Ask how it meshes with the definitions that they just created for themselves. Do we need to add/ modify anything on this definition? :
 - “Behaviour Change is a participatory process of working with individuals or communities to encourage and sustain practices or behaviours that lead to positive health outcomes. Communication, including mass media, mobile platforms, and interpersonal, should be used to support the process of health promotion through:*
 - establishing new social norms around use of products, services, or practicing of behaviours*
 - reinforcing or reminding people of messages delivered through other channels*
 - disseminating information*
 - raising awareness*
 - creating demand for a specific product, service, or behaviour*
 - advocating necessary changes to decision maker.*

Session 1: What is Behaviour Change?

(Continued)

- Now lead the group in a brainstorm to complete the second phrase: The difference between BCC and IEC is... Take notes on a flip chart, using two columns—one for BCC and one for IEC. Make sure to tell the group that IEC is not wrong or bad, and it is useful and appropriate in many situations. In fact, IEC is a PART of BCC.
- Show slides titled “Health education and IEC” and “Behaviour Change Communication” ensure that the following points were raised:
 - Health education and IEC:
 - o Usually consists of activities that convey information
 - o Tells listeners/participants what they should ideally do and the reasons why (from a public health perspective)
 - o Do not always address current and feasible behaviours; obstacles/strategies to change; and motivations (reasons to do things)
 - o Rarely presents information from the participant groups’ or audiences’ perspectives
 - o Are often one-way communications
 - Behaviour Change Communication:
 - o Focuses on the behaviour and all audience groups involved in decisions about that behaviour
 - o Frequently promotes feasible or intermediary improved behaviours as opposed to only ideal ones
 - o Tailors the communication specifically to address the barriers and motivations to changing the behaviour
 - o Incorporates the perspective of the audience group
 - Ask the group to think about their work in this area and offer some examples of when they have used BCC and when they have used IEC. Take several volunteers’ examples, but limit the overall discussion on this point to 5 minutes.
 - Tell the group that in many ways, BCC is an outgrowth of IEC. Over the years, for many subject areas, program managers and researchers have realized that just providing someone with information is not always enough. Education, while important, doesn’t always lead to behaviour change.

DATA FOR DECISION MAKING

Demographic and Health Surveys www.measuredhs.com/accesssurveys

A highly-trusted on-line resource on health and population trends in 85 developing countries.

UNICEF’s Child Info Website www.childinfo.org

An on-line resource including UNICEF’s statistical information, including data used in UNICEF’s flagship publications, The State of the World’s Children and Progress for Children. Also here are links to UNICEF-supported Multiple Indicator Cluster Surveys (MICS).

Session 1: What is Behaviour Change?

(Continued)

WHO Statistical Information System *www.who.int/whosis*

WHO's annual World Health Statistics reports present the most recent health statistics for the organization's 193 Member States.

Zambia Central Statistical Office *www.zamstats.gov.zm/*

A range of reports and statistics on Zambia.

Cochran Collaboration *www.cochrane.org*

Publish the Cochrane Reviews, which are systematic reviews of primary research in human health care and health policy. They investigate the effects of interventions for prevention, treatment and rehabilitation and assess the accuracy of diagnostic tests for a given condition in a specific patient group and setting. Each systematic review addresses a clearly formulated question; for example: What is the optimal duration of breastfeeding? All the existing primary research on a topic that meets certain criteria is searched for and collated, and then assessed using stringent guidelines, to establish whether or not there is conclusive evidence about a specific treatment.

Activity 2: “Twister” game (20 minutes)

- Now ask the participants to stand up. Tell them that they will see the difference between IEC and BCC in action.
- Explain that they will learn that even when a goal is clear, getting there sometimes requires creative solutions.
- Unroll the twister game board. Explain that you will play two rounds of this game.
- Ask for two volunteers to play round 1 of the “twister” game.
- Explain the rules: One volunteer is the player, the other is the coach. The coach will select “behaviours” for the player by drawing turns one by one out of a paper bag. The coach will read the behaviour for the player off the paper exactly as written and then the player will try to do whatever the instruction is. They will try to move from row 1 to row 10 by ONLY following the instructions from the coach and not doing anything else at all with their bodies. The coach is not allowed to work with the player at all in doing the behaviour. They read the instruction, the player tries to do it. If they cannot do the behaviour or do anything BUT the behaviour, they are eliminated from the game.

For example—if the player starts on row 1 with their left hand on a diamond and selects the next turn as right cheek to the triangle, they must put their right cheek on the triangle without moving any part of their body. Once there, they can move from their left hand from previous row. If getting their right cheek to the triangle requires moving other parts of their body or shifting their left hand from the triangle, they are eliminated.

Each turn represents moving forward one row on the board. The object is to complete all the turns and get through the board.

Session I: What is Behaviour Change?

(Continued)

NOTE TO FACILITATOR FOR ROUND 1: Frequently, these turns will seem impossible to carry out without any intermediary steps. For example, if the first selected turn tells the player to put his/her right knee on a triangle and the next selected turn is their left elbow on a circle, he/she must make that transition without touching any other part of their body to the board. In this round, if the player cannot do this or accidentally touches any part of their body to the board besides the instructed action, the game is over. This continues until the player either "wins" by completing all the turns without any intermediary steps, or is eliminated.

- Ask for two more volunteers to play round 2 of the game.
- Explain that the object of the game in round 2 is the same. The difference is that, in this round, if they cannot do the action, the coach can help the player figure out an intermediary step to take. They are never "out" until they succeed in reaching the other side of the board.

NOTE TO FACILITATOR FOR ROUND 2: In this round, the impossible becomes possible because the player can do anything he or she needs to do in order to carry out the selected turn. The coach should offer suggestions to help the player move from one turn to the next. For example, if the player's first turn has them put their left knee on a triangle and the second requests them to put their hand to the circle, the coach could suggest "if you lift up your knee, you might be able to reach your hand to the circle better". If the first turn has the player with his left hand on the diamond and the second turn asks him to put his cheek on the square, the coach could say "if you take off your glasses, you might better be able to put your cheek on the square." This supported, negotiated work continues until the player has completed all 10 turns.

Activity 3: Discussion (10 minutes)

- Ask the group the following questions and facilitate a discussion around the answers.
 - What was the goal of the game? (Following the given behaviours to get from one end to the other)
 - In the first round, what were some of the barriers to achieving that goal? (It was very physically challenging, instructions were not clear, etc.)
 - How was that different in the second round? (The barriers were the same, but small intermediary steps were presented to help the player do each behaviour. The coach and the player worked as a team, rather than the coach just instructing the player.)
 - Which round was more helpful to achieving the goal?
 - How do you think this relates to our discussion of BCC vs. IEC?
 - How might this relate to your role as an agent of change/program manager for BCC/IEC? (Instructions must be clear and feasible, and creating behaviour change must be a participatory process between the coach and the actor or the community. People also need a chance to try things out and figure out how it can work for them).

Session 1: What is Behaviour Change?

(Continued)

- Summarize the main point, saying that successfully helping the players achieve the goal in the game required the coach to not just give information, but to figure out what was feasible for the player to do, to provide clear instructions, to work with the player to help him or her do the action and to allow for flexibility. This is the same process they will use in developing successful behaviour change activities.

Twister Board Game

(For use with Unit 1, Session 1, Activity 2)

Instructions for making Twister Board:

Flatten and tape together enough cardboard boxes to stretch 20 feet long by 4 feet wide. Make 10 rows of 1 foot each and 4 columns of 1 foot each. Use a marker to fill in circles, squares, triangles and diamonds randomly in all the squares. A finished board might look like the one here.

If you cannot find cardboard, you can use flipchart paper taped together. In such case, it would be better to have the players remove their shoes to avoid tearing the board.

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|----|---|---|--|---|
| 1 |  |  |  |  |
| 2 |  |  |  |  |
| 3 |  |  |  |  |
| 4 |  |  |  |  |
| 5 |  |  |  |  |
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| 10 |  |  |  |  |

List of Verbs for Formulating Learning Objectives*

“Turns” for drawing from paper bag during Twister game

Write or print each of these “turns” on its own slip of paper. Have the “coach” draw them one at a time from the bag during play and help the player execute the action. (Note that some of the turns are repeated; for example, it is possible to draw “right foot, circle” three times). There are 10 “turns” here to match the 10 rows on the board.

Right Cheek—Circle
Left Knee—Circle
Left Foot—Square
Right Elbow—Square
Head—Square
Nose—Triangle
Right Hand—Triangle
Head—Triangle
Left Ear—Diamond
Left Elbow—Diamond

Session 2: Best Practices: Case Studies of Successful and Non-Successful Behaviour Change Program

| | |
|----------------------------|---|
| Time | 90 minutes |
| Learning Objectives | <ul style="list-style-type: none"> • Establish common understanding of key terms: health promotion, behaviour change, • Identify best practices/principles of “good” behaviour change interventions • Apply analysis of best practices to previous Zambia BCC work |
| Preparation | <ul style="list-style-type: none"> • Read session carefully • Review accompanying PowerPoint slides |
| Materials | <ul style="list-style-type: none"> • Flip chart paper • Markers |
| Methodologies | <ul style="list-style-type: none"> • Presentation • Personal reflection • Large group discussion |

Activity 1: Case Study Presentations (45 minutes)

- Show slide titled “Learning Objectives” from Unit 1, and read them aloud.
- Explain to the group that they will now look at two examples of behaviour change interventions carried out in other parts of the world. Ask the group to pay careful attention because they will be asked their opinion on whether or not the intervention had any impact or not.
- Present Case Study 1: Improving Young Child Feeding in Indonesia. NOTE: Do not show the “results” slide yet).
- Ask the participants to each write down whether or not they thought the intervention presented was effective in reaching its stated goal and why or why not. Have 2-3 participants share their thinking and write key points on a flip chart, dividing comments into two columns “why” or “why not”.
- Now present slide titled “Case Study 1: RESULTS.” This slide demonstrates that yes, in fact, the program was successful in reaching its goal. Refer to the list already begun by the group on why they thought the program was successful. Show slide titled, “Case Study 1: Indonesian Nutrition Improvement Program “ and emphasize that the program was successful because it included:
 - o Collaboration with audience to try out strategies before widespread promotion
 - o Careful tailoring of messages to actual barriers to behaviour change
 - o Careful segmentation of audience groups
 - o Appropriate and effective use and combination of mass media with interpersonal communication and reminder materials
- Tell the group that you’d now like to look at a second example. Present slides “Case Study 2: Dominican Republic Delayed Sexual Debut” through slide starting “Talk with your sons and daughters about sex—silence is your worst enemy” in Unit 1 Accompanying Handouts: Case Study 2: Dominican Republic Delayed Sexual Debut. Again, do not show the results slide. Ask the group to think about this case study. Ask each person to again jot down whether they thought the intervention reached its goal and why or why not.

Session 2: Best Practices: Case Studies of Successful and Non-Successful Behaviour Change Program

- Ask for a few (2-3) volunteers to share their reflections. Take notes on a flip chart divided into two columns “why” and “why not.”
- Now present Case Study 2: RESULTS slide. Point out that this slide demonstrates that while exposure to the campaign was high and some knowledge increased, there was NO behaviour change, meaning there was no impact on the health problem.
- Ask the group to return to their list and think again about why this program might not have seen its desired impact. Show slide 30, titled “Case Study 2: Dominican Republic Delayed Sexual Debut” to summarize why this campaign did not have its intended effect and tell the group that communications can fail if any part of the process breaks down. In this case, we did good research and created a sound strategy. At the end of the day, our failure to fully or adequately pre-test the material with the correct target audience was what doomed it.

Activity 2: Small Group Work: Best Practices (25 minutes)

- Point out to the large group that the reasons they identified for the success of the first case study and the lack of success in the second are, in fact, the take-away “best practices.”
- Show slide titled “Best Practices for Behaviour Change Projects” and refer participants to Participants Reference Material #1-2. Add any additional points that were brought up during Activity 1. Tell the group that these are at the highest level and each component of a project, such as materials development, capacity building, or M&E has its own set of best practices.
- Now tell the group that you would like for them to think about and share their own experiences working in BCC in Zambia. Split the large group up into four smaller groups by numbering the participants 1, 2, 3, 4, 1, 2, 3, 4... and so on.
- Have each group find separate places to sit and pass out Training Handout #1-1: Best Practices Small Group work to each of the group members. Tell the groups they have 25 minutes for this exercise. The handout asks each of the members to think of one experience they have had working on a BCC project, to consider that experience in the context of the best practices the group has just identified and the case studies they have just seen. Once everyone has had a chance to think of an example, each small group member should share with the other members of the small group:
 - o What aspect of their example was a best practice?
 - o Any difficulties faced in following best practices and any lessons learned? (for example, there was no budget for research to really understand the context)
- Once all the group members have shared their example and reflection, each small group should reconsider the list of best practices and decide if there is anything missing or anything that needs to be modified, based on their own experiences rather than just the case studies. One group member should take notes on this point to present back to the rest of the group.

Session 2: Best Practices: Case Studies of Successful and Non-Successful Behaviour Change Program

Activity 3: Large Group work: Discussion and Processing (20 minutes)

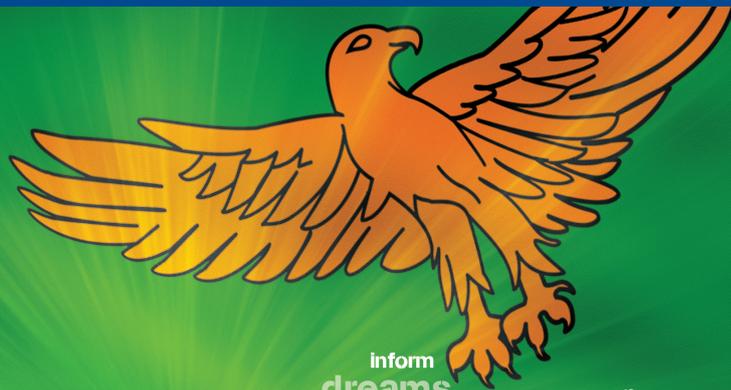
- Bring the groups back together as a whole. Ask for a spokesperson from each group to present in 5 minutes or less:
 - Any changes or modifications to the list of best practices previously defined by the whole group
 - Any major challenges group members faced in implementing best practices
- Tell the group that the rest of the training will focus on a process that will hopefully enable best practices for each and every project.
- Ask the group if there are any final questions or comments. If not, thank the group for its participation so far and close the session.

Best Practices Small Group Work Instruction (For use with Unit 1, Session 2, Activity 2)

- You have 25 minutes for this exercise.
- The group should begin by nominating a person to take notes and to present back to the large group.
- Each member of the group should first think of one experience they have had working on a BCC project, and to consider that experience in the context of the best practices the group has just identified and the case studies they have just seen. Once everyone has had a chance to think of an example, each small group member should share with the other members of the small group:
 - What aspects of their example was a best practice?
 - Any difficulties faced in following best practices and any lessons learned? (for example, there was no budget for research to really understand the context)
- Once all the group members have shared their example and reflection, each small group should re-consider the list of best practices and decide if there is anything missing or anything that needs to be modified, based on their own experiences rather than just the case studies.
- The note-taker/presenter should be prepared to present the following bullets back to the large group:
 - Any changes or modifications to the list of best practices previously defined by the whole group
 - Any major challenges group members faced in implementing best practices

Trainer's Manual

UNIT 2



empower

act

honor

people

inspiration

teamwork

educate

strength

trust

believe

motivation

support

share

achieve

inform

dreams

enable

learn

create

behaviour

courage

own

opportunity

goals

change

desire

challenges

success

UNIT 2: Applying a Strategic Framework

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Module 1: Behaviour Centred Programming

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Module I, Session I: Behaviour Centred Programming

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|----------------------------|--|
| Time | 60 minutes |
| Learning Objectives | <ul style="list-style-type: none"> • Establish common understanding of key terms: health promotion, behaviour change, • Define behaviour & strategy • List the six steps in the Behaviour-Centred Programming strategy • State one reason why we “put behaviour first” • Name 5 types of activities that can change behaviour |
| Preparation | <ul style="list-style-type: none"> • Read the session carefully • Review relevant PowerPoint slides • Make copies of pages 2-8 of the Quick Guide to Behaviour Centred Programming document on flip chart paper |
| Materials | <ul style="list-style-type: none"> • Flipchart paper • Markers • Reference Materials 2-1 and copies of the Quick Guide to Behaviour Centred Programming |
| Methodologies | <ul style="list-style-type: none"> • Discussion • Presentation • Brainstorm |

Activity 1: Defining Behaviour & Strategy (10 min.)

- Tell the group that the word “behaviour” has been used frequently in the discussion so far, but that no one has yet defined just what is meant by “behaviour.”
- Ask the group to brainstorm what makes something a behaviour. List responses on a piece of flipchart paper. Ensure that there is general agreement on a definition that includes the following elements:
 - It is an ACTION.
 - It is specific, concrete, and measurable.
- Display the PowerPoint slide with a list of sample “behaviours” on the wall as well as other words that are not behaviours.
 - think
 - wash (behaviour)
 - attend (behaviour)
 - feel
 - participate (behaviour)
 - explain (behaviour)
 - know
 - feed (behaviour)
 - put (behaviour)
- Ask a participant(s) to identify which are “behaviours” and why. Display the next PowerPoint slide that indicates which are behaviours.
- Ask other participants whether they agree with the answers given.

Module I, Session I: Behaviour Centred Programming

- Show the following statements on the next PowerPoint slide:
 - Put infant to suckle on mother's breast within one hour after birth
 - Give only breast milk to baby for six months
 - Know the benefits of breast milk compared to infant formula
 - Wash both hands with soap and water after defecating
 - Know the proper way to wash hands
- Ask participants to identify which are behavioural statements and which are not.
- Ensure that the three statements that begin with “Put” and “Give” and “Wash” are identified as behaviours, and that the reason is that they describe concrete, measurable actions, whereas the other two statements describe internal processes that cannot be measured or observed unless an action is carried out. [NOTE: For example, you cannot measure whether someone KNOWS how to do something unless the person either tells you how to do it, or better yet, shows you how to do it. Therefore, “know how to” is not measurable and therefore is not a behaviour.]
- Ask participants to explain why we “put behaviours first.”
- Ensure that the following points are made:
 - Individual and/or collective behaviours are critical to ensuring an intended health outcome. (E.g., for newborn health and nutrition a key behaviour is breastfeeding, more specifically, immediate breastfeeding. The behaviour entails a mother (or midwife or mother-in-law) putting the baby to the breast to begin suckling within an hour after birth.
 - Behaviours are the “bottom line” in health programs. Simply having the knowledge is not enough—there is a gap between knowing something and doing the right thing about it or even knowing HOW to act on it. The ACTION is what makes a difference in the health outcome. (E.g., knowing that breastmilk is the best source of nutrition for young children will not directly impact health; however, immediate and exclusive breastfeeding will!)
- Now explain that the word “strategy” is also one that we frequently discuss but rarely define. Ask for 2-3 volunteers to define what the word “strategy” means as it relates to health communications. Take notes on the flip chart.
- Ask the rest of the group to comment on the definitions, adding or taking away as they see fit. After the group discussion has subsided, post the PowerPoint slide with the definition of “strategy” and compare it to the definition developed by the group:

A strategy is a plan to achieve a particular goal or result. It is driven by evidence, include multiple but tightly integrated channels, stakeholder groups, a focus on impact, including evaluation of impact and use of a process in which the target audience is not just a passive recipient, but also has a voice in creating the direction of the communication. It should help ensure that program activities and communication messages are “on strategy” and not merely planners' personal ideas.

Module I, Session I: Behaviour Centred Programming

- Inform the participants that Reference Material #2-1 has the basic definitions for “behaviour” and “strategy.”

Activity 2: Overview of Behaviour Centered Programming (50 min)

- Hang the flip chart sheets (prepared ahead of time) with the “Behaviour Centred Programming” diagram (which should be identical to p.2 of the Quick Guide to Behaviour Centred Programming) and the “Behaviour Centred Programming Strategy Matrix” (which should be identical to p.3-8 of the Quick Guide). Note that the “Behaviour Centred Programming Strategy Matrix” consists of 6 sections). It is helpful to see how these sections flow from one to the next, so for purposes of the version on flip chart paper that is hung up on the wall, the first three sheets of flip chart paper (which show “1. Situational Assessment,” “2. Behavioural Analysis,” “3. Program Definition,” and “4. Strategic behaviour Change Activities”) should be posted so that they form one continuous long matrix. The flip chart paper with “5. Communication Plan Matrix” should be posted directly below the “Communication” column of the flip chart paper labelled “4. Strategic Behaviour Change Activities” (since the “Communication Plan Matrix” is where the details for the “Communication” column are broken out.) The flip chart sheet labelled, “6. Monitoring and Evaluation Plan,” can be placed to the side of all of the flip chart sheets since it represents an activity that is cross cutting through multiple portions of the matrix.
- Explain to the participants that the process that we are about to review in this training is simply a way think about, organize, and plan health communications which takes into account the most current thinking about IEC, behaviour change and behaviour change communications. We are building upon other approaches, such as the “P-Process” that was introduced to many health communications experts in Zambia by John’s Hopkins University. We want to be clear that we are not asking people to completely “discard” their previous approaches if they have found them to be useful in developing EFFECTIVE health communications, but, rather to consider what we will be reviewing as a way to expand or build upon these other approaches.
- Now refer the participants to the “Behaviour Centred Programming” diagram (p.3 of the quick guide to BCP) and the “Behaviour Centred Programming Strategy Matrices” (p.4-9 in the quick guide to behaviour centred programming). Tell the group that the quick guide is their essential tool in ensuring that behaviour is at the centre of their program, no matter what activities are involved. You will walk the group through each one during the remainder of the workshop. Use the PowerPoint slides titled “Snapshot: Behavior-Centered Programming” through “Monitoring and Evaluation Plan” to accompany your presentation.
- First have them refer to the Behaviour Centred Programming diagram (p.3 quick guide) and point to the flip chart paper with this diagram. Tell the group that this diagram represents all the various steps they will go through in developing an intervention. Explain that first they will describing a health problem and then do a situational assessment (p.4 quick guide, slide titled “Situational Assessment”) which consists of looking at the scientific evidence to determine a list of ideal behaviours, then choosing priorities from those ideal behaviours to determine the key behaviours and making an initial determination of who might be the target audiences.

Module I, Session I: Behaviour Centred Programming

- Say that the next step is to conduct a behavioural analysis (p.5 of the quick guide, slide titled “Behaviour Analysis”) that consist of research, on those key behaviours to really understand them—are people already doing them? Why or why not? What barriers exist? What motivations exist to people practicing them? Are there any improvements people can make that will help get them closer to the ideal than they currently are, even if it doesn't get them all the way? These questions are only illustrative of the kind that will be asked. You will go into much more detail later in the training on how to come up with questions you need answered, how to answer them and how to use the answers.
- Tell the group that once the analysis of the behaviours in question is complete, then you move on to defining the program by clearly stating a program goal, your behavioural objectives and narrowing down who is the final target audience (p.6 of the quick guide; Slide titled “Step 3: Program Definition”).
- The next step is to develop the strategic activities for the program (Step 4: Strategic Activities Planning, p.7 of the quick guide; slide titled “Strategic Behaviour Change Activities”) that includes planning for communications (by which we mean behaviour change communications, such as IPC, posters, campaigns, theatre, etc.) but also other activities like community mobilization, training and capacity building, logistics, etc.
- Show the next PowerPoint slide titled “Communications Plan” and explain that the next step in the planning process is to take the “Communication” column from section 4 of the Behaviour Centred Programming Strategy Matrix and “expand” it to create the “Communication Plan” (step 5. of the Behaviour Centred Programming Strategy Matrix p.8), which helps define exactly what materials (posters, drama performance scripts, radio spot scripts, etc.) need to be developed to accomplish the communication activities. Review the Communication Plan Matrix.
- Tell the group that the final step in the planning process is to create a “Monitoring and Evaluation (M&E) Plan” (see p.9 in the quick guide and slide titled “Monitoring and Evaluation Plan.”) The M&E Plan helps you focus on exactly what you will be monitoring and evaluating, who will be collecting the data, where they will be collecting it, and how the data will be used. It is important to be clear that M&E needs to be planned for from the very beginning of the process and carried out throughout the life of your intervention. Review the M&E Plan matrix.
- Summarize the session by saying that they will spend the rest of the training covering each of the columns in the matrices in detail. First up is how to do a situational assessment.

Module 2: The Situational Assessment

Module 2: Situational Assessment

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Module 2, Session 1: The Situational Assessment

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| Time | 125 minutes |
| Learning Objectives | <ul style="list-style-type: none"> • Explain the definition of a situational assessment • Explain the importance of doing a situational assessment • Be able to use existing data and work with technical experts to clearly state the health problem. • Use data and evidence to identify the audience and a set of “ideal” behaviours that when practiced, have a positive impact on the health problem |
| Preparation | <ul style="list-style-type: none"> • Identify priority “key” behaviours on which to focus • Read the session thoroughly • Review relevant PowerPoint slides • Photocopy Handouts # 2-1, 2-2A, 2-2B, 2-3A, 2-3B • Decide which participants should be assigned to each of the 2 health problems that will be covered in the small group work in Activity 5. Half the participants will work on stunting in 6 to 12 month olds and the other half will work on diarrhoea in children under 5 years of age. Make a list of who belongs in which group on news print to post at the front of the room during Activity 5. |
| Materials | <ul style="list-style-type: none"> • Photocopies of Handouts 2-1, 2-2A, 2-2B, 2-3A, 2-3B (one per participant) • Flipchart papers • Markers • Facts for Life booklets |
| Methodologies | <ul style="list-style-type: none"> • Presentation • Discussion • Individual reflection • Small group work |

Activity 1: Introduction to Situational Assessment (20 min)

- Show slide titled “Situational Assessment Learning Objectives” in Unit 2. Read the learning objectives aloud.
- Now display PowerPoint slide titled, “What is a situational assessment?” and ensure that the following points are covered:
 - It involves describing a particular situation as it exists now.
 - It is carried out before the strategy is developed and program activities get underway
 - It informs the strategy and program activities
 - It involves reviewing what has been done in the past to address the problem at hand.
- Now show slide titled, “Why Analyse Past Activity” and discuss why we need to analyse past activities when we plan a program and ensure that the following points are made:
 - It provides information about behaviours related to the health problem.
 - It helps identify information gaps and issues that require further information.
 - It can be used to determine design of data collection (e.g., questionnaire design, questions to ask)
 - It provides valuable information about what other projects’ and programs’ activities related to the same issue are successful or unsuccessful

Module 2, Session 1: The Situational Assessment (Continued)

- Show the PowerPoint slide titled, “A Situational Assessment Includes:” and discuss what are the components of a situational analysis and tell the participants that they will go into detail for each one:
 - Health problem identification
 - Identification of the ideal behaviours and audiences using existing data
 - Identification of key behaviours using established criteria
 - Identification of various audience groups

Activity 2: Presentation and Discussion: What do we mean by “health problem” (10 min)

- Now say that identifying the health problem is the first part of doing a situational assessment. Post the PowerPoint titled, “Health Problem Definition,” and tell participants that they have this information in their Reference Material 2-2. Ask for a volunteer read the definition out loud.
A health problem definition must include specific information on the following elements of the problem:
 - o Health area: (e.g. Malaria, HIV/AIDS, WASH, Child Health)
 - o Description of the problem: (e.g. incidence of malaria each year, rate of HIV incidence, rate of diarrhoea incidence , prevalence of under-nutrition)
 - o Affected or stakeholder group (mothers, kids, sex workers, truck drivers, etc.)
- Explain that with a clear health problem statement, you will have a simpler task as you plan research, choose audiences for the communication intervention, determine desired behaviour changes, and identify program objectives and activities.
- Mention to the group that while it is common that their work begins after the health problem has already been defined, it is still important to understand how that problem relates to their work and how those problems should be defined.
- Return to the already posted flip chart paper with the blank Behaviour Centred Programming Strategy Matrix, and point out that the Health Problem Statement would be written in the space provided above the matrix. Tell the participants that they will work in teams to fill in a Behaviour Change Strategy Matrix during the remainder of the training and that in order to save time, the trainers have chosen two specific health problems as examples that will be used in the small group work:
 - Problem 1: 53% stunting in Zambian children between 6-23 months of age.
 - Problem 2: 3% of Zambian children under 5 years of age die of diarrhoea
- Tell the participants that half of them have been assigned to work on the stunting issue and half of them have been assigned to work on the diarrhoea in under 5 year olds issue and that during the rest of the training they will work in these teams to fill in the remaining columns (or components) of the strategy matrix. You will let them know later who has been assigned to what group.

Module 2, Session 1: The Situational Assessment (Continued)

Activity 3: Presentation, Large Group Discussion: What are ideal behaviours and how do we identify them? (5 min)

- Tell the participants that now it is time to look at the behaviours that address the health problem. Ask the group to think about the concept of an “ideal behaviour” and ask for a volunteer to give a definition. Write down the answer(s) on flip chart paper.
- Explain that there is scientific evidence that concretely shows a causal relationship between an ideal behaviour and making a difference in solving a health problem. Drinking uncontaminated water reduces the incidence of diarrhoea. Sleeping under a bed-net reduces the likelihood of malaria transmission and therefore decreases the incidence of malaria. For each health problem there might be a number of behaviours that impact on it. Refer to the definition provided by the volunteer(s). Ask the group if anyone wants to change it or add to it. Post the PowerPoint slide titled, ““Ideal” Behaviour is;” with a definition of an ideal behaviour (and point out to the participants that they can find this definition in their Reference Material #2-2) and compare it to the definition provided by the volunteer to ensure that the discussion includes the following:

An ideal behaviour is one that is determined by scientific study to have a direct positive impact on a health problem. Frequently, there is a set of ideal behaviours that all impact on the problem. The “ideal” behaviour does not describe challenges in practicing that behaviour or whether or not people are already practicing it or not. It simply applies the science.

- Distribute copies of the “Facts for Life” document. Explain that this document is one place where they can look for “ideal behaviours” for various health problems because it provides practical information about childbearing and giving children the best start in life. The messages are based on the latest scientific findings by medical and child development experts around the world and the “ideal” behaviours (as determined by the scientists) are provided for many health topics that are commonly addressed by health communication campaigns. Give the participants a few minutes to look through the document.
- Emphasize that the “ideal behaviours” or “key messages” that are presented in the book are often used as the key messages in campaigns, but this usually does not produce effective communications leading to behaviour change because they don’t necessarily take into account the feasibility of those behaviours or give any option for how to practice them. Tell the group that these ideal behaviours then **SHOULD NOT BE USED** as messages in communications. Point out that we will discuss how to develop more effective messages later.
- Ask participants to brainstorm where else they might get information about “ideal” behaviours. Be sure that possible answers include sources such as experts in the field, WHO, UNICEF, etc.

Module 2, Session 1: The Situational Assessment (Continued)

Activity 4: Discussion and Brainstorm: Key Behaviours (5 min)

- Return to the pre-prepared flip chart paper with the Behaviour Centred Programming Strategy Matrix. Note to the group that you just discussed the column: “Ideal Behaviours.” Now, you want to look at the next column to the right, “Key Behaviours.” Tell the group that key behaviours are a subset of ideal behaviours. Usually, you cannot possibly address the entire set of ideal behaviours in a program because of lack of resources or because you do not want to overwhelm your target audience. You therefore need to examine your list of ideal behaviours and narrow that list down by determining which ones are the priorities.
- Ask the group to brainstorm what some of the criteria for prioritizing some ideal behaviours over others are. Display the PowerPoint slide titled, “Prioritizing Behaviours” and ensure the criteria discussion includes:
 - o Provides the biggest health impact
 - o Magnitude of the problem with the behaviour (how many people are not currently practicing it)
 - o Support from partners/political support
 - o Availability of necessary resources
 - o What other groups are already addressing—you might want to add your efforts to the mix to really create a large scale impact or you might want to spread your effort to a different aspect of the problem
 - o Ease of changing the behaviour (this you might not know until you do your behavioural analysis, but if you do have any information on this from global examples or otherwise, it would be good to use it.

Activity 5: Presentation and Large Group Discussion: Target Audience – Priority Group and Influencing Group (5 min)

- Explain that once you have determined your key behaviours, it is time to define who your target audience(s) will be. Effective health communication interventions reach audiences (1) who are most affected by the health problem, (2) who have the greatest potential for being responsive to the intervention, and (3) who are the most reachable.
- Display the PowerPoint slide 23 labelled, “Target Audience,” and tell the participants that the target audience is usually divided into two categories, the “Priority Group” (sometimes called the “Primary” Target Audience) and the “Influencing Group” (sometimes called the “Secondary” Target Audience) and read the two definitions:
 - o Priority Group = the group of people who will perform the positive behaviour
 - o Influencing Group = the group of people who influence the priority group. They can either support or prevent the priority group from adopting positive behaviours (e.g. fathers, older women, traditional healers, community, and religious leaders)
- Explain that sometimes there is confusion when the behaviour is done to a child (breastfeeding, vaccination, sleeping under a mosquito net). In this case the mother or caretaker is the priority group.

Module 2, Session 1: The Situational Assessment (Continued)

- Ask the participants to turn to the “Target Audience Definition and Five Ways to describe your Priority and Influencing Groups” Reference Material #2-3 and display the PowerPoint slide labelled, “Describe Priority Group.” Explain that the more specifically you can describe your priority and influencing groups the more effectively you will be able to design your intervention. Say that there are usually 5 ways to describe your priority group:
 1. Demographic features
 2. Something most group members DO
 3. Something most group members WANT
 4. Something that keeps the group from “doing the right thing”
 5. Readiness to adopt the new behaviour (Stage of Change: pre-awareness, awareness, decision-making, action, maintenance)
- Display the PowerPoint slide labelled, “Priority Group Graphic” and point out that they have a copy of this graphic in their Reference Material #2-4. Ask for 1 volunteer to read the example in the boxes on the right hand side of the handout. Point out how the Behaviour Change strategy designer would take the information into consideration when designing a BC strategy. For example, if the priority group is not literate, then written materials should not be used. If they do not listen to the radio then this channel of communication will not be most effective. Invite participants to ask any questions.
- Summarize the main points covered during this session. (5 min)
 - o Look at everything from the priority group’s point of view.
 - o Maximize your resources by reaching the largest number of people through the same message, materials or activities.
 - o Describe your priority group with as much specificity as possible (use the 5 ways).
 - o Design your BC strategy taking into consideration the groups’ characteristics.

Activity 5: Small Group Exercise: Identifying Ideal Behaviours, Key Behaviours, and Target Audiences (1 hr., 20 min)

- Post the PowerPoint slide that says, “SMALL GROUP WORK: “1. Situational Assessment.” Tell the participants that they are now going to break up into small groups to fill in the first section of the Behaviour Centred Programming Strategy Matrix. Post the PowerPoint slide labelled, “Small Group Subject Areas” and explain that half of the participants have been assigned to work on one health problem -- stunting in 6 to 12 month olds -- and the other half have been assigned to work on a different health problem -- diarrhoea in children under 5 years of age. Show the next two PowerPoint slides with the blank “1. Situational Assessment” matrices and explain the specific health problem that each group will handle (3% of Zambian children under 5 years of age die of diarrhoea and 53% stunting in Zambian children between 6-23 months of age).
- Post the flipchart of who has been assigned to each topic and what group they are in and review it.
- Give each participant a copy of either Training Handout #2-1A or B depending which group they are in. (This hand out is a blank “1. Situational Assessment” portion of the Behaviour Centred Programming Strategy Matrix) with their specific health problem and Training Handout #2-2 (which is instructions for what they will do in their small group work).

Module 2, Session 1: The Situational Assessment (Continued)

- Post the PowerPoint slide labelled, “Instructions Small Group Work: 1. Situational Assessment,” and review what they are supposed to do in their small groups:
 - Identify “Ideal Behaviours” (use Facts for Life) & write them in the first column on their Behaviour Centred Programming Strategy Matrix (give the group 50 minutes maximum to identify their ideal behaviours)
 - Inform trainer when done with identifying ideal behaviours
 - Trainer will assign team a Key Behaviour & distribute an information packet
 - Identify your Target Audience(s) (use info packet) and write them in the third column labelled “Target Audiences” (give the group 30 minutes maximum to identify their target audiences)
- Ask that each group identify one person as the note taker because each group will be presenting their entire strategy matrix back to the rest of the participants. Tell the groups to inform one of the trainers when they have completed filling in the column on “ideal behaviours” on their matrix.
- The trainers should circulate among the groups to answer questions and to be available when each group has completed their list of ideal behaviours. When a group has its list of ideal behaviours, tell them that in “real life” they would now examine their list of ideal behaviours against the 5 criteria for prioritizing behaviours (discussed earlier in this session) to determine which key behaviours they will prioritize. Tell them that for purposes of this training, we have already chosen “key behaviours” for each group:
 - Tell the participants that the groups working on:
 - stunting will focus on the key behaviour of complementary feeding and
 - diarrhoea in under 5’s will focus on the key behaviour of handwashing.
- Distribute the respective information packets to each participant in the group at the time that you assign them their key behaviour. (Training Handouts #2-3A and #2-3B. Each member of each group will get one information packet for the respective topic that their group is dealing with. So each person will get a packet on EITHER complementary feeding for 6-12 months olds to reduce stunting OR handwashing for the prevention of diarrhoea.)
- Point out to the participants that the information in their packets is NOT exhaustive for each of their topics, but it is meant to provide enough information for use during the training. They should NOT use these information packets outside of the training since they are not a compilation of all the available data. Tell the group to use the information in the packet to identify the Target Audience group(s) for their assigned Key Behaviours and have them record them in the appropriate column in their blank matrices. Inform them that they should hold onto their information packet because they will continue to use it later in the training.
- Tell the groups that they have a total of 1 hour and 20 minutes for this exercise. Although they will not present their work until a bit later, each group should have one “scribe” who will carefully take notes on the handout or electronically so that they can easily present their work when the time comes.

Module 2, Session 1: The Situational Assessment (Continued)

Activity 6: Daily Evaluation: DAY 1(5 min)

- Bring the groups back together and congratulate them on getting through the first intense day. Distribute the training evaluation for Day 1 and ask that each person complete it and hand it back to you before leaving for the evening.

Situational Assessment Matrix

For use with Unit 2, Session 2, Activity 5

| | | |
|---|----------------|------------------|
| HEALTH PROBLEM: 53% stunting in Zambian children between 6-23 months of age | | |
| I. Situational Assessment | | |
| Ideal Behaviours | Key Behaviours | Target Audiences |
| | | |

Situational Assessment Matrix

For use with Unit 2, Session 2, Activity 5

| | | |
|--|----------------|------------------|
| HEALTH PROBLEM: 3% of Zambian children under 5 years of age die of diarrhoea | | |
| 2. Situational Assessment | | |
| Ideal Behaviours | Key Behaviours | Target Audiences |
| | | |

Instructions for Small Group Work

(For use with Unit 2, Session 2, Activity 5)

- Identify “Ideal Behaviours” (use Facts for Life) & write them in appropriate column
- Inform trainer when done with identifying ideal behaviours
- Trainer will assign team a Key Behaviour & distribute an information packet
- Identify your Target Audience(s) (use info packet)

Research Summary Stunting/Complementary Feeding

(For use with Unit 2, Session 2, Activity 5: and rest of Unit 2)

RESEARCH SUMMARY

Health Problem: 53% of children under 5 are stunted in Zambia.

Key Behaviour for Focus: Appropriate Complementary Feeding from age 6 months to 2 years
Complementary Feeding includes a number of behaviours:

- **Frequency of feeding**
- **Amount of food given at each feeding**
- **Density or consistency of food**
- **Diversity or different kinds of food**
- **Utilization and proper hygiene**
- **Active feeding style**

NOTE: The following research summary contains real facts, from actual research conducted in the field. Where appropriate, sources are cited. This summary, however, is NOT intended to be comprehensive or represent in any way the state of the art learning on issues relating to stunting in children under 5. It is intended for use during the BCP training only.

The Republic of Zambia has one of the highest rates of stunting in children under 5 of any nation. Although there is some variation in the data, with rates ranging from 39 per cent to 53 per cent, according to the 2007 DHS, 45 per cent of children under five are stunted and 21 per cent are severely stunted. Stunting is apparent even among children less than 6 months of age (18 per cent). Wasting is also somewhat of a problem, with a national average of 5 per cent of children under 5 wasted, but levels of wasting are within the globally accepted standard. National prevalence of wasting shows a stable trend or insignificant variations between 1992 and 2002. According to the Zambian National Food and Nutrition Commission, because wasting rates are within the global acceptable range (about 5 per cent), there is no need for an emergency feeding program.

¹FAO web site: http://www.fao.org/ag/agn/nutrition/Zmb_en.stm

²Zambia Child Health Situation Analysis (2004)

³Annual Report on the Food and Nutrition Situation in Zambia—2006

⁴Duration of Breast Feeding in Zambia: <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1060670/>

Research Summary Stunting/Complementary Feeding (For use with Unit 2, Session 2, Activity 5: and rest of Unit 2)

Duration of breast feeding is strongly associated with the linear growth experiences of children and the association changes with the infant's age. One strong risk factor suspected to be responsible for the poor growth performance of children is the low nutritional quality of the weaning foods which are used to supplement breast milk during the lengthy weaning period. In Zambia, nearly all (98 per cent) of children are breastfed; this occurs regardless of background characteristic. More than half (57 per cent) of infants were put to the breast within one hour of birth and 93 per cent started breastfeeding within the first day. 61 per cent of infants below six months of age are exclusively breastfed, but younger children are more likely to be exclusively breastfed. 86 per cent of infants below two months are exclusively breastfed, compared with 35 per cent of infants aged 4-5 months. The median length of breastfeeding in Zambia is 4 months. As many as 24 per cent of children aged 2-3 months and 62 per cent of children aged 4-5 months are receiving food supplements in addition to breast milk.

Although women tend to agree with advice given on exclusive breastfeeding, many do not practice EBF for a variety of reasons. These include traditional beliefs that children need water and food before 6 months of age; some women feel they do not have sufficient milk to breastfeed exclusively for six months; a belief (particularly among fathers) that women who do not eat sufficiently themselves will not produce adequately nutritious breast milk; misunderstandings about whether breast milk is really sufficient to meet a baby's needs during the first six months; feelings of maternal guilt because they feel the child is watching them eat, and it is unkind not to give water to even a very young baby; time constraints (related to work); misunderstandings regarding feeding in the context of HIV; and a taboo against expressing breast milk. In addition, some Zambia mothers believe that a woman who becomes pregnant will begin to produce 'dirty' milk and should stop breastfeeding if she has a child under the age of one. Many mothers think they are not producing enough milk to satisfy the baby because they are not eating well enough, and they are not producing good enough quality milk because of poor diet. About half of children are given water with salt during the first month of life.

Once feeding has been introduced, the poor quality of these foods--characterized by high viscosity and low energy density--and inappropriate feeding practices have been highlighted recently by the World Health Organisation (WHO) as part of the major causes of malnutrition and the subsequent dire rates of stunting. This is especially true in the second semester of the first year of life in poor settings.

Mothers and caregivers give various reasons for initiating complementary feeding—chiefly the need to satisfy an infant's hunger when parents perceive that breast milk is not enough for the child, but mothers do not realize the needed frequency, amount, variety, calorie density, and nutritional content needed by their growing toddlers. Between 6 and 23 months, children consume foods made from grains more often than any other food group. Among breastfeeding children in this age group, 79 per cent eat foods made from grains, and 68 per cent eat fruits and vegetables rich in vitamin A. Overall, a relatively small proportion of children consume cheese, yogurt, and other milk products (4 per cent). Inclusion of vegetables and legumes in porridge is acceptable, although legumes are not available for roughly half of the year and some caregivers express concern over the time consuming nature of preparing beans. Inclusion of fish for young children is not generally acceptable. Additionally, many households have low daily meal frequency, particularly during the late dry season and early rainy season. Although commercially processed complementary foods

⁵Zambia DHS-2007

⁶Zambia Child Health Situation Analysis (2004)

⁷Formative Assessment of Infant and Young Child Feeding Practices at the Community Level in Zambia. Infant and Young Child Feeding Project 2009

Research Summary Stunting/Complementary Feeding (For use with Unit 2, Session 2, Activity 5: and rest of Unit 2)

are available in Lusaka, they are very expensive, with the lowest priced selling at US\$4 per kg. Thus, lack of affordable complementary foods was found to be a major constraint on mothers' feeding practices. In general, grandmothers and fathers express strong interest in supporting the care and nutrition of young children, but mothers do not often cite them as important influences.

In most cases (70 per cent), mothers feed the child. The rest of the time children are fed by the grandmother, sibling or house-help. The feeding location is predominantly (75 per cent) in the sitting area of the family house with the child held on the mother/caretaker's lap. Verbal encouragement is frequently observed (up to 75 per cent of the time) in most cases was occasioned by the child's refusal to eat. Children are fed from plastic cups and spoons for porridge or fed by hand. Leftover food was eaten by an older member of the family (mother, sibling or any other member of the household).

Vitamin A supplementation of children (aged 6 to 59 months) is accomplished during twice-yearly Child Health Weeks (CHWs). Sugar fortification, which began 1998, and is mandated by law, is viewed by some as an appropriate longer-term approach to improving the vitamin A status of the population. However, other studies found that Vitamin A capsule supplementation coverage among risk groups has been erratic. High coverage rates have been achieved during large campaign-style strategies (the Child Health Weeks) that extend beyond the traditional health system; however, these have been costly and are not likely to be sustainable. Coverage levels achieved during routine supplementation have ranged from

While some mothers do know the value of enriching children's foods with fat or protein, it is most common to feed thin, un-enriched corn porridge with either sugar or salt to children. Between 6 and 23 months, children consume foods made from grains more often than any other food group. Among breastfeeding children in this age group, 79 per cent eat foods made from grains, and 68 per cent eat fruits and vegetables rich in vitamin A. Overall, a relatively small proportion of children consume cheese, yogurt, and other milk products (4 per cent). Inclusion of vegetables and legumes in porridge is acceptable, although legumes are not available for roughly half of the year and some caregivers express concern over the time consuming nature of preparing beans. Inclusion of fish for young children is not generally acceptable. Additionally, many households have low daily meal frequency, particularly during the late dry season and early rainy season. Although commercially processed complementary foods are available in Lusaka, they are very expensive, with the lowest priced selling at US\$4 per kg. Thus, lack of affordable complementary foods was found to be a major constraint on mothers' feeding practices. In general, grandmothers and fathers express strong interest in supporting the care and nutrition of young children, but mothers do not often cite them as important influences.

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⁸Formative Assessment of Infant and Young Child Feeding Practices at the Community Level in Zambia

⁹Zambia DHS-2007

¹⁰TIPs for Improved Rainy Season Infant and Child Feeding

¹¹Report on the Implementation of the Positive Deviance/Hearth Approach in the Management of Malnutrition in Lukulu District

¹²Modification of Complementary Foods in Zambia: <http://fex.ennonline.net/25/modification.aspx>

¹³Complementary Feeding Practices and Nutrient Intake from Habitual Complementary Foods of Infants and Children Aged 6-18 Months Old in Lusaka, Zambia

Research Summary Stunting/Complementary Feeding (For use with Unit 2, Session 2, Activity 5: and rest of Unit 2)

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In general, caregivers receive most of their information on infant and young child feeding from health facilities. This guidance is provided through under-5 clinics, antenatal care, and a variety of outreach activities. Additionally, community-based organizations and programs are sometimes sources of information. The media—particularly radio and, in some areas, newsletters or brochures—were also a commonly cited source of information on infant and young child feeding. The following health facility community outreach activities are being implemented nationally mostly through the neighbourhood health committee: individual and group counselling, community education, micronutrient campaign and social mobilization during the breastfeeding week and child health weeks. There is need to involve non-health organizations in conducting IYCF activities in the community especially agriculture extension workers and teachers, who have a wider representation within the community. There is a national IEC strategy for nutrition being developed that includes IYCF. During the annual breastfeeding week, biannual child health weeks and the Nutriscan weekly program, there are visual, audio and print materials that are disseminated throughout the country. These include copies of posters, T-shirts, leaflets and TV/radio programs

¹⁴Zambian National Strategy and Plan of Action for the Prevention and Control of Vitamin A Deficiency and Anemia

¹⁵Assessment of IYCF in Zambia

Research Summary Diarrhea/Handwashing

(For use with Unit 2, Session 2, Activity 5: and rest of Unit 2)

RESEARCH SUMMARY

Health Problem: 3% of children under 5 die each year from diarrhoea disease in Zambia.

Key Behaviour for Focus: Handwashing at all critical times

NOTE: The following research summary contains real facts, from actual research conducted in the field as well as contextual data. Where appropriate, sources are cited. This summary, however, is NOT intended to be comprehensive or represent in any way the state of the art learning on issues relating to handwashing. It is intended for use during the BCP training only.

Contaminated water, inadequate sanitation and poor hygiene cause over 80 per cent of all disease in developing countries. One gram of faeces can contain 10 million viruses, one million bacteria, 1000 parasite cysts and 100 parasite eggs. As a child's immune system is not fully developed until around six months, infants can be particularly at risk when exposed to these elements¹.

In the Republic of Zambia, three per cent of children die from diarrhoea-related causes each year. Even in urban areas, such as Lusaka, diarrhoea remains a significant challenge. Diarrhoea is reported to be amongst the top 5 reasons for children to be admitted to the University Teaching Hospital in Lusaka². While oral rehydration therapy has been successful in helping to decrease deaths due to acute diarrhoea, the rate of diarrhoea cases has, unfortunately, not decreased.

It has been proven that one of the best ways to fight diarrhoea in infants is exclusive breastfeeding for the first six months of life. In a study conducted by Columbia University, researchers found that in Zambia, infants between the ages of 4 and 6 months consistently had diarrheal episodes increase by almost two-fold when weaned early, when compared with a group following the suggested six month exclusive breastfeeding plan³.

Following exclusive breastfeeding, another of the most significant practices that contributes to the reduction of cases of diarrhoea in infants is good hygiene, including consistent and thorough handwashing at certain critical times. Thoroughly washing one's hands for at least 20 seconds⁴ is suggested before preparing food, eating and nursing and after using the toilet or changing a diaper⁵ in order to prevent the spread of faecal-borne diseases that cause diarrhoea, especially in those most susceptible, such as young children and those with weakened immune systems. It is critical that a majority of people wash their hands in order to break the transmission cycle. Many adults have developed partial resistance or immunity to diarrhoea-causing intestinal diseases and as such do not always believe that they have a role to play in eliminating these diseases from their communities. However, they are still frequently carriers of the bacteria, parasites, or viruses and must also wash their hands at the critical times.

Studies show that current behaviour with regards to handwashing at all critical times is poor. For example, one study showed that while 80 per cent of households bathed daily, but did not wash their hands after defecation⁹. In this instance, access to water was not a barrier; people also reported knowing that they "should" wash their hands, but the behaviour was still not practiced. In those households where a handwashing station was established right outside the latrine, with a pitcher for pouring water, a basin and soap, the rates of handwashing increased to almost 75 per cent.¹⁷

Research Summary Stunting/Complementary Feeding (For use with Unit 2, Session 2, Activity 5: and rest of Unit 2)

In many places, however, access to water is still a problem. Since 1990, USAID reports that water supply has increased in both urban and rural Zambia, however, they have stated that Zambia is still unlikely to meet clean water and sanitation MDGs. In fact, in rural Zambia, only 41 per cent of people have access to a nearby supply of clean water¹⁸. The average walk to a water source taken by one woman is 45 minutes¹⁹. Without access to water, proper handwashing practices are difficult—if not impossible—to perform, leading to increased likelihood of diarrhoea and diarrhoeal related deaths in infants.

To combat the water shortage, some Zambian households have built tippy-taps, which allows people to stretch water supplies by pouring a smaller amount of water than would have to be used by traditionally pouring water from a pitcher. Likewise, it helps many by being able to be used without the help of someone holding a pitcher. Reports in rural Zambia indicate that only 5 per cent of families currently use tippy-taps¹⁶, but there has also been no significant investment made in promoting tippy-taps or disseminating instructions on how to create them. They are acceptable tools to most Zambians who experience using them, as they are easy to construct/easy to copy locally. However, there have been reported problems of finding suitable containers to use in construction, along with improper drainage below tippy-taps which can cause mud and form puddles which add to mosquito populations¹¹.

Adding to lacking water supplies, many rural poor perceive soap as a prohibitive cost to proper handwashing. One study looked at both the urban and rural poor of Zambia and demonstrated that households categorized as “poor” or “very poor” groupings—which may include up to 85 per cent of the population—lack the funds to buy soap⁷. At the same time, however, almost all households that had soap available for bathing and laundry, did not use it for handwashing.

Although substitutes for soap—such as sand or ash—are available for those unable to afford soap, very few rural Zambians (less than 10 per cent¹⁹) indicate awareness or belief in the efficacy of these methods. In some areas of Zambia, studies have shown that certain root or stem bark extracts are valued as a substitute for soap¹². While it has been demonstrated that sand and ash are effective in removing faecal coliforms from hands,¹³ such scientific analysis has not yet been applied to these extracts to see if they have a similar effect. Rather, it is possible that the extracts just produce a pleasant smell which can cover up the lingering smell of faecal matter. With the introduction of programs meant to increase the use of soap substitutes there has been mild success in implementing use of sand and ash in lieu of soap with 54 per cent of households currently seeming willing to use the substitute¹⁵.

In general, information about the importance of handwashing has not been widely disseminated to the general population. Reports show 67 per cent adults in Zambia who do not know the importance of handwashing¹⁴. In places where handwashing is recognized as important, many caregivers indicate that the number of times they actually need to wash their hands to do it at all “critical times” is very high and they simply do not always have the time. Set ups such as handwashing stations have been shown to improve rates of handwashing because it decreases the amount of time the activity takes. Additionally, many caregivers say that they do not believe a child’s waste is dirty and as such they are not worried about touching it or do not think to wash their hands after contact with a diaper or soiled clothing.

Some projects have seen some successes in improving handwashing rates. UNICEF efforts, through the uses of Zambian public schools, have helped spread information not only to children in the schools, but adults around the area. For example, the Government Basic School in Choma has helped the surrounding area,

Research Summary Diarrhea/Handwashing

(For use with Unit 2, Session 2, Activity 5: and rest of Unit 2)

helping to create strong social norms around handwashing through the use of student dramas and student-led community outreach. UNICEF reports that these productions were partially sparked by outbreaks of diarrheal diseases, cholera, and dysentery caused by poor hygiene that nearly forced the school to close in the past. Kids in these programs become the stewards of behaviour change in the household. In other programs, handwashing has been associated with a pride in a clean household and clean children as well as an economic benefit--healthy children cost less and rates have correspondingly improved.

REFERENCE

¹ Newborn immune system <http://www.wellness.com/reference/allergies/newborn-immune-system/>

² Amadi, Beatrice, Role of Food Antigen Elimination in Treating Children With Persistent Diarrhea and Malnutrition in Zambia

³ Fawzy A, Arpadi S, Kankasa C, Sinkala M, Mwiya M, Thea DM, Aldrovandi GM, Kuhn L.

Early weaning increases diarrhea morbidity and mortality among uninfected children born to HIV-infected mothers in Zambia. Source Columbia University, Gertrude H. Sergievsky Center, College of Physicians and Surgeons and Mailman School of Public Health, New York, New York, USA.

⁴ NSF International <http://www.nsf.org/>

⁵ Hand washing is an easy way to prevent infection. Understand when to wash your hands, how to properly use hand sanitizer and how to get your children into the habit.

By Mayo Clinic staff

⁶ ZAMBIA Water and Sanitation Profile <http://www.hip.watsan.net/page/3359>

⁷ The poor of Zambia speak: Who would ever listen to the poor? John T Milimo, Toby Shilito, Karen Brock Published by the Zambia Social Investment Fund, 2002 <http://www.sarpn.org.za/CountryPovertyPapers/Zambia/poorspeak/poorspeak.pdf>

⁸ Children are the best teachers in Zambia's drive for better hygiene Christyne Bahringer http://www.unicef.org/infobycountry/zambia_43206.html

⁹ Hygiene in Three Communities: A Case Study of Behaviour Related to Hygiene.

M F C BOURDILLON+ <http://archive.lib.msu.edu/DMC/African%20Journals/pdfs/social%20development/vol5no1/jsda005001008.pdf>

¹⁰ Groundwater Quality: Zambia http://www.wateraid.org/documents/plugin_documents/zambiagroundwater.pdf

¹¹ Akvo Report: Tippy Tap. http://www.akvo.org/wiki/index.php/Tippy_Tap

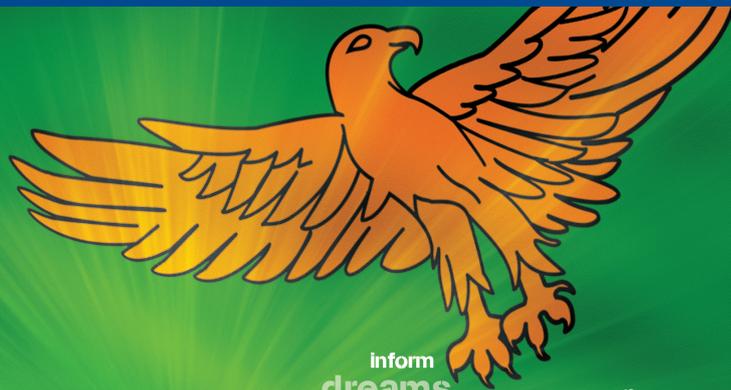
¹² African ethnobotany: poisons and drugs : chemistry, pharmacology, toxicology Hans Dieter Neuwinger

¹³ REVIEW OF HAND WASHING PROGRAMS www.irc.nl/content/download/.../Hand%20Washing%20HIP%2020Jan06.pdf

^{14/15/16/17/18} Statistic fabricated for purposes of training

Trainer's Manual

DAY 2



empower

act

honor

people

inspiration

teamwork

educate

strength

trust

believe

motivation

support

share

achieve

inform

dreams

enable

learn

create

behaviour

courage

own

opportunity

goals

change

desire

challenges

motivation

success

share

Review of Concepts Situational Assessment

| | |
|----------------------------|--|
| Time | 10 minutes |
| Learning Objectives | <ul style="list-style-type: none"> Reviewed concepts from Day 1 |
| Preparation | <ul style="list-style-type: none"> Read the session carefully Construct the ball made from flip chart paper Write the review questions on strips of paper and attach each to the ball so they can be easily unravelled one question at a time |
| Materials | <ul style="list-style-type: none"> Ball made from flip chart paper secured with masking tape with the review questions taped to it Strips of paper with review questions written on them |
| Methodologies | <ul style="list-style-type: none"> Group exercise Discussion |

Activity 1: Review

- Select 5-7 key questions that cover items from the previous day and write them each on their own flip chart paper. Questions can include the following, or you may select your own.

 - Why should we “put behaviour first”?
 - What are two best practices for behaviour change programs?
 - Communication is only one component of a behaviour change program. Name at least one other component.
 - Ideal behaviours are scientifically defined. Give an example of one.
 - Define a key behaviour.
 - What are 5 criteria you can use to define your target audience.
- Once the questions have been written on flip chart papers, crunch up the first paper into a ball. Wrap the second paper around the first, using tape if necessary to hold the ball together. Then wrap the third paper around the first and second and so on until all of the papers have been layered into one big ball.
- Ask the participants to form a circle. Tell them that you want to review the concepts that were introduced and covered the day before.
- Explain, “As the ball is thrown to you, you must each pull off one strip of paper & answer the question written on it; after you respond, please throw the ball to someone else. You can ask others for help in answering the question if necessary.”
- Begin the game with a lively toss to a participant and continue the game until all of the questions have been unravelled & responded to. If incorrect or incomplete responses are given, ask participants to help their team mate.

Module 3: Behavioural Analysis

| | |
|--|----|
| Module 3: Behavioural Analysis | |
| Session 1: Overview of Behavioural Analysis | 57 |
| Session 2: Conducting Research | 63 |
| Review of Concept: Behavioural Analysis | 70 |
| Session 3: Defining Behavioural Objectives & Audience Groups | 82 |

Module 3, Session 1: Overview of Behavioural Analysis

| | |
|----------------------------|---|
| Time | 1 hour |
| Learning Objectives | <ul style="list-style-type: none"> • Understand the main theories of behaviour change |
| Preparation | <ul style="list-style-type: none"> • Describe the difference between key behaviours and feasible behaviours • Explain the process for conducting a behavioural analysis • Read the session carefully |
| Materials | <ul style="list-style-type: none"> • Photocopies “theories at a glance” booklet • Flipchart paper • Markers |
| Methodologies | <ul style="list-style-type: none"> • Brainstorm • Presentation • Discussion |

Activity 1: Discussion: What is Behavioural Analysis? (20 min)

- Explain that many programs just jump from the behaviour and priority group straight to the activities, without giving much thought to why people currently do what they do and what may be preventing them from adopting the healthier behaviour.
- Tell the group that the key behaviours they identified in the last session are something we want people to do, but we have no idea if they are doing them already, or if they are feasible (or possible) for them to do, and why or why not.
- Post the PowerPoint slide of the filled-in Example of a Behaviour Analysis (see below) and tell the participants that they have a copy of this in their Reference Material #2-8. Tell the participants that section “2. Behavioural Analysis” is the portion of the behaviour change programming process where we focus on current behaviours, barriers that are preventing individuals from carrying out the behaviours, things that can encourage people to implement the behaviour, and what sub-behaviours or small doable actions are options if the ideal behaviour is not attainable. Go through the example, column by column and tell the participants we will review in detail what information should go in each of the columns and how that information is obtained.

| Ideal Behaviours | Current Behaviours | Existing Behaviours | Existing Facilitating Factors | Improved Sub-Behavioural/Samll Do-able Actions |
|-----------------------------------|---|--|--|---|
| Consume 3 servings vegetables/day | Only consumes vegetables at most 1 time a day | <ul style="list-style-type: none"> • Prep is time-consuming • need to be cooked • spoil easy • kids don't like | <ul style="list-style-type: none"> • Cheap • Lose weight • Feel lika a good mom | <ul style="list-style-type: none"> • Buy carrots to leave in fridge • Use sweet potatoes • use frozen vegetables |

Module 3, Session 1: Overview of Behavioural Analysis (Continued)

- Tell the group that understanding these issues, i.e. “current behaviours” and what needs to happen to make sure the behaviours are “feasible” is really what behavioural analysis, the second section in our Behaviour Centred Programming Strategy Matrix, is about.
- Explain that the best place to start when thinking about behaviour is to determine what people are currently doing and why. This information is gathered during the formative research stage, which we will cover later on.
- Explain that many people’s current behaviours are not helping them to stay healthy and our job as health promoters is to help our target audience move toward healthier behaviours. The “gold standard” (or “best”) behaviour are the ideal behaviours that we have identified as key behaviours. However, sometimes it is not possible for people to carry out these behaviours—they are not “feasible.”
- Tell the participants that it is important to try to understand WHY people do not carry out the key behaviour(s). Information on these barriers is gathered during the formative research stage. Ask the group to brainstorm reasons why someone may not carry out a desirable behaviour. Show the slide titled “Thinking about barriers” and make sure that the list includes:
 - 1) expected negative outcome,
 - 2) lack of commitment to doing action,
 - 3) incompatibility with self-image,
 - 4) lack of skills,
 - 5) lack of perceived ability to carry out action,
 - 6) lack of perceived supportive social norms,
 - 7) anticipated negative emotions after performing action,
 - 8) lack of supplies (goods, etc.) needed
- Tell participants that it is equally important to understand existing facilitating factors, which are the things that encourage or help a person do the key behaviour. Ask the group to brainstorm things that might be facilitating factors. Make sure that the list includes:
 - 1) an expected positive outcome,
 - 2) intention to do the action,
 - 3) compatibility with self-image,
 - 4) having skills to do action,
 - 5) confidence that can do the behaviour,
 - 6) supportive social norms,
 - 7) anticipated positive emotions after performing action,
 - 8) availability of supplies (goods, etc.) needed,
 - 9) existing supportive systems/programs
- Tell the participants that information about barriers and facilitating factors is identified from existing data and new data that are gathered during formative research. Sometimes it is helpful to use a theory of behaviour change to help you think through these potential facilitating factors and barriers.

Module 3, Session 1:

Overview of Behavioural Analysis (Continued)

Activity 2: Introduction to Behaviour Change Theories (5 min.)

- Tell the participants that thinking about some of the elements in behaviour change theories can be useful when developing the questions that will guide their research. Let's briefly look at some behaviour change theories and a model.
- Show the PowerPoint slide with the Theory Definition and point out to the participant's that they also have this definition written in Reference Material #2-6. Ask for a volunteer to read it aloud.

(From US Department of Health and Human Services; Theory at a Glance; A guide for health promotion practice).

A theory presents a systematic way of understanding events or situations. It is a set of concepts, definitions, and propositions that explain or predict these events or situations by illustrating the relationships between variables. Theories must be applicable to a broad variety of situations. They are, by nature, abstract, and don't have a specified content or topic area. Like empty coffee cups, theories have shapes and boundaries, but nothing inside. They become useful when filled with practical topics, goals, and problems.

- Ask for a volunteer to comment on this definition, specifically identifying how a theory of behaviour change might be useful to them as health communicators.
- Explain that the many theories of behaviour change are useful insofar as they allow a program manager or policy maker to structure his or her thinking about the problem at hand. They do not solve the problem and sometimes can make things more complicated. Tell the participants that some theories focus on individuals as the unit of change. Others examine change within families, institutions, communities, or cultures. Adequately addressing an issue may require more than one theory, and no one theory is suitable for all cases.
- Explain that you will present an overview of 3 of the main theories models and how they might be used to structure a behavioural analysis and this information – plus additional information about the 3 theories – is in their Reference Material #2-6, "Theories of Behaviour Change." If people have additional questions or are interested in reading further about other theories, they have a list of references in their manual.
- Tell the group that you will briefly describe the Health Belief Model and the Stages of Change Model. Then, you will present one called the "Determinants Model of Behaviour and Health Promotion" that merges principles of many theories to create a new model of behavioural determinants.

Activity 3: Discussion – Behaviour Change Theories/Models (20 min)

- Display the PowerPoint slide of the health belief model (HBM). This is the same diagram as what is included in the Reference Material #2-6. Walk through each of the boxes of the diagram, explaining them to the participants using the information and example in the Reference Material. Give the group a chance to ask questions and reflect on your summary.

Module 3, Session 1: Overview of Behavioural Analysis (Continued)

- Now show the PowerPoint with the diagram of the stages of change (SOC) theory. This is the second theory in the Reference Material #2-6. Walk the group through that theory using the information and example contained on the Reference Material. Again ask the group to reflect on your summary. If a volunteer does offer an example, ask them to explain in what way the group specifically applied the theory to their research and subsequent programming. Ask if there were any challenges to using the theory and why they picked that one in particular.
- Lastly, present the determinants of behaviour change model. Display the PowerPoint slide of the diagram of the “Determinants Model of Behaviour and Health Promotion.” Tell the group that this model is not a theory in and of itself, but it pulls various things from other theories to create something that is specifically useful to analysing ALL the possible factors that might motivate or inhibit a behaviour change. It forces the programmer to consider factors relating to the individual AND the individual’s environment, whereas the SOC theory only looks at the individual and the number of factors in the HBM is very limited. This is much broader and very specific. Not all of these factors will be relevant in every situation, but it gives something around which to structure your thinking and questions about what you need to know.

Activity 4: Discussion – Small Do-Able Actions (15 min)

- Now tell the group that there is another issue that we need to think about. If the key behaviour is not feasible, sometimes there are sub-behaviours or small improvements that an individual can carry out. This set of behaviours is often called “improved behaviours” or “small do-able actions.” These behaviours may either create some improvement over current practice OR in some cases, eventually lead to adoption of the ideal behaviour.
- Post the PowerPoint slide labelled “Improved Sub-behaviour” and point out that this definition is in the participant’s Reference Material #2-8. Ask for a participant to read the definition out loud.

Improved sub-behaviours are:

- o Components of actions or tasks that lead to the desired or ideal behaviour. They are a building block, a stepping stone to the IDEAL practice.
- o Behaviours that, when practiced consistently and correctly, will lead to health improvement.
 - o Considered feasible by the individual/household, from the individual/household members’ point of view, considering their current practice, available resources, and particular social context. The behaviour is feasible because people FEEL they can DO it NOW, given existing context and resources.
 - o Although the behaviour falls short of an ideal practice, it will more likely be adopted by more individuals/households because it is considered feasible within the local context.
 - o It is effective – because it makes a difference to the household and the community.

Module 3, Session 1: Overview of Behavioural Analysis (Continued)

- Now tell the group that sometimes, these sub-behaviours themselves make an impact on health. Show the PowerPoint slide with the “Example Behaviour Ladders” and tell participants they have a copy of this in Reference Material #2-9. These graphics show possible improved behaviours organized as hierarchical ladders with the least desirable sub-behaviour on the left to most desirable on the right. Walk through the examples on the ladder from least desirable to most desirable explaining that:
 - o The top ladder shows that the least desirable behaviour if you have an underweight child (who is old enough to feed itself) is to let it feed from the family dish because it is very difficult to know exactly how much the child has eaten of what foods. The next step up is to have someone, such as an older sibling, feed the child from the family dish because the sibling can be more certain about portion size. Of course, if you scoop out the child’s full portion into a bowl and let her feed herself, then you can be certain how much the child started with and ended with in the bowl. However, a young child can drop a lot of food on the floor or smear a lot of it on her face, so there can still be food that was not consumed from her portion. The “ideal” behaviour, or behaviour most likely to bring about a positive health outcome, is when an adult feeds the young child from a bowl that has the child’s portion in it. This way an adult can closely monitor exactly how much the child ate.
 - o The middle ladder starts with the least desirable behaviour on the left of practicing open defecation. An improvement is to bury your waste (like a cat) because the human waste is at least covered. But an even better behaviour (as shown by studies) is to have all family members put their faeces in an unimproved pit latrine. But one of the problems in a basic unimproved latrine is that it is very difficult to keep clean because it has a dirt or waddle floor and has no ventilation. So, an even better solution is to have an improved latrine because the washable slab on the floor makes it easier to clean, because it will have some sort of cover for the hole to prevent flies from spreading the germs. However, the most ideal situation is to have an improved latrine that also has ventilation to remove the noxious odours.
 - o The bottom example is for steps that a household can take to try to prevent malaria. Burning wood, dung or leaves will produce smoke, which tends to help keep the mosquitoes away, but it is not very effective and can lead to upper respiratory infections. Using a mosquito coil that has chemicals in it will keep mosquitoes away even better. But, applying repellent to your skin works even better than the coils. Sleeping under an untreated bed net will improve the protection you get at night, but using TREATED curtains will keep even more mosquitoes out of the household. The highest level of protection is gained by using a treated bed net or bed clothes.
- Tell the group that with some behaviours, experts have already defined these ladders. For instance, detailed lists exist for nutrition and young child feeding and WASH. If you are trying to create a ladder that does not already exist for a behaviour, you need to make sure to consult with experts in the field to make sure that the various proposed improved behaviours will actually contribute to improved health outcomes.
- Tell the group that this kind of analysis, where improved behaviours that lead to a health benefit are identified, is not always applicable, because it is not possible to “break down” the behaviour into smaller actions. For example, there is not a “small improved behaviour” for using a seat belt. Either you

Module 3, Session 1: Overview of Behavioural Analysis (Continued)

use the belt or not. However, even in these cases, there are still sub-behaviours that can be identified for all behaviours that lead a person closer to being able to do the ideal behaviour.

- Take handwashing as an example. We know that creating a handwashing station makes it much easier for people to actually wash their hands. Therefore creating a station should be promoted by your program as a sub-behaviour when your goal is to increase rates of proper handwashing. Ask the group if they can think of some other examples. (Answers can include purchasing a condom and having it near the bed, putting a reminder sticker or poster in the house for when a child is next due for immunization, creating a birth plan, or an emergency transportation fund, etc.). Emphasize that these are not program initiatives, but rather things that a person can do that will facilitate them ultimately doing the desired behaviour.
- Discuss with the participants “when” the use of small doable actions/behavioural ladders come into play in a communications campaign. For various reasons (such as “political” reasons), it may or may not be possible to include messages in a national level media campaign that reflect small doable actions/improved sub-behaviours. For instance, billboards or posters may need to show the “ideal” behaviour of handwashing with soap. But concepts about a sub-behaviour, such as using alternative cleansers like ash, might be introduced in interpersonal communication activities that are supporting the national level campaign, or they could be woven into a radio drama. It is therefore important to understand what (if any) improved sub-behaviours/small doable actions exist and when it is appropriate to integrate them into your program.
- Review with the participants that once you have a solid grasp on the various barriers and facilitating factors for your particular behaviour and have identified and possibly tested sub-behaviours that will lead your target audience to being able to perform the behaviour, you are then ready to define behavioural objectives and develop your program.

Module 3, Session 2: Conducting Research

| | |
|----------------------------|--|
| Time | 5 hours 30 minutes |
| Learning Objectives | <ul style="list-style-type: none"> • Understand the main theories of behaviour change • Explain the purpose of formative research to a program • Explain how to develop research questions • Discuss existing research sources • Identify the appropriate timing for formative research • Understand the difference between qualitative and quantitative research and when to use each • Identify gaps in existing research and key questions for original research • Explain the necessary inputs to conducting and using original research (sample, methodology, analysis, confidentiality, etc.) • Describe the primary methods for original formative research • Select the appropriate research method for the kind of information that is needed |
| Preparation | <ul style="list-style-type: none"> • Read the session carefully • Review accompanying PowerPoint sessions |
| Materials | <ul style="list-style-type: none"> • Photocopies of handouts #2-4, 2-5, 2-6A and 2-6B • Copies of Theory at a Glance booklet |
| Methodologies | <ul style="list-style-type: none"> • Discussion • Presentation • Small group work • Reading/analytic exercise • Compare/contrast • Analysis |

Activity 1: Large Group Discussion and Presentation: Formative Research (10 min)

- Tell participants that although they've already thought a little bit about what it means to analyse behaviours, in this session they will discuss the process in more detail. Recognize that there is a much longer and more in-depth training course on just formative research than this. This session is meant to give an overview and link with that course, establishing firmly where formative research comes in the process and why it is so important.
- Post the PowerPoint slide labelled, "What is formative research" and ask a participant to read the definition. Point out to the participants that this definition appears in their Reference Material #2-10. Ask the participants to "improve" on this definition by adding to it or changing it.
- Formative research is a type of research or information collection from participant groups to understand ideal behaviour from the perspective and context of target group. The goal is to identify feasible, acceptable and effective strategies to improve certain behaviours. Formative research is done in the beginning of a program or activity and the findings are used to develop strategies, messages, interventions, etc. Formative research includes both existing research (data) and new research and the information is used to fill in the "Behavioural Analysis" portion of the Behaviour Centred Programming Strategy Matrix.

Module 3, Session 2: Conducting Research (Continued)

- Ask participants what they want to achieve by formative research and write their responses on a piece of flip chart paper. When they have finished making suggestions, post the PowerPoint slide labelled, “Formative Research Goals” and cross check it with the participant’s list to make sure that all the points are included:
 - Identify current behaviours
 - Identify if key behaviours can be carried out by target audience
 - Identify small, feasible improvements or alternatives to the key behaviours
 - Identify facilitating factors
 - Identify barriers
 - Identify issues in the enabling environment that would inhibit or promote change in behaviours
 - Identify all important audience groups
 - Provide an opportunity for participant groups to make their own suggestions on what practices the program should promote and facilitate.
 - Test feasibility of solutions

Activity 2: Large Group Work: Forming Research Questions (20 min)

- Tell the participants that the first step you have when looking at existing research or to conduct new research is to define exactly what it is you want to learn. In other words, you need to develop the questions for which you are seeking answers.
- Ask the participants to turn to Reference Material #2-11 and give them a few minutes to look over the questions (see below). Solicit suggestions for additional questions that they might ask during their research.
- General
 - What are people currently doing? Why?
 - Is the key behaviour one that people can practice? Why or why not?
 - What kinds of barriers exist to improving or changing the current behaviour?
 - What needs to happen to enable the change?
 - What kinds of motivators/supports exist to encourage the improved behaviours?
 - What kinds of motivators/barriers exist to discourage the improved behaviours?

Opportunity

- Are the goods or services needed to carry out the behaviour available?
- Is the service delivery considered to be good quality?
- Is the product/good needed to carry out the behaviour considered good/attractive/valuable?
- What are the social or cultural pressures to do or not do the behaviour?
- Is the behaviour regularly practiced in the community and held up as a standard?
- How does the person’s socioeconomic status affect their ability to do the behaviour? (Do they have the money? Is the behaviour something that someone from their social class is “allowed” to do by society?)
- Are there policies that make it difficult/easy for the person to carry out the behaviour? (For example, clinic hours)

Module 3, Session 2: Conducting Research (Continued)

Ability

- o Does the person have the necessary knowledge to carry out the behaviour?
- o Does the person think that they can carry out the behaviour?
- o Who would influence the decision to change?
- o Do the person's peers or family emotionally and physically support implementing the behaviour?

Motivation

- o What motivates that behaviour?
 - o Is it something that the person wants to do or to have?
 - o Does the person feel that they have control over whether they can or cannot do the behaviour?
 - o Are there religious beliefs that may influence carrying out the behaviour?
 - o What is the person's attitude towards the behaviour?
 - o What beliefs influence the person to practice/not practice the behaviour?
 - o Is the person planning on doing the behaviour? Do they want to do it?
 - o Who makes the decision about the behaviour?
 - o How does the person feel about the behaviour?
 - o Is the person willing to pay for the good or services? Do they see a value to it?
 - o What perceived risks might influence someone to carry out the behaviour?
 - o What perceived consequences might influence someone to carry out the behaviour?
 - o What does the person think others are doing? How do the perceived actions of others influence the individual in their decision to undertake the behaviour?
 - o Does the person have the intention do carry out the behaviour?
 - o Do they believe that the desired outcome will be a result of practicing the behaviour?
- Summarize the brainstorm by saying this lists of possible questions is not exhaustive, but rather illustrative of the kind of thinking that needs to happen to understand behaviour. During actual research, the questions need to be tailored to the behaviour being studied. For instance, if you are looking at condom use, one of our potential questions is “are the goods or services needed to carry out the behaviour available.” In order to tailor it to condom use, you might design a series of questions like the following:
 - o Tell me about where you get condoms?
 - o How far away is that?
 - o What is the experience of buying them like—are they always available?
 - o What are the hours of this establishment like?
 - o Are they open when you would go?
 - o Is it safe to go there at night?
 - The information that is sought through these questions is gained through formative research which seeks to collect information from your target audience to understand ideal behaviour from their perspective and context. The goal is to identify feasible, acceptable and effective strategies to improve certain behaviours. Formative research is used in a program or activity to develop strategies. Tell the group that you will address how to do formative research in a bit more detail in the next session, but the questions the group just generated during the brainstorm are those that will need to be answered during the formative research in order to move forward in developing a strategy.

Module 3, Session 2: Conducting Research (Continued)

- As we discussed previously, the answers to some questions already exist. Some you will have to do original research to answer. Let's start with existing information.

Activity 3: Existing Research: Information Sources (30 min)

- Reiterate to the group that much of what they need to know to complete a behavioural analysis is already known. They just need to find it and analyse it.
-
- Ask the group how they normally begin a search for information on a particular health issue or behaviour. Guide the discussion with the following questions and make notes of key points on flip chart paper:
 - o What documents do they consult? Where do they look for information?
 - o How easy is it to get information? Do people/agencies regularly share research findings? Who is the keeper of information?
 - o Is there a methodology to gathering materials or is it more whatever comes across their desk?
 - o What kind of process could be used? (i.e. getting all organizations working on a particular issue together to think about key behaviours and what is already known about them.)
- Review the PowerPoint slides labelled, "Sources of Information" and ask the participants to look at Resource Material # 2-12 "Sources for Programming Information and Research." Ask if anyone has any other websites they would suggest adding to the list.
- Reinforce that information that is not already available in existing sources will be the focus of any new research that they conduct.

Activity 4: Presentation: Conducting Original Research (30 minutes)

- Tell the group that in many cases, the answers to some of the questions you need answered are not known and you will have to conduct original research. Remind the group that this training is NOT going to go into detail on how to conduct or manage original research, but rather provide an overview and a common language with which to work with M&E or research professionals in doing such research.
- Show the PowerPoint slide labelled, "conducting original research"
- Discuss how we often mistakenly assume that just because the project staff comes from the target country that they know the perspective of the priority and influencing group. Ask: Why isn't this true? Explain that you need to look at everything from the perspective/point of view of the priority group who may live a very different life under very different circumstances than the project staff. Ask: Why is this important? What will happen if we don't consider things from the priority group's perspective? [Response: we will not be able to motivate them toward the desired behaviour.]
- Discuss "audience segmentation" for research purposes.
 - Why do you need to segment your audience? [Answer: To reach people who can give you the answers you are seeking.]

Module 3, Session 2: Conducting Research (Continued)

- How should you choose whom to interview/observe during your research? [Answer: Look at the data you are trying to get and think about who might be able to provide you the answers. You can also see what groups other researchers have chosen as participants. Possible sources might include members of your priority group, influential group, service providers, decision makers (village elders, heads of household, etc.), policy makers, providers of goods that are needed to carry out the behaviour, etc. Once you have selected who you think are the research participants who might be able to give you the information you need, consider whether it may be productive to divide the group into smaller subsets in order to ensure you get the information you are seeking. Some categories to consider when sub-dividing your research participants include:
 - Behavioural: what are they doing now?
 - Geographic: urban/ rural; main island/ outer islands
 - Demographics: education; socioeconomic status; age; gender; marital status
 - Cultural: culture; religion; social class
- This kind of segmentation will need to be done for all of your target audiences, including the primary groups as well as any influencer groups.

Activity 5: Formative Research Methods Overview (30 minutes)

- Show the PowerPoint slide titled, “Research Techniques” with the comparison table for qualitative vs. quantitative research. Tell the group that they have much more detailed information on when to use qualitative research and when to use quantitative in their reference packets—Participants Reference Material # 2-13.
- Ask for a volunteer to read the qualitative column and a different one to read the quantitative one. Ask the group to offer some examples of when a qualitative study would be appropriate and when a quantitative one would be best.

| Qualitative | Quantitative |
|---|---|
| <p>Asks why? How?</p> <ul style="list-style-type: none"> • Provides depth of understanding • Studies motivations • Difficult to have exact replication. • Often used for exploratory research. | <p>Asks how many? How often?</p> <ul style="list-style-type: none"> • Measures level of occurrence • Studies actions • Easy to conduct exact replication • Is definitive |

- Explain that researchers can choose from a range of techniques, both qualitative and quantitative, or a combination of the two, to gather the needed information. It is useful to identify research questions first and then afterwards select the most appropriate techniques to answer the questions.
- Now ask the participants about any qualitative research methods or techniques and quantitative research methods that they know or have done. Write answers on flipchart paper.

Module 3, Session 2: Conducting Research (Continued)

- Show slides “Research Techniques, continued” through “Behavioural Analysis” in Unit 2 accompanying PowerPoints. Briefly discuss each of the methodologies. Let the participants know that this training is not going to cover how to implement these methodologies, but they should understand the methodologies well enough to be able to decide which methods are right to answer their particular questions. Tell the group that again, they have much more information on these methodologies in their reference materials—#2-13.

Activity 6: Small group work: Behavioural Analysis (2 hours)

- Tell the groups that now would be the time when they would develop their research plan using some of the things you just talked about and then conduct the original formative research and analysis. However, they will not actually be doing any formative research in this training. Instead, they will use the information contained in the reference packet they received during their last small group exercise. This information is a simulation of the KIND of information that might be obtained through existing channels or through original research.
- Refer the participants back to the Behaviour Centred Programming Strategy Matrix posted on flip chart paper on the wall. Point out that during their last small group work they completed the first section, “1. Situational Assessment” where they defined the ideal and key behaviours and target audiences. Tell the participants that now they will spend time in their small group work teams to fill in the second part of the matrix labelled, “2. Behavioural Analysis: Current Behaviours, Existing Barriers, Existing Facilitating Factors, and Improved Sub-Behaviours/Small Do-Able Actions.”
- Show the PowerPoint slide labelled with the blank version of the “Behavioural Analysis Matrix”, and tell the participants that every small working group needs to get a copy of this printed out before they divide up into their groups.
- Show the PowerPoint slide labelled, “Instructions for Small Group Work: 2. Behavioural Analysis” and tell the participants they need to:
 - Fill in as much of the Behavioural Analysis portion of the matrix as possible (from information in the packets and from data that they may already know), but remind the participants that it is okay to leave items blank if they do not have supporting data.
- Distribute copies of Training Handouts 2-4 and 2-5 (copies of the matrix and instructions for the small groups) and tell the participants they have 2 hours to complete this task.

Activity 7: Taking Stock (90 minutes)

- Have each group briefly present back to the rest of the participants their matrix, as it stands. As each group goes, the facilitator should use the completed examples of the matrices (Training Handouts #2-6A and 2-6B) for stunting and diarrhoea prevention to provide feedback to the groups. Ask the participants what was challenging for them and if there are still aspects of doing a behavioural analysis that don't make sense. Answer questions by asking members of the other group that worked on the same topic what they think.

Module 3, Session 2: Conducting Research

(Continued)

- Pass out copies of Training Handouts #2-6A and 2-6B to the groups, explaining that this handout is kind of the “answer key.” Much of what they just presented is reflected in the matrix. Emphasize that this handout does not mean that what they thought of was wrong and in fact the matrices in real life would always look different depending on who develops it. Explain that you just wanted to bring all the groups back together to the same place and have a fresh copy to start with for the next day. If there are things that the group thought of not reflected on the matrix, feel free to add them.
- Ask the participants to look over these clean matrices this evening and come in the morning with any lingering questions or concerns.

Activity 8: Daily Evaluation: DAY 2 (5 min)

- Distribute the training evaluation for Day 2 and ask that each person complete it and hand it back to you before leaving for the evening. Conclude for the day.

Instructions for Small Group Work on Behavioural Analysis

- Fill in Behavioural Analysis matrix (from info in the packets and from data that they may already know); okay to leave items blank if do not have supporting data.

Blank Behavioural Analysis for Use in Small Group Work

| 2. BEHAVIOURAL ANALYSIS | | | |
|-------------------------|-------------------|-------------------------------|--|
| Current Behaviours | Existing Barriers | Existing Facilitating Factors | Improved Sub-Behaviors/Small Do-Able Actions |
| | | | |

Completed Situational Assessment and Behavioural Analysis; Stunting

| HEALTH PROBLEM: 53% Stunting in Children <2 | | |
|---|---|---|
| I. Situational Assessment | | |
| Ideal Behaviours | Key Barriers | Target Audiences |
| <ul style="list-style-type: none"> • Appropriate Pre-natal nutrition during pregnancy • Immediate Initiation of Breastfeeding • Exclusive Breastfeeding up to 6 months • Continued Breastfeeding up to 2 years • Appropriate complementary feeding 6 months to 2 years • Periodic micro nutrient Supplementation • Regular deworming • Vaccination • Growth Monitoring | <p>Appropriate complementary Feeding 6 months to 2 years:</p> <ul style="list-style-type: none"> • Meal frequency • Consistency of food • Amount of food at each meal for age • Diversity of foods at each meal/per day (protein, fat, carbohydrate) • Continued feeding when sick • Feeding style (caregiver feeds from own dish) • Food storage (covered and not left out for more than 1 hour) • Water treatment (all water used to make baby's food is treated by boiling chlorine, filtration or other product) • Continued breastfeeding to 2 years | <ul style="list-style-type: none"> • Mothers and caregivers of children from 6 months to 2 years |

Completed Situational Assessment and Behavioural Analysis; Stunting

| 2. BEHAVIOURAL ANALYSIS | | | |
|--|---|--|---|
| Current Behaviours | Existing Behaviours | Existing Facilitating Factors | Improved Sub-Behaviors/Small Do-Able Actions |
| <ul style="list-style-type: none"> • Most children (97%) are breastfed to 1 year, but a 2 years, only 50% are still breastfeed • Mothers stop breastfeeding if they become pregnant again • Children are not fed an adequately diversified diet- consumption of grains is very high, but protein and fat is very low. • Legume and vegetable consumption is adequate only at certain times of the year • Children are not fed frequently enough (3x day + 2 snacks), particularly during the late dry season. | <ul style="list-style-type: none"> • A good diversity of food are not always available • Mothers do not know the correct amount or consistency of food to feed their child • Mothers believe pregnancy turns their breastmilk bad • Mothers and fathers believe that if the woman is not eating enough herself, she cannot continue to breastfeed the child • Mothers work outside the hoe and cannot express milk • Some proteins, such as fish and dairy products, are not seen as acceptable for young children • Commercially available complimentary foods very expensive | <ul style="list-style-type: none"> • Mothers prefer to give their children foods prepared at home • The mother usually feeds the child herself • Mothers want to see their children thrive and grow | <ul style="list-style-type: none"> • Feed 2X day instead of 3 during dry season, but also give a small snack • Add oil to the porridge to provide source of fat and thicken it • Add protein—egg, chicken- to meals at least twice a week • Stockpile foods that are dry-able like legumes for the dry season to feed specifically to the <2. • Continue BF in the morning and evening (before/after work). • Use local foods rather than commercially sold ones |

Completed Situational Assessment and Behavioural Analysis; Diarrhea Disease

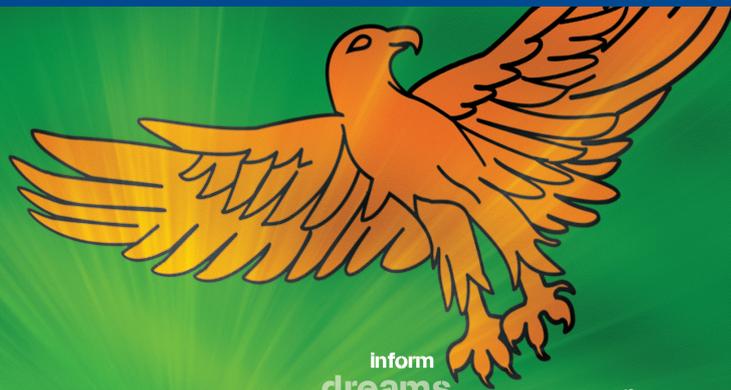
| HEALTH PROBLEM: 3% Zambian children under the age of 5 die of diarrhea | | |
|---|--|---|
| I. Situational Assessment | | |
| Ideal Behaviours | Key Behaviours | Target Audiences |
| <ul style="list-style-type: none"> • Drinking treated & safe water • Handwashing (HW) after using the latrine, & changing baby's diaper, & before preparing food, eating feeding a child, & nursing • Helping children under 5 wash their hands • Proper human waste disposal & management • Eating a balanced diet rich in nutrient content • Consuming ORS & extra fluids • Seeking medical care at signs of dehydration | <ul style="list-style-type: none"> • Handwashing with soap before • Eating (for child old enough to feed itself) • nursing <p>Handwashing with soap after</p> <ul style="list-style-type: none"> • using the latrine (for caregiver & child old enough to use latrine) • changing baby's diaper | <ul style="list-style-type: none"> • Caregivers of children under 5 • Children under 5 years of age |

Completed Situational Assessment and Behavioural Analysis; Diarrhea Disease

| 2. BEHAVIOURAL ANALYSIS | | | |
|---|--|--|--|
| Current Behaviours | Existing Barriers | Existing Facilitating Factors | Improved Sub-Behaviors/Small Do-Able Actions |
| <ul style="list-style-type: none"> Caregivers not washing hands consistently after coming into contact with human waste and before feeding or nursing child Infants/young children almost never washing hands (on their own or with adult's help) | <ul style="list-style-type: none"> Water has to be hauled from a long distance and is available in limited amounts (rural areas) Water is expensive for households (urban areas) Household norm is to use soap only for laundry, dishes, bathing, and HW when hands smell, look dirty (but not for routine HW) Soap and water not available near latrine or area where eating/nursing takes place Caregivers have limited time to be washing their own hands or teaching a child to wash his/her hands young children's waste not perceived as "dirty/contaminated" Having a young child die is seen as "normal", even though it is a source of emotional pain Soap very expensive | <ul style="list-style-type: none"> A sense of "pride" is associated with having a clean looking household Clean looking children are a source of pride Caregivers say they would be more willing to wash their hands and to help young infants/children wash their hands if soap and water are available Almost every household already has some kind of soap (laundry or bath soap) Households want to decrease the amount of money they spend on medicines and going to the health center | <ul style="list-style-type: none"> Place water and soap outside the latrine Place water and soap near location where baby's diaper is changed Place water and soap near area where family eats and bay is nursed Caregiver wash hands a minimum of 4 times per day Caregiver teach crawling babies—5 years old to wash hands Use a soap substitute like ash or sand Make a tippy tap and set it up at the handwashing station |

Trainer's Manual

DAY 3



empower

act

honor

people

inspiration

teamwork

educate

strength

trust

believe

motivation

support

share

achieve

inform

dreams

enable

learn

create

behaviour

courage

own

opportunity

goals

change

desire

challenges

motivation

success

Review of Concepts (Maternal Mortality Reducation Behavioural Analysis)

| | |
|----------------------------|--|
| Time | 60 minutes |
| Learning Objectives | <ul style="list-style-type: none"> Reviewed concepts from Day 2 |
| Preparation | <ul style="list-style-type: none"> Read the session carefully Review accompanying PowerPoint slides |
| Materials | <ul style="list-style-type: none"> Copies of training handout #2-7A, Maternal Mortality information packet and #2-7B completed situational assessment and behavioural analysis matrices for Maternal Mortality Reducation example Flipchart Markers |
| Methodologies | <ul style="list-style-type: none"> Group exercise Discussion |

Activity 1: Review (10 minutes)

- Welcome the group to the day. Tell them that you want to start out by reviewing what you talked about yesterday afternoon.
- Ask for a volunteer to walk through each column in the behavioural analysis section of the matrix and explain briefly what is meant to go in each column.

Activity 2: Example (50 minutes)

- Tell the group that you want to try another example of behavioural analysis using a new example.
- Pass out copies of the Maternal Mortality information packet, Training Handout #2-7A. Tell the group that the health problem for the new example is the high rate of Maternal Mortality. Reducing it through delivery with a skilled-birth attendant is the key behaviour for the program.
- Give each person 10 minutes to read the packet to themselves. Show slide titled, “Step 1: Situational Assessment What’s the problem? What’s the solution?” and ask them to note down in the margins:
 - What the major barriers are to safe delivery with skilled birth attendants
 - What the existing facilitating factors are
 - Any other relevant contextual information
 - What a set of small-doable actions might be
 - The important audience groups
- Show a blank behavioural analysis matrix slide and have the group use their thinking to fill in the new matrix. Take notes on a flip chart.
- Now show the completed behavioural analysis matrix for Maternal Mortality Reducation slide. Ask the group how this one compares with the one they just came up with. Are there any omissions? Would they change/add anything?
- Ask if there are any final questions on the topic of behavioural analysis. Make sure this is clearly understood by all participants before moving on. Pass out copies of Training Handouts #2-7B, Situational Assessment and Behavioural Analysis, Safe Motherhood for the participants to take as reference tools.

Program Brief Safe Motherhood

Health Problem: Maternal mortality ratio of 550/100000

Ideal Behaviours:

- Women deliver with skilled attendant (hospital, clinic, or with community nurse-midwives)
- Women participate in at least 3 antenatal care sessions with trained attendant during pregnancy
- Women receive a postpartum visit within 3 days of birth
- Women achieve optimal nutrition during pregnancy (quantity and quality)
- Women space their pregnancies at least 2 years apart.
- Women delay childbearing (and marriage) until at least 18

Key Behaviour: Women deliver with trained attendant

Primary Target Audience: Pregnant Women

Context:

Country X has one of the highest maternal mortality ratios in the world, with approximately 550 per 100,000 women dying during or immediately following childbirth. Reducing this ratio has become a top priority for the country. Although a number of interventions have been shown to affect the maternal mortality rate (MMR), the most effective intervention, resulting in saving the most lives, is for women to deliver their children with a skilled birth attendant.

Recognizing the lack of physical access that many women have to a hospital or clinic, the government of Country X has committed to training a new cadre of skilled community nurse-midwives who will undergo extensive preparation before being stationed in rural districts around the country. These midwives, together with the doctors and obstetric nurses at the few regional hospitals in the country, will be the frontlines of the effort to reduce the high MMR. They will emphasize modern obstetric principles and hygiene, such as provision of safe delivery birthing kits. The trained midwives will adopt a standard of practice that includes immediate disposal of all biomedical waste such as the placenta, and use of only government approved pharmaceutical interventions, such as misoprostol, for complications.

Currently, only 5% of women deliver in a facility, and only 20% in total deliver their babies with an attendant who would qualify as skilled. Instead, most women labour in private or with one female family representative until she reaches the very end of labour, when a traditional attendant and the woman's female relatives join her to help urge the baby out. Women usually labour in various positions, moving as they need, but it is common to tie a rope from the ceiling of the birthing hut from which they can support themselves as they squat or pull on the rope as they bear down to push the baby out. The placenta is never pulled out after the baby, but rather is delivered naturally and then immediately taken for preparation to be buried in a sacred family place. The baby is immediately anointed with water, which has been blessed by the highest ranking member of the baby's clan. If the mother's labour becomes prolonged, her female relatives assist the labour by pushing on her stomach to aid in the delivery. Haemorrhage is considered a sign that the baby will be fiery in life and is considered a positive birth outcome. If the mother's bleeding does not quickly stop, however, she is treated with an herbal remedy, Blue Cohosh leaves and Borage oil, that causes weak uterine contractions.

Program Brief Safe Motherhood

(Continued)

More than 50% of women in Country X live more than 15km from a health facility. When they go to a facility, they are charged—either in currency or trade such as soap. With 65% of families in Country X making less than \$1 a day, many women say that they simply cannot afford going to a facility. Women say they are afraid of what goes on in a hospital and that their baby's natural spirit will be suppressed if they are forced to deliver in an unnatural way.

Further, the skilled midwives who already exist and are stationed in the villages are not regularly paid, even though they are government employees, so many expect payment from women for antenatal services as well as deliveries, usually in trades such as 10 pieces of soap, or 10 kilos of sugar. Women report cases in which they are insulted and belittled if they cannot pay.

Husbands do not usually enter into matters of delivery, but in some small studies, they report feeling that no more money should be allocated to their wives labour and delivery, as birthing babies is something natural that women have been doing forever that should not require medical treatment. There is distrust of the government and a belief that the government is trying to eradicate the traditional ways and make money.

Women feel that the most important moment in their life is the one in which their first child is born. They become complete as a woman, fully initiated and recovering from the labour is seen as urgent. The sooner the recovery takes place, the sooner she can take her rightful place as the matriarch of her own family, officially leaving behind her mother and her mother-in-law as the decision makers.

Completed Situational Assessment and Behavioural Analysis; Safe Motherhood Example

| HEALTH PROBLEM: Maternal mortality ratio of 550.100000 | | |
|--|---|--|
| I. Situational Assessment | | |
| Ideal Behaviours | Key Barriers | Target Audiences |
| <ul style="list-style-type: none"> • Women deliver with skilled attendant (hospital, clinic, or with community nurse-midwives) • Women participate in a least three antenatal care sessions with trained attendant during pregnancy • Women receive a postpartum visit within 3 days of birth • Women achieve optimal nutrition during pregnancy (quantity and quality) • Women space their pregnancies at least 2 years apart • Women delay childbearing (and marriage) until at least 18 | <p>Women deliver with skilled attendant (hospital, clinic or with community nurse-midwives)</p> | <ul style="list-style-type: none"> • Pregnant Women • Families of pregnant women • trained birth attendants • Traditional birth attendants |

Completed Situational Assessment and Behavioural Analysis; Safe Motherhood Example

| 2. BEHAVIOURAL ANALYSIS | | | |
|--|---|--|---|
| Current Behaviours | Existing Behaviours | Existing Facilitating Factors | Improved Sub-Behaviors/Small Do-Able Actions |
| <ul style="list-style-type: none"> • Only 5% deliver in a facility/20% deliver with a skilled attendant • 80% deliver independently with a traditional attendant and female relatives at the end of labor • Laboring happens in many positions, including using a rope suspended in the ceiling as a support • Placenta is delivered naturally/taken for burial • Rites/blessing are performed immediately after birth • Traditional herbs are given for PPH | <ul style="list-style-type: none"> • Svcs of midwives are \$\$/women can't afford them • Women are afraid of modern ways of hospitals • Husbands don't believe hospital deliveries are necessary • Husband distrust modern medicine • Facilities are far from the home | <ul style="list-style-type: none"> • Women feel that a successful birth is critical to their identity as a woman • The government has already invested in a training program for midwives to be based in communities | <ul style="list-style-type: none"> • Women create a birth plan and consult with a skilled attendant prior to birth • Women attend prenatal classes/support groups to learn from other women about ways to incorporate traditional practices into a modern birth. • Women discuss transportation issues with their husbands |

Module 3, Session 3: Defining Behavioural Objectives & Audience Groups

| | |
|----------------------------|---|
| Time | 15 minutes |
| Learning Objectives | <ul style="list-style-type: none"> • Use research findings to define final behavioural objectives for the behaviour change program • Use research findings to solidify choice of audience groups for program implementation |
| Preparation | <ul style="list-style-type: none"> • Read session carefully • Prepare necessary flipchart paper |
| Materials | <ul style="list-style-type: none"> • Photocopies of handout #2-8A |
| Methodologies | <ul style="list-style-type: none"> • Discussion • Brainstorm • Small group work |

Activity 1: Defining Behavioural Objectives (5 minutes)

- Show slide titled, “Learning Objectives” and read them aloud.
- Tell the group that once you have completed your research you will know exactly WHAT behaviours you are going to target and WHAT your priority group will be for your behaviour change intervention. The next step is to define your program.
- Show the slide with the diagram of how the program definition fits into the overall picture. Explain that the program definition basically just establishes a roadmap for where you are going—it defines your objectives in terms of behaviour and your target audience group. Walk the participants through the slide and make sure that they understand. Emphasize that the behavioural objectives are different from communication objectives in that they are much bigger. Ultimately, achieving your communication objectives will lead to achieving your behavioural objectives. You will discuss communication more in a while. For now, it is critical to decide what it is you are ultimately trying to do and that’s what the behavioural objectives are asking of you.
- Ask the group to brainstorm what are the characteristics of an objective and write their suggestions on flip chart paper. Show PowerPoint slide titled “Program Definition” and emphasize what many people already know—that an objective should be SMART:

| | | |
|----------|-------------------|---|
| S | Specific | Significant, Stretching, Simple |
| M | Measurable | Meaningful, Motivational, Manageable |
| A | Attainable | Appropriate, Achievable, Agreed, Assignable, Actionable Action-oriented, Aligned, Aspirational |
| R | Realistic | Results-focused, Resourced (funded), Relevant |
| T | Time-bound | Timely, Track-able, Tangible |

Module 3, Session 3: Defining Behavioural Objectives & Audience Groups (Continued)

- Have the group name some of the behaviours they have been considering and discussing. Write 2 or 3 examples on a flipchart paper. If the group is struggling, examples can include:
 - o Birth/delivery with a skilled attendant
 - o Handwashing with ash
 - o Giving an adequate quantity of food at each meal
- Now have the group try to convert each of the 2-3 behaviours listed (or the examples above) into behavioural objectives. For example, a behavioural objective for Birth/delivery with a skilled attendant might be:
 - o The objective is to increase rates of women who deliver with a skilled birth attendant from 25% to 40% in the first two years of the project.

Activity 3: Finalizing target audience (5 minutes)

- Call attention to the fact that the behavioural objectives include an audience group. Remind the group that at this stage, the primary audience group and the potential influencer groups have been extensively discussed, defined and researched. The only thing left to do is go back to the original audience segmentation done as part of the situational assessment and, considering all the research findings, make sure those audience groups are, in fact, the critical ones. Perhaps you learned something in your research about a different influencer group you hadn't originally considered? Perhaps one you thought would be important was not? Before moving on to develop your strategy, these groups need to be finalized.

Activity 4: Presentation Safe Motherhood example (5 minutes)

- Present PowerPoint next slide also titled, "Program Definition" to remind participants of where in the matrix you have come to.
- Present slide titled, the Program Definition (Behavioural Objectives and Final Target Audience group) for the safe motherhood example that we saw previously and pass out Training Handout #2-8A. Read it aloud and note that in this case, the behavioural objectives are very high-level and that you could break that down into smaller chunks if you wanted to (based on the actions/practices listed in your small do-ables column.)
- Tell the group that they will have a chance to practice doing this in after they go through the session on activities planning.

Completed Program Definition Matrix for Safe Motherhood

| 3. Program Definition | | |
|---|---|--|
| Program Goal | Behavioural Objectives | Final Target Audiences |
| <p>To decrease all-cause maternal mortality from 550/100,000 per year to 250/100,100 per year in 2 years.</p> | <p>To increase rate of deliveries with skilled birth attendant among all pregnant women in Country X from 20% to 45% in 2 years</p> | <ul style="list-style-type: none"> • Pregnant mothers • Husbands • Traditional birth attendants • Female relatives • Existing relatives • Existing midwives • New midwives • Traditional leaders |

Module 4: Strategy Formulation

| | |
|---|-----|
| Module 4: Strategy Formulation | |
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Module 4, Session 1: The Behaviour Change Strategy

| | |
|----------------------------|--|
| Time | 150 minutes |
| Learning Objectives | <ul style="list-style-type: none"> • Understand the inputs to a comprehensive behaviour change strategy • Understand how communications fits into a BC strategy • Develop Strategic Behaviour Change Activities |
| Preparation | <ul style="list-style-type: none"> • Read the session carefully • Review accompanying PowerPoint slides |
| Materials | <ul style="list-style-type: none"> • Copies of Training Handout #2-8, #2-9, & #2-10 • Flipchart paper • Markers |
| Methodologies | <ul style="list-style-type: none"> • Discussion • Presentation |

Activity 1: Introduction to the behaviour change strategy (30 minutes)

- Show slide titled, “Learning objectives for the behaviour change strategy session” and read them aloud.
- Explain to the group that the next step, once they have finished their behavioural analysis and defined behavioural objectives is to develop the behaviour change strategy and the communications plan. In this session, you will explore the behaviour change strategy.
- Ask the group to think about when they first received the behaviour-centred programming strategy matrix and discussed the words “strategy”. Show slide titled “Strategic Behaviour Change Activities” and remind the group of a definition for “strategy.” They have seen this definition before, but ask for a participant to once again read it aloud to give context to what they are doing in this session.

A strategy is a plan to achieve a particular goal or result. It is driven by evidence, includes multiple but tightly integrated channels, a multiplicity of stakeholder groups, a focus on impact, including evaluation of impact and use of a process in which the target audience is not just a passive recipient, but also has a voice in creating the direction of the communication. It should help ensure that program activities and communication messages are “on strategy” and not merely planners’ personal ideas.

- Tell the group that in this session, they will use everything that they have done previously to develop their strategy or plan for facilitating the desired behaviour change. As you have discussed, this requires ultimately eliminating the barriers, increasing supports and leveraging motivations. But these are just terms. It is in the strategy that you actually explain HOW you will do these things.
- Have the group look at page 7 in their quick guide to behaviour centred programming booklets. Remind participants that they have already seen this, but you want to now go into it in detail.
- Turn to the pre-written flipchart paper (sheet #6) posted on the wall with Step 4 (Strategic Behaviour Change Activities) of the matrix written out. Ask for a volunteer to read the headings at the top of each column. Note that “communication” is only one category of many that can be used to effect behaviour change. Reinforce that the behaviour change strategy needs to take into account ALL the activities that need to be implemented in order to affect behaviour change.

Module 4, Session 1: The Behaviour Change Strategy (Continued)

- Ask the group to brainstorm some examples of activities for each column. Write their examples in the appropriate column on the flipchart paper. Once the discussion has dwindled, show slide titled “Refining the Scope” with examples of what can be included in each column.

| 4. Strategic Behaviour Change Activities | | | | | |
|---|---|--|--|---|--------|
| Communication | Training | Community Mobilization/ Collective Action | Commodity or Technology | Advocacy | Others |
| <p>MASS MEDIA Radio drama Radio spots Billboards TV</p> <p>COMMUNITY LEVEL Community Theatre house-to-House Counselling Visits Group Discussion Meetings</p> <p>MOBILE APPLICATIONS SMS Reminder Website Friendster application (Facebook, other)</p> <p>Other</p> | <p>Health worker training on interpersonal Communication</p> <p>Regional manager training on management of BCC programs</p> <p>Theater troupe training on post performance discussions</p> <p>Other</p> | <p>Champion communities activities</p> <p>PHAST/Open Defecation Free Activities Savings Collectives for emergencies</p> <p>Other</p> | <p>Sale/dissemination of health commodity like bednets, soap, condoms, oills, etc...</p> <p>Sanitation marketing activities</p> <p>Availability of family planning services</p> <p>Other</p> | <p>Clinic hours changed to better accommodate mothers</p> <p>National policy changed to allow traditional birth attendants to use medicine for postpartum maemorrhage</p> <p>Fines for those families not using bednets</p> <p>Others</p> | |

- Tell the group that this example matrix is also found in their participants’ reference materials booklet, Material # 2-15. They are welcome to add categories (columns) as needed. If they see the need for a kind of activity that doesn’t fit anywhere else, it can become its own column. Also, if some categories (such as policy change) are not relevant in this case, they can omit it.
- Emphasize that ALL activities necessary to ensure a change in behaviour should go into the strategy, even if it is ultimately not something the health promotion team will be directly responsible for overseeing. Otherwise, communication will not be well integrated into a program.
- Explain that in the next session, they will look at what goes into a communication-specific plan where they will determine what kind of communication they want to use. Reiterate that all of these various kinds of activities in the behaviour change strategy must work together to support and reinforce each other.

Module 4, Session 1: The Behaviour Change Strategy (Continued)

- Pass out training handout # 2-8B, the completed strategic behaviour change activities matrix for the safe motherhood example. Show slide titled “Small group work: behavioral objectives/target audiences & Strategic Behavior Change Activities,” and walk the group through the example and ask if anyone has any additions or suggestions for changes.
- Remind the participants that communications is NOT just campaign development, but also includes interpersonal communications and community-level communications such as theatre and discussion groups.

Activity 2: Refining the Scope (15 minutes)

- Now tell the group that the final step is to take a look at the whole picture they have created and decide if the scope of the proposed program is feasible. This includes looking at the number of behavioural objectives you have listed and deciding if you really can address all of them and, if so, if you have proposed activities that indeed are capable of addressing them. (e.g. one short radio spot cannot address 5 behavioural objectives, but a longer, in-depth radio drama can).
- Ask the group to brainstorm some of the criteria that might be necessary to consider when refining the scope. List responses on a flip chart, then show the PowerPoint slide titled “Refining the Scope” (#73) and ensure the discussion includes the following:
 - o What are the financial resources of your program? Can they cover the breadth of the scope proposed?
 - o What are your human resources? Is there a team in place to manage the scope you have proposed?
 - o Do you have partners in place to execute the activities? If not, how difficult will it be to get partners in place? Without partners to execute some of the activities, does it make sense to do the others? (e.g. without community health workers working at a household level to help mothers improve feeding practices, does it make sense to do a national radio spot?)
 - o Are some of your behavioural objectives things other groups are already working on? Perhaps you can join forces or maybe you want to direct your attention to a different aspect.
 - o Do your activities allow for working with multiple objectives?
 - o Will you use a phased approach or everything all at once?

Activity 3: Small Group Work: Behavioural Objectives, Target Audience Group and Activities Development (60 minutes)

- Have the participants form into their work-teams again. Pass out Training Handout #2-9 (blank Step 3, and Step 4 matrices) and Training Handout #2-10 instructions for small group work on behavioural objectives and final target audience, and strategic behaviour change activities development

Module 4, Session 1: The Behaviour Change Strategy (Continued)

- Use the “clean” copies of the situational assessment and behavioural analysis matrices they were given that morning (Training Handouts #2-6A and B) to build a program:
 - o Establish program goal
 - o Define their final list of behaviours as behavioural objectives
 - o Re-examine their choice of primary and influencer audience groups and finalize their choices. (step 3)
 - o Complete the strategic activities matrix (Step 4)
- Tell them that when they do this in real life, they will not only fill in the matrices, but they should also write a document that will go into more detail on the background and process, the behavioural analysis sources and results, the process of audience segmentation and the activities proposed.
- Give the groups 60 minutes to complete the tasks. Once finished, each will present their work and receive feedback.

Activity 3: Presentations: Behavioural Objectives, Target Audience Group and Activities Development (45 minutes)

- Have each of the groups present their work and provide feedback using the completed matrices for each case study. (Training Handouts #2-12 A &B). These will be distributed to the participants in Session 3 of this module, but just use them here to support you in providing feedback.

Completed Behaviour Change Strategic Activities Matrix for Safe Motherhood

4. Strategic Behaviour Change Activities: Safe Motherhood Example

| Communication | Training | Community/ Mobilization/ Collective Action | Commodity of Technology | Advocacy |
|---|---|---|----------------------------|---|
| <p>MASS MEDIA</p> <p>Radio drama on integration of traditional and modern medicine in birthing (e.g. labor positions, placenta burial, etc...) and the importance and possibility of coexistence of both kinds.</p> <p>Radio spots to emphasize the benefit of a skilled attendant in ensuring a successful birth and the new availability of midwives</p> <p>Billboards to reinforce radio drama and radio spots</p> <p>COMMUNITY LEVEL</p> <p>Community Theater on how traditional practices can still be done at the same time as modern medicine</p> <p>Pregnant women's discussion groups about their fears and introductions to midwives who will explain how everything could work (discussion guides)</p> <p>Individual sessions to work with women and their husbands to create a birth plan including emergency planning and savings for any fees that might be incurred (counseling cards)</p> <p>Religious and traditional leaders talk to the community about how using a midwife increases the chance of a successful birth experience (talking point guides)</p> | <p>Training for midwives on how to integrate traditional practices into modern medicine and how to be a partner in the process of delivery as opposed to the director</p> <p>Training for CHWs on counseling for this topic</p> <p>Training of religious and traditional healers on how and when to talk with their communities about this topic AND why it is important.</p> | <p>Safe Mother's Day celebrations to honor mothers, and their children and to encourage them to be as safe as possible (including speeches by traditional healers, traditional healers and modern medicine practitioners to discuss how the various approaches can coexist.</p> | <p>None required</p> | <p>Allowing for traditional practices to coexist with modern medicine, including permitting the woman to keep the placenta, labor in any position she wishes and perform rituals immediately after birth.</p> |

Blank Matrices for Small Group Work

| 3. Program Definition | |
|------------------------|------------------------|
| Behavioural Objectives | Final Target Audiences |
| | |

Blank Matrices for Small Group Work

| 4. Strategic Behaviour Change Activities: Safe Motherhood Example | | | | |
|---|----------|--|----------|-------|
| Communication | Training | Community/ Mobilization/ Collective Action | Advocacy | Other |
| | | | | |

Instructions for Small Group Work on Defining Behavioural Objectives, Developing Behaviour Change Strategic Activities and Communications Plan

You have 60 minutes for this exercise:

- Use the “clean” copies of the situational assessment and behavioural analysis matrices they were given that morning (Training Handouts #2-6A and B) to build a program:
 - o Define final list of behaviours as behavioural objectives
 - o Re-examine choice of primary and influencer audience groups and finalize their choices.
 - o Complete the strategic activities matrix (Step 4)
- When you do this in real life, you will not only fill in the matrices, but you should also write a document that will go into more detail on the background and process, the behavioural analysis sources and results, the process of audience segmentation and the activities proposed.

Module 4, Session 2: The Communications Plan

| | |
|----------------------------|--|
| Time | 150 minutes |
| Learning Objectives | <ul style="list-style-type: none"> • Understand the difference between a communications plan and a behaviour change strategy. • Understand the inputs/sections of a communications plan • Develop a communications plan |
| Preparation | <ul style="list-style-type: none"> • Read the session thoroughly • Review accompanying PowerPoints |
| Materials | <ul style="list-style-type: none"> • Photocopies Training Handouts #2-11, #2-12 and #2-13 and #2-14 • Flipchart paper • Markers |
| Methodologies | <ul style="list-style-type: none"> • Discussion • Presentation • Brainstorm • Small group work |

Activity 1: Large group discussion (20 minutes) What is a communication plan?

- Show slide titled, “Learning Objectives,” and read them aloud.
- Show slide containing the blank communications plan and describe what goes in each box (use p.8 of the quick guide text as a guide). Emphasize to the group that the purpose of a communications plan is to provide a detailed roadmap for the “communications” category in the BC strategy. They are tightly linked. In fact, each “activity” column (communications, training, community action, etc.) could and should have its own detailed strategy or plan, depending on the project. If you are promoting or selling a product, a marketing plan would be necessary. If you are emphasizing advocacy to change policy, a detailed advocacy plan would be necessary. In this instance, since we are tasked with creating strategic communications, we will focus on creating a plan for communications.
- Ask the group to think about the exercise they just completed where they defined their Strategic Behaviour Change Activities. Ask them what information they did NOT include in that strategy that would be necessary to include in a communications plan. Answers should include: primary message, secondary message, and material or channel for each audience group.
- Emphasize that the message content that go into the communications plan should be based directly on the behavioural analysis that was conducted to identify the barriers/motivations/supports and should address those things directly. Frequently this is one of the hardest things to do. In the next activity, they will practice doing this. Tell the group that the most important thing to remember is that

**MESSAGES SHOULD ADDRESS BARRIERS/FACILITATING FACTORS,
not necessarily the behaviour itself.**

- Note to the participants that their responsibility with messages is to create the CONTENT of the message. The actual message (what goes on the poster, what goes in the counselling card, what is said on the radio) is something a creative agency will usually come up with.

Module 4, Session 2: The Communications Plan (Continued)

Activity 2: Brainstorm – Developing Message Content (20)

- Ask the participants to brainstorm what they consider to be the characteristics of a “good” message. Note the responses on flip chart paper. Make sure that they include the following:
 - o It is evidenced based
 - o It is easy to understand
 - o It addresses a barrier or encourages a support/motivating factor for a behaviour
 - o It is believable
- Now ask the group to reflect on what the words “Evidenced-based” mean. List the responses on a flip chart.
- After a short brainstorm, tell the group that creating evidenced-based messages for communicating means using the findings from their behavioural analysis to create those messages.
- Show the slide titled “Good message development” and have a volunteer read it aloud. Pass out Training Handout #2-11 and tell the group that this should be their reference for how to develop a strong message.
- Now show the next slide, the message development example and present the following short example:
 - o The key behaviour is consistent and correct condom use among all partners,
 - o The research shows that major barrier to consistent and correct condom use is that many people believe that a regular partner asking them to use a condom means he or she is being unfaithful.
 - o A campaign was developed in which radio ads went out, billboards went up and posters were plastered all over the country telling men to “Save your Life. Use a Condom.” Community Health Workers spent time working with community groups telling them how HIV is transmitted and that using a condom is a good way to prevent it.
- Ask the group if they think the program is “evidenced-based”. Why or why not?
- Tell the group that in this instance, this program IGNORED the evidence, going right back to the key behaviour and just simply telling people to practice it. The planners did the correct research, they uncovered something critical, but then they didn't USE it to construct their communications.
- Ask the group what alternate strategies might have been used?
 - o Answers could include:
 - Segment your audience—start with people who are just starting a new relationship and ensuring that they are safe
 - Focus on the consistent message—once you start, don't stop—you don't know anything different now than you did in the beginning because the past is never past with HIV.
 - Use media that allows for a more thorough explanation and exploration of the subject like a docudrama

Module 4, Session 2: The Communications Plan (Continued)

- Pass out Training Handout #2-12, Communications Plan Example: Safe Motherhood and display the corresponding slide. Use the tool to walk the group through what a communications plan might look like.
- Note to the group that one aspect of communications that you are not going into great detail on in this training is using mobile technologies. Show the slide titled, “Tips for Leveraging Technology in Communications,” and briefly go through it, noting that the participants have a copy of this table in the Participants Reference Materials (#2-16).

Activity 3: Considerations for how to present the message (20 minutes)

- Now ask participants to think briefly about their experiences with HOW messages are presented. Ask, “Is it better to be positive or negative? To play on fear or hope? To address myths head on or just address the facts?”
- Allow for a few minutes (10 maximum) discussion about these ideas.
- Refer participants to Participants Reference Material #2-17 “Considerations for How to Present the Message”. Tell the participants that this material is a copy of two longer articles they can read later but you want to touch on a couple highlights. Show slide titled, “Considerations for Presenting the Message” and note:
 - Myths are a challenge for communicators.
- Frequently when a communications effort tries to convince people a myth or misinformation is incorrect, they actually end up reinforcing the very myth/misinformation. By mentioning it, it is almost as though the myth is being legitimized.
 - Fear can be a powerful tool in communication, but fear-based communication should be approached cautiously as messages, images or concepts that are too frightening or are not culturally appropriate can cause some in the target audience to avoid the message altogether. To use fear, the threat must be imminent—it is difficult to make people sufficiently (for behaviour change) afraid of something that is not likely to happen or is not likely to happen soon.
- Now lead a discussion about how to deal with myths and misinformation in light of these research findings. Ensure the group agrees that if a myth represents a barrier that is preventing someone from practicing a key behaviour and it must be addressed, it is important to be factual and not to repeat the myth in the communications. Fear can be used, but it must be culturally appropriate and the communication must also provide concrete steps which can be taken to avoid the negative consequences presented.
- Tell the group that now they have seen some examples it is time to jump in and use everything they have done so far to define their program, create a behaviour change strategic activities plan and a communications plan, including using the behavioural analysis to create concrete, evidenced-based ideas for messaging.

Module 4, Session 2: The Communications Plan (Continued)

Activity 4: Small Group Work: Communications Planning (60 minutes)

- Have the participants form into their work-teams again. Pass out Training Handout #2-13 (blank Step 5 matrices) and Training Handout #2-14 instructions for small group work on communications planning. Have the groups:
- Use the work they did on defining the program and strategic behaviour change activities to now:
 - Determine which activities require communication to support them (all of the communication column plus others likely) and develop a communications plan to detail how those communications will be developed.
- Give the groups 60 minutes for this exercise. When they are complete, they will each present their work.

Activity 5: Presentations: Behavioural Objectives, Target Audience Group and Activities Development (45 minutes)

- Have each of the groups present their work and provide feedback using the completed matrices for each case study. (Training Handouts #2-15 A & B). These will be distributed to the participants in Session 3 of this module, but just use them here to support you in providing feedback.

Tips on Good Message Development

REMEMBER:

1. Messages must resolve a barrier to behavior change identified in the behavioral analysis step of the BCP process.
2. DO NOT just repeat the ideal/key behavior as a message—respond to the barriers, play up the facilitating factors.
3. The immediate result of the message will be the resolution of the barrier or the connection of the facilitating factor to the behavior. This result can also be called a communication objective—what you want to happen when your target audience encounters the message and communication piece.

7 “Cs” of communication development:**A good message:**

1. is **CLEAR**
2. **COMMANDS** attention
3. **CATERS** to heart and head (have a rational and an emotional appeal)
4. **COMMUNICATES** a benefit
5. **CREATES** trust
6. is **CONSISTENT**
7. has a **CALL** to action

Communication Plan Example: Safe Motherhood

(Note, this example only illustrates ONE Activity and corresponding material. A plan should detail ALL Necessary communication tools)

| 5. Communication Plan Example: Safe Motherhood | | | | | | |
|--|----------------------------------|---|---|--|---|---|
| Activity | Material | Audience | Result of Using Material/Communication Objective | Primary Message | Secondary Message | Who/How will material be used? |
| MASS MEDIA <ul style="list-style-type: none"> • Radio • Drama | Radio drama (Scripts production) | Mothers and extended family Traditional attendants | <p>Mothers believe that modern delivery methods will also allow room for their traditional practices</p> <p>Mothers take tours of birthing wards to get comfortable with process</p> <p>Mother seek skilled delivery at birth</p> | <p>Modern medicine does mean your traditions are wrong or cannot be practiced</p> <p>Modern birthing practices simply give a mother an additional tool to ensure her health and that of her newborn baby</p> | <p>Extended family should support mothers in choosing a skilled attendant because it is the best of both worlds</p> <p>Mothers need to develop a birth plan to be prepared for any circumstance—the baby's future is at stake</p> | <p>Facilitated radio listener clubs</p> <p>General public on radio with additional discussion by DJ</p> |

Communication Blank Matrices for Small Group Work

| 5. Communication Plan | | | | | | |
|-----------------------|----------|----------|--|-----------------|-------------------|--------------------------------|
| Activity | Material | Audience | Result of Using Material/Communication Objective | Primary Message | Secondary Message | Who/How will material be used? |
| | | | | | | |
| | | | | | | |
| | | | | | | |

Instructions for Small Group Work on Defining Behavioural Objectives, Developing Behaviour Change Strategic Activities and Communications Plan

You have 60 minutes for this exercise:

Use the work you did on defining the program and strategic behaviour change activities to now

- Determine which activities require communication to support them (all of the communication column plus others likely) and develop a communications plan to detail how those communications will be developed.

- When you do this in real life, you will not only fill in the matrices, but you should also write a document that will go into more detail on the background and process, the behavioural analysis sources and results, the process of audience segmentation and the activities proposed.

Module 4, Session 3: BC Strategy and Communication Plan Summary (and Daily Evaluation)

| | |
|----------------------------|--|
| Time | 35 minutes |
| Learning Objectives | <ul style="list-style-type: none"> • Reflect/reinforce the entire strategic process as each group presents its work so far |
| Preparation | <ul style="list-style-type: none"> • Read the session carefully • Study the example matrices so as to be able to provide feedback on the groups' work. |
| Materials | <ul style="list-style-type: none"> • Copies of Training Handouts #2-15A and #2-15B • Flipchart paper • Markers |
| Methodologies | <ul style="list-style-type: none"> • Presentations by groups • Discussion |

Activity 1: Processing (15 minutes)

- Distribute Training Handout #2-15A and 2-15B, the filled in examples of strategy matrices and communications plans for WASH/Proper Disposal of Faeces and Nutrition/Complementary Feeding, and give the groups a few minutes to look through them. Tell the groups that these are very similar to what they came up with, but were developed as part of the curriculum to provide an “answer key.” Ask if anyone has any questions or concerns and address them.

Activity 2: Prioritization Discussion (15 min)

- Tell the group that these presentations were excellent and captured extensive thinking. In real life, this is often done successfully—a set of communication objectives, key messages are outlined using the behavioural analysis and really representing excellent work. However, frequently, the scope of programs is enormous—when we start talking about trying to address barriers and use motivations, the list grows and grows. There are too many things to address and all of them seem to be critical.
- Emphasize that it is not only NOT feasible for one program to do so much but also so many messages and activities at one just confuse the audience. Ask the group how they think they should prioritize. What can be done?
- Answers should include:
 - If some of the communications objectives are promoting intermediary steps to the ideal behaviour, are some steps more easily done than others? Do some make more of an impact than others?
 - Are some issues more widespread or weigh heavier than others?
 - If all the messages and barriers seem equally important then is there a way to programmatically spread them out—either in a phased approach or use different kinds of media for different messages?
 - Interpersonal communication and more complex media such as serial radio dramas can handle many messages. With IPC, the session is specifically tailored to what the particular barrier is for that particular individual. The counsellor needs extensive training on all the possible situations he or she might face, but the end communication should be clear and precise. With radio dramas, each message is handled one at a time and tied to the next.

Module 4, Session 3: BC Strategy and Communication Plan Summary (and Daily Evaluation)

Activity 3: Daily Evaluation: DAY 3 (5 min)

- Distribute the training evaluation for Day 3 and ask that each person complete it and hand it back to you before leaving for the evening. Conclude for the day.

“Answer Key” Matrices Stunting/Complementary Feeding

| 3. Program Definition | |
|--|--|
| Behavioural Objectives | Final Target Audiences |
| <p>To increase appropriate complementary feeding among mothers and caregivers of children aged between 6 months to 2 years from 25% practicing all associated behaviours to 40% in the first two years of the project.</p> | <p>Mothers and caregivers with children 6 months to 2 years Secondary Fathers Mothers of older children Grandmothers and Health workers</p> |

“Answer Key” Matrices Stunting/Complementary Feeding

| 4. Strategic Behaviour Change Activities: Stunting/Complementary Feeding | | | | |
|---|---|--|--|--|
| Communication | Training | Community/Mobilization/Collective Action | Commodity of Technology | Advocacy |
| <p>MASS MEDIA</p> <ul style="list-style-type: none"> Radio drama on integration of traditional and modern media Radio Spots targeted to moms with children of particular ages to remind them of important feeding tips Radio Drama representing groups of mothers discussion challenges of feeding their children and sharing tips on doing it the right way to help them grow Reminder tools for mothers about quantity, quality of food and how to enrich food with locally available items like palm oil Reminders for fathers and other support figures to be supportive and assist the mother in preparing meals or helping feed the infant. <p>Interpersonal Communication</p> <ul style="list-style-type: none"> Counseling at health posts/monthly weighing stations House to house counseling sessions Radio listener clubs and facilitated mothers support groups | <p>Training volunteer nutrition workers on growth monitoring and promotion, tailored counseling and communication skills</p> <p>Training and demonstrations for families on healthy food preparation using widely available sources</p> <p>Training for community leaders on social mobilization and how to initiate growth monitoring and promotion</p> <p>Trainers for family members on gardening (if necessary)</p> | <p>Community-based Growth promotion</p> <p>Community-led food demonstrations/communal lunch days</p> <p>Community food donation program to support especially vulnerable children (e.g. poorest of the poor, OVCs, etc...)</p> <p>Creation of community owned and maintained gardens</p> | <p>Seeds for gardening</p> <p>Scales for health workers for weighing and tracking growth</p> | <p>Advocacy to ensure wide-spread availability of fortified foods</p> <p>Working with clinics to establish and enforce effective referral and follow-up care for mothers with children who are found to have severe acute malnutrition</p> |

“Answer Key” Matrices Stunting/Complementary Feeding

5. Communications Plan: Stunting/Complementary Feeding

| Activity | Material | Audience | Result of Using Material | Primary Message | Secondary Message | Who/How will material be used? |
|---|--|---|--|--|---|--|
| Radio spot | Script Recording spot | Caregivers Household members work | Awareness of risks of poor HW practices Awareness benefits of good HW practices | Wash your hands at least 4 times a day and help babies and children under 5 years of age to wash their hands | Clean hands-good parent or caregiver Clean child hands-happy healthy child | Scheduled broadcasting on community & commercial radio stations |
| Radio drama for entertainment and discussion in radio listener groups | Script for 8 15-minute radio “soap opera” episodes 8 recorded soap opera episodes | Caregivers Household members | Awareness of risks of poor HW practices & benefits of good HW practices Improved knowledge of how to wash, when to wash, how to teach child to wash, how tippy taps can help reduce water used for HW, how to make liquid soap to extend soap supply. | Wash your hands at least 4 times a day Help babies and children under 5 years of age to wash their hands & develop HW habit Put HW station outside latrine & eating area Build s tippy tap & make liquid soap | Take pride in clean hands Clean hands help keep your child healthy and alive HW helps prevent diarrhea & the fewer episodes of diarrhea, the better your child will grow and learn & less money spent on medicine/doctors | Air one episode a week, (but play it twice during week) so series of 8 episodes is broadcast over 2 months Hold community listening groups with guided post-listening discussions |

“Answer Key” Matrices Stunting/Complementary Feeding

| 5. Communications Plan: Stunting/Complementary Feeding | | | | | | |
|--|--------------------|---|---|--|--|--|
| Activity | Material | Audience | Result of Using Material | Primary Message | Secondary Message | Who/How will material be used? |
| Reminder materials | Poster or calendar | Mothers of children under 2 Father and other support network | Mothers or fathers will remember what they should try to do or have agreed to do to improve feeding their child | Children of X age group need to each X times a day, (Fill in/ based on age) Will include place for mothers to check if they have in fact given their child the right amount | Consistency should be such that the food does not run off the spoon. | In households as a static tool to remind mothers memories on how to feed her child. Should be introduced first by a health worker in a one-on-one visit. |
| Household visits | Counseling cards | Health worker Caregiver | Mother will have actionable recommendations for changes she can make to her current feeding practices | Will have many messages because of its nature as a counseling card and be age dependent for 6 months, messages will emphasize exclusive breastfeeding including how to expressmilk, that breastmilk is still safe during pregnancy and that all mothers even if not eating a lot themselves, make enough milk. | | By the nutrition worker in household counseling sessions |

“Answer Key” Matrices Stunting/Complementary Feeding

5. Communications Plan: Stunting/Complementary Feeding

| Activity | Material | Audience | Result of Using Material/Communication Objective | Primary Message | Secondary Message | Who/How will material be used? |
|----------------------------|---------------------------------|--------------------------------------|--|--|---|--------------------------------|
| Facilitated group meetings | Discussion points/flip charts | Caregivers of each age-range grouped | Caregivers will feel solidarity with other mothers on overcoming barriers Caregivers will understand specific recommendations for her age child and ways to access local products to enhance what she’s already doing | Flip chart will have multiple messages Below 6 months: Breastmilk is all our babies need. Breastmilk from both sides and express it when you have to leave the baby. 6 months and up: We can easily find all we need here to grow our babies strong—we just need to use what we have and grow what we don’t There are ways to enhance what is already being done with oil or a little extra | Radio listener clubs, large gatherings | |
| Food demonstrations | Illustrations-based recipe card | Caregivers | Mothers will remember what they saw during the demonstration and be able to repeat it in their own homes | Instructions for how to prepare appropriate foods | To remind moms of what they see hear and do in cooking demonstrations | |

“Answer Key” Matrices Diarrhea Disease/Handwashing

| 3. Program Definition | |
|--|--|
| Behavioural Objectives | Final Target Audiences |
| <p>Caregivers wash hands with soap and water after they defecate, after they change baby’s diaper and before feeding a child/nursing a child</p> <p>Caregivers teach babies that are crawling to 5 year olds to wash their own hands with soap and water</p> | <p>Caregivers of children from birth to 5 years old</p> <p>Children 5 years old and under</p> <p>Community outreach workers and health facility personnel who are conducting individual counseling and group activities in the community and who are visiting households</p> |

“Answer Key” Matrices Diarrhea Disease/Handwashing

4. Strategic Behaviour Change Activities:

| Communication | Training | Community Mobilization/ Collective Action | Commodity or Technology | Advocacy | Other |
|--|---|---|--|--|--|
| <p>MASS MEDIA</p> <p>Radio Spot Radio Drama</p> <p>Interpersonal Communication</p> <ul style="list-style-type: none"> • Guide for community workers on HW promotion (when, how & why to wash hands, how to build tippy tap & set up HWV station) • Visual aids on HWV • Community theatre | <p>Training of community outreach workers for organizing/leading radio listening groups</p> <p>Training of community health and outreach workers to promote HWV</p> <p>Training of theatre groups</p> | <p>Formation of radio listening groups</p> <p>Supporting households to build tippy taps outside of latrines and near eating areas</p> | <p>Introduction of tippy taps and trainings for households members on how to build them</p> <p>Teaching households how to make liquid soap</p> | <p>Getting religious leaders to speak about the importance of HW and building HW stations in places of worship</p> <p>Working with health service to ensure that health post staff are encouraging HWV in households and have tippy taps with soap as models at health posts</p> <p>Getting NGO's to promote HWV</p> | <p>Working with soap suppliers to ensure that soap is available at commercial outlets at the village level (end of the supply chain)</p> |

“Answer Key” Matrices Diarrhea Disease/Handwashing

| 5. Communications Plan | | | | | | |
|------------------------|---|---------------------------------|---|--|--|--|
| Activity | Material | Audience | Result of Using Material | Primary Message | Secondary Message | Who/How will material be used? |
| Radio spot | Script Recorded spot | Caregivers Household members | Awareness of risks of poor HW practices Awareness benefits of good HW practices | Wash your hands at least 4 times a day and help babies and children under 5 years of age to wash their hands | Clean hands = good parent or caregiver Clean child's hands = happy healthy child | Scheduled broadcasting on community & commercial radio stations |
| Radio drama | Scripts for 8 15-minute radio “soap opera” episodes 8 recorded soap opera episodes | Caregivers Household members | Awareness of risks of poor HW practices & benefits of good HW practices Improved knowledge of how to wash, when to wash, how to teach child to wash, how tippy taps can help reduce water used for HW, how to make liquid soap to extend soap supply | Wash your hands at least 4 times a day Help babies and children under 5 years of age to wash their hands & develop HW habit Put HW station outside latrine & eating area Build a tippy tap & make liquid soap | Take pride in clean hands Clean hands help keep your child healthy and alive HW helps prevent episodes of diarrhea, the better your child will grow and learn (& less money spent on medicine/doctors) | Air one episode a week (but play it twice during week) so series of 8 episodes are broadcast over 2 months Hold community listening groups with guided post-listening discussions |

“Answer Key” Matrices Diarrhea Disease/Handwashing

5. Communications Plan (p. 2)

| Activity | Material | Audience | Result of Using Material | Primary Message | Secondary Message | Who/How will material be used? |
|--|---|--|--|---|---|--|
| 1 to 1 counseling Small group presentations | Counseling cards Flip chart | Caregivers Household members | Awareness of risks of poor HW practices & benefits of good HW practices Know when to wash hands Know when to wash hands with soap (or ash) Know how to build tippy tap & make liquid soap Know how/where to place HW station | Wash your hands at least 4 times a day (after using latrine, before feeding a child) Help babies and children under 5 years of age to wash their hands & develop HW habit Put HW station outside latrine & eating area Build tippy tap & make liquid soap | Negotiate small doable actions | Use counseling cards during 1 to 1 counseling at health facilities and during home visits Use flip chart during group facility or in community activities |
| 1 to 1 counseling Small group presentations | Reference guide for health worker and community outreach worker on HW | Community outreach worker Health facility staff | Provide reference source for HW information (covering subjects listed in row above) Guidelines for organizing group activities | Info needed to counsel on HIV (benefits, how to wash, when to wash, how to build/use tippy tap, how to make liquid soap, where to place HW stations, how to help children develop HW habit, etc.) | Techniques for motivating behaviour change through negotiating small doable actions | Used as reference material during staff training Used by staff as information source after training |

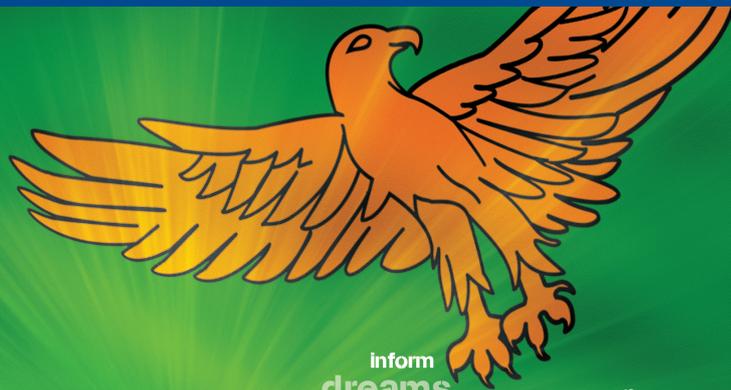
“Answer Key” Matrices Diarrhea Disease/Handwashing

5. Communications Plan (p.3)

| Activity | Material | Audience | Result of Using Material | Primary Message | Secondary Message | Who/How will material be used? |
|-------------------|--|-------------------|--|---|---|--|
| Community theatre | Script for community production integrating HW information & messages | Performers | Awareness of risks of poor HW practices & benefits of good HW practices Know when to wash hands Know when to wash hands with soap (or ash) Know how to build tippy tap & make liquid soap Know how/where to place HW station | Wash your hands at least 4 times a day (after using latrine, before feeding a child) Help babies and children under 5 years of age to wash their hands & develop HW habit Put HW station outside latrine & eating area Build tippy tap & make liquid soap | Take pride in clean hands Clean hands help keep your child healthy and alive HW helps prevent diarrhea & the fewer episodes of diarrhea the better your child will grow and learn | Theatre presentations at community level |
| Community theatre | Guide for leading group discussion after theater production presentation | Discussion leader | Understanding of how to generate and lead a post performance discussion Factual information HW | Instructions for generating & leading discussion Factual info on HW (how to, when to, etc.) | None | Guided group discussion after presentation to generate community dialogue/action & to answer questions |

Trainer's Manual

DAY 4



empower

act

honor

people

inspiration

teamwork

educate

strength

trust

believe

motivation

support

share

achieve

inform dreams

enable

learn

create

behaviour

courage

own

opportunity

goals

challenges

change

desire

success

Review of Concepts: Strategy and Communication Planning

| | |
|----------------------------|---|
| Time | 30 minutes |
| Learning Objectives | <ul style="list-style-type: none"> Reviewed concepts from Day 3 |
| Preparation | <ul style="list-style-type: none"> Read the session carefully Review accompanying PowerPoint slides |
| Materials | <ul style="list-style-type: none"> Copies of Training Handout #2-13 Flipchart Markers |
| Methodologies | <ul style="list-style-type: none"> Group exercise Discussion |

Activity 1: Processing/Presenting (30 minutes)

- Ask the participants to think about their work on the previous day in developing a behaviour change strategy and communications plan for their two health problems. Show slide titled “Communications Plan Example: Safe Motherhood (one activity/material)” of Unit 2 Accompanying PowerPoint slides.
- Ask for a volunteer to offer an example of what kinds of activities they need to think about when planning their program. Ask for a different volunteer to think about another kind, until all columns in the matrix are mentioned. After each volunteer gives his/her example of a “kind” of activity (e.g. communication, advocacy, etc.), ask them to further explore that example and suggest an actual activity that would fall into that category.
- Now ask for a volunteer to list the kinds of information that would be included in a communications plan.
- Lead the group in a short discussion on how they normally plan their program—do these matrices seem like they would be helpful? Complicate the process? What tools/documents do they normally produce in their planning process? Can they see how to fit these kinds of tools into what they already do?
- Distribute copies of Training Handout #2-13, and show slide titled “Tips for leveraging technology in communications.” Checklist for BCP process. Tell the group that the end format isn’t what is critical. The critical piece is making sure they have completed all of these steps.
- Remind the group that they now have three sets of completed matrices—one for the health problem of stunting and the key behaviours of complementary feeding; one for the health problem of diarrhoea in children under 5 and the key behaviour of handwashing and one for the health problem of maternal mortality and a key behaviour of delivery with a trained attendant. These, together with the Quick Guide to Behaviour Centred Programming can serve as memory aides in the future, so they should save them all together.

Checklist for Behaviour Centered Programming Process

| | | Done? | Notes |
|----|---|-------|-------|
| 1 | Identify or construct a health problem statement | | |
| 2 | Define the set of ideal behaviors | | |
| 3 | Prioritize ideal behaviours: key behaviours | | |
| 4 | Identify and describe the priority audience and influencer groups | | |
| 5 | Conduct Behavioural Analysis, including identifying and testing improved (small doable) behaviours | | |
| 6 | Analyze the findings, specifically identifying the most important barriers/motivators/determinants of change. | | |
| 7 | Refine primary and influencer audience groups as necessary. | | |
| 8 | Choose activities for the project that work with the audience groups to address the most important barriers/motivators/determinants of change | | |
| 9 | Establish indicators to monitor and evaluate the effectiveness and timelines/methods for M&E | | |
| 10 | Plan for implementation of activities described including: | | |
| | a. Communications Plan | | |
| | b. Training/capacity building plan | | |
| | c. Community mobilization plan | | |
| | d. Advocacy plan | | |

UNIT 3: Implementation

| | |
|---|-----|
| Session 1: Overview of Issues in Implementation | 118 |
| Session 2: Partnerships | 121 |
| Session 3: Pre-testing | 123 |

Session 1: Overview of Issues in Implementation

| | |
|----------------------------|---|
| Time | 60 minutes |
| Learning Objectives | <ul style="list-style-type: none"> List the necessary steps to successfully implement a behaviour centred program strategy Identify points of potential challenge and plans for overcoming them |
| Preparation | <ul style="list-style-type: none"> Read the session carefully Make copies of training handout #3-1 |
| Materials | <ul style="list-style-type: none"> Photocopies of Training Handout #3-1 Flipchart paper Markers |
| Methodologies | <ul style="list-style-type: none"> Discussion Brainstorm |

Activity 1: To-Do List Brainstorm/discussion (15 minutes)

- Show slide titled, “Learning Objectives (Unit 3, Session 1, Activity 1)” from Unit 3 Accompanying PowerPoints. Read the listed learning objectives aloud:
 - List the necessary steps to successfully implement a behaviour centred program strategy
 - Identify points of potential challenge and plans for overcoming them
- Tell the group that now they have developed their evidence-based behaviour change activities and communications plans, the next step is to roll it out. Ask for the group to think through what the various steps or to-do items required to implement their strategies might be. The trainer should take notes on the discussion points on a flip chart paper. Allow 10 minutes or so for this exercise. (Note—if participants are struggling to understand the kind of steps we mean here, offer some suggestions from the handout that will be provided in the next bullet, Training Handout #4-1).
- Once discussion has subsided, pass out Training Handout #3-1, Implementation Planning Components. Show the PowerPoint slides matching each bullet and talk the group through the considerations for each one, using the PowerPoint slides to provide more detail on the creative brief.
 - Partnership planning:
 - What partners are required for implementing the strategy?
 - How can those partners be engaged or further engaged?
 - What support do they need now and in the future?
 - Communication materials/job aids development:
 - Writing a creative brief
 - Hiring a creative agency (If project staff is experienced and the materials are fairly simple and straightforward, then they can design them instead of an agency)
 - Materials production and pre-testing
 - Media planning/purchasing

Session I: Overview of Issues in Implementation

- o Logistics organizing:
 - Who will conduct activities?
 - Where will they conduct them (community common areas? Schools? Churches? Clinics?)
 - How will the implementers receive and keep track of the resources and materials to conduct the activity?
 - When/on what schedule will they conduct the activities?
- o Capacity building
 - Concretize various audiences for capacity building
 - Spell out training objectives for each audience
 - Develop training materials/tool-kits
 - Identify master training cadre
 - Plan and conduct trainings for master trainers and participants
- o Monitoring (both of media and of activities)
 - Identify internal capacity for various kinds of monitoring required
 - Identify/contract monitoring agency/agencies as required
 - Create/approve guides or data collection instruments
 - Formalize process for integrating monitoring data into programming
- Note to the group that in this training, you will only be delving further into the issue of pretesting and partnerships, but that in the set of Participants Reference Materials, there is more information on many of these steps, including outlines for creative briefs, tips for successfully working with an agency, media planning and buying and other pieces of the puzzle. Refer them to Materials #3-1, 3-2, and 3-3.

Activity 2: Overcoming Challenges to Implementation Discussion (15 minutes)

- Now ask the group to consider actually taking these steps. Pose the following questions:
 - o What kinds of experiences has the group had previously with managing implementation of a process like this? Have they written creative briefs? Worked with agencies? Have 1 or 2 volunteers share their experiences and any lessons learned. Take notes on a flip chart of any important points.
 - o What kind of challenges do they envision facing?
 - o What kind of support do they see needing to ensure this list gets carried out and the strategy that they so carefully planned gets brought to life?
 - o Any other thoughts the group has on implementation?
- Ask if anyone has any final comments or questions and close the session.

Implementation Planning Components

(For use with Unit 3, Session 1, Activity 1)

Once you have your behaviour change strategy and communications plan in place, you are ready to roll-out your program. The following is a list of the various elements that will need to be carefully planned and managed:

- o Partnership planning:
 - What partners are required for implementing the strategy?
 - How can those partners be engaged or further engaged?
 - What support do they need now and in the future?

- o Communication materials/job development:
 - Writing a creative brief
 - Hiring a creative agency (If project staff is experienced and the materials are fairly simple and straightforward, then they can design them instead of an agency)
 - Materials production and pre-testing

- o Media planning/purchasing

- o Logistics organizing:
 - Who will conduct activities?
 - Where will they conduct them? (Community common areas? Schools? Churches? Clinics?)
 - How will the implementers receive and keep track of the resources and materials to conduct the activity?
 - When/on what schedule will they conduct the activities?

- o Capacity building
 - Concretize various audiences for capacity building
 - Spell out training objectives for each audience
 - Develop training materials/tool-kits
 - Identify master training cadre
 - Plan and conduct trainings for master trainers and participants

- o Monitoring (both of media and of activities)
 - Identify internal capacity for various kinds of monitoring required
 - Identify/contract monitoring agency/agencies as required
 - Create/approve guides or data collection instruments
 - Formalize process for integrating monitoring data into programming

Session 2: Partnerships for Implementation

| | |
|----------------------------|--|
| Time | 30 minutes |
| Learning Objectives | <ul style="list-style-type: none"> • Identify key kinds of strategic partnerships for implementation • Understand approaches/tips for working with various kinds of partners |
| Preparation | <ul style="list-style-type: none"> • Read the session carefully • Review accompanying PowerPoint slides |
| Materials | <ul style="list-style-type: none"> • Flipchart paper • Markers |
| Methodologies | <ul style="list-style-type: none"> • Discussion • Brainstorm |

Activity 1: Partnerships (60 minutes)

- Show slide titled, “Learning objectives” and read them aloud.
- Tell the group that partnerships play a key role in ensuring that programs are successful and sustainable.
- Ask the group to think about the KINDS of partners that they might engage. Take notes on a flip chart and then show slide titled: “Possible types of partners.” Compare lists and add to the prepared one if necessary:
 - Stakeholders
 - Implementers (national, provincial, district—both NGOs and MOH)
 - Sponsors/donors
 - Media partners
 - Community partners
- Ask the group to think about how they might work with different kinds of groups. Show slides titled “To-dos for Implementation: The creative brief contents” through “To-dos for Implementation: Capacity Building” and discuss the particulars of each group. Ask the participants to really contribute their thinking on HOW you work with each group and write notes on a flip chart. Use the following questions to structure the conversation:
 - o Who are members of this partners group?
 - o How are they funded?
 - o At what stage in the process do these partners come in? (Are they just handed materials and a plan to execute, or are they part of the planning?)
 - o How does the MOH work with these implementers?
 - o How is the private sector involved? Do they need to be?
 - o Does the group have any suggestions for ways in which partnerships could better be established and developed?
- When you get to the discussion on corporate sponsors/donors, and bringing in celebrity spokespeople, refer the participants to Participants’ Reference Material #3-4 and 3-5 to let them know they have more information and tips for going about this.

Session 2: Partnerships for Implementation (Continued)

- When discussing the celebrity partner angle, if the conversation does not naturally bring out challenges to working with celebrities, use the following story as a cautionary tale of what can happen when a celebrity spokesperson goes awry.
- UNICEF was sponsoring a national communications campaign targeted to kids aged 10-14 with the objective of decreasing the age of sexual debut. The campaign featured a series of commercial-length mini-dramas with animated pre-teen characters playing games and telling each other “their darkest secrets.” Each character’s secret was a learning lesson for why kids should wait to have sex, why they should talk to their parents, who they should go to if they need to talk to someone besides their family member, etc. The campaign also featured national billboards, a flood of school-related pieces like stickers and notebooks featuring the set of characters and key messages, take-home posters, and radio jingles. Additionally, the program managers engaged a wildly-popular local rap artist to write a song and record a video targeted to younger kids with the message: wait to have sex, for now, stay in school, and focus on you. The song and video became viral hits and worked to reinforce the overall campaign objectives. At the same time, this rap artist lived a very public life full of many girlfriends, drunken parties, and lewd dancing. In one launch event, several very young girls rushed the stage and began dancing with him. Caught in the moment, he started dancing in a very inappropriate manner. Everything was caught on film and subsequently aired continuously on the news, all but unravelling whatever progress the campaign had otherwise made.

Session 3: Pretesting

| | |
|----------------------------|--|
| Time | 120 minutes |
| Learning Objectives | <ul style="list-style-type: none"> • Identify principles of good pre-testing • Understand programmatic concerns of pretesting • Distinguish between approaches to pretesting various kinds of communication materials • Source existing tools and resources for pretesting |
| Preparation | <ul style="list-style-type: none"> • Read the session carefully • Review accompanying PowerPoint slides |
| Materials | <ul style="list-style-type: none"> • Photocopies of Training Handouts #3-2, and #3-3 • One colour print out of the poster for the pre-testing role play • Flipchart paper • Markers |
| Methodologies | <ul style="list-style-type: none"> • Lecture/presentation • Discussion • Role Play |

Activity 1: Pre-testing Basics (20 minutes)

- Present slide titled, “Learning objectives for Pretesting.” Read them aloud.
- Now show the next slide and remind the participants of the list of best practices you created in the first session you went through together:
 - o Used research to determine multi-pronged program strategy
 - o Tailored media messages including radio to specifically address barriers learned from formative research
 - o Used appropriate and diverse channels for communication
 - o Presented concise, clear, and focused messages in a way that resonated with the target audience
 - o Allowed for participation of community and community ownership
 - o Allowed for flexibility to ensure the promoted action was feasible for the target audience
- Tell the participants that following the process you just went through is one very critical element of ensuring that a program lives up to these “best practices.” However, as they saw in the second case study, if the communication strategy is right, but the communication itself fails, then the program fails.
- To ensure that this does not happen, pre-testing is critical.
- Ask the participants to brainstorm a definition for pre-testing and jot notes on the flipchart paper. Show the next slide titled “pre-testing definition” to make sure that the participants’ definition is similar to the one described:
- Pre-testing, sometimes called field testing, helps project staff know whether the intended audience understands the key message(s) and likes the draft materials before they are produced in final form. In pre-testing, an interviewer shows the draft materials to members of the intended audience and asks open-ended questions to learn if the message is well understood and acceptable -- in sum, if it works.

Session 3: Pretesting

(Continued)

- Now display the slide titled “Pre-testing: Objectives.” Ask the group to consider what the objectives are for pre-testing. If not mentioned, say that pre-testing is not to get the “right” answer or to get the audience to see or hear what you see. The objectives of pre-testing include measuring all of the following:
 - Comprehension- clarity of content and presentation
 - Attractiveness- elements that make people want to see/hear the material
 - Acceptance- audience feels they can accept it – not offensive, is believable, does not trigger disagreement
 - Involvement- audience can identify with the materials and recognizes that message is meant for them
 - Call to action- most materials asks, motivates or induces audience to carry out a particular action.
- Now ask the participants who should be the participants in a pre-test? Display slide titled “Media partners”:
 - The audience for whom the materials were developed and who will use them AND
 - Gatekeepers or authorities—those individuals who control the distribution channels for your communications materials. These can include program managers, religious leaders in the community, local government officials, national government officials, or media outlets. They should be given a chance to review and comment on materials at the pre-testing stage to ensure buy-in and a seamless roll-out.
- Display the slide titled, “key principles of pre-testing” and walk through it with the participants.
 - Provides measurements on effectiveness of communication
 - Requires agreements about how the results will be used
 - Provides controls to avoid bias in results (an independent agent should usually conduct pre-testing. If that isn’t possible, at least several people from the communications development team should be a part of the process)
 - Demonstrates reliability and validity (sample needs to be carefully chosen and representative of target)
- Finally, display the next slides and note a few key things to keep in mind that are critical to successful pre-testing.
 - Timing—rounds of pre-testing affect programming. Make sure to build in adequate time for ample revisions.
 - Budget—must be allocated at beginning, included in contract with agency
 - Buy-in—people must be willing to accept changes, even significant ones
 - Develop materials as technically and strategically sound as possible before pretesting.
 - Make sure to use your creative brief—materials should be designed to achieve a purpose and their evaluation should focus on whether they are achieving that purpose
 - No magic number for rounds of pre-tests: Criteria are set by:

Session 3: Pretesting

(Continued)

- budget
 - the scope of the project (national communications might require more extensive pre-testing to account for geographic, language, and cultural differences)
 - The complexity of the material being developed (one poster vs. a video). The more complex the material, typically the more people whose feedback you will need to gather, which usually implies more rounds of pre-testing
 - The complexity of the problem/message the material is addressing. Again, the more complex, the more people you might need to involve in the pre-testing.
 - After completing the first focus group and/or 10 in-depth interviews, stop and take stock of your early results. If the results indicate that there is a rejection/misunderstanding of the material, you need to stop the pre-testing process and make revisions before you continue with more pretesting. It is recommended that if any changes take place to the communication, it be pre-tested again before final production.)
 - before starting pre-testing, establish the percentage of target audience expected to be able to capture the main message, understand the materials and accept the material (for instance, 90% of the audience will capture the main message when viewing the video)
 - target audience characteristics/skill level (for instance, materials for low-literate audiences might need more pre-testing rounds to achieve the desired comprehension level than the materials for a highly literate audience)
 - The number of audience segments. The material should be tested with all the audience segments who will use it
 - The number of geographic regions. The material should ideally be tested in all the major geographic regions where it will be used
- Tell the participants that if you are only going to be able to do ONE round of pre-testing (which is not considered ideal, but is sometimes the only thing that is possible), then it is critical that the draft that is pre-tested is as close to the final look/feel/presentation of the material as possible.
 - Individuals involved in developing the materials (staff, artists, writers) should be involved in the pre-testing because they then gain first-hand knowledge of what works/does not work, which will help them make improvements. [NOTE: this means that if the media house that produced the materials is not in-charge of the pre-testing, which is preferable, then the organization taking the lead on pre-testing must be willing to involve media house staff.]

Activity 2: Process for Pre-testing (20 minutes)

- Display the slide titled “Pre-testing Process.” Tell them that the pretesting process should more or less follow these steps and, as you go through them, explain each one using the information below:
 - o Define your sample by characteristics (same group characteristics [e.g. ethnic group, region, etc.], same individual characteristics [e.g. age, number of kids, etc.], and convenience sample). You should work closely with the agency on making this decision.
 - o Determine how many people you are going to pre-test with (complexity of the material, complexity of the problem, number of audience segments, number of geographic regions, etc.) You should work closely with the agency on making this decision.
 - o Determine the percentage of the pre-testing participants whom you expect to understand the key

Session 3: Pretesting

(Continued)

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Session 3: Pretesting

(Continued)

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 - After completing the first focus group and/or 10 in-depth interviews, stop and take stock of your early results. If the results indicate that there is a rejection/misunderstanding of the material, you need to stop the pre-testing process and make revisions before you continue with more pretesting. It is recommended that if any changes take place to the communication, it be pre-tested again before final production.)
 - before starting pre-testing, establish the percentage of target audience expected to be able to capture the main message, understand the materials and accept the material (for instance, 90% of the audience will capture the main message when viewing the video)
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 - Individuals involved in developing the materials (staff, artists, writers) should be involved in the pre-testing because they then gain first-hand knowledge of what works/does not work, which will help them make improvements. [NOTE: this means that if the media house that produced the materials is not in-charge of the pre-testing, which is preferable, then the organization taking the lead on pre-testing must be willing to involve media house staff.]

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 - o Define your sample by characteristics (same group characteristics [e.g. ethnic group, region, etc.], same individual characteristics [e.g. age, number of kids, etc.], and convenience sample). You should work closely with the agency on making this decision.
 - o Determine how many people you are going to pre-test with (complexity of the material, complexity of the problem, number of audience segments, number of geographic regions, etc.) You should work closely with the agency on making this decision.

Session 3: Pretesting (Continued)

- o Determine the percentage of the pre-testing participants whom you expect to understand the key messages and accept the material (for example, when 90% of the target audience who is exposed to your material understands and likes it, then you will stop pre-testing)
- o Select the technique to be used (focus groups, in-depth interviews, observation, etc.) You should work closely with the agency on making this decision.
 - FGDs – good to use when: pre-testing TV/radio; material is used in group setting; difficult to do individual interviews; during concept development
 - In-Depth Interviews – good to use when: pre-testing print materials; sensitive topic, participants are geographically scattered,
 - Observation – good to use when: need to see how material or product is handled/used by end-user
- o Design the instruments and guidelines. You need to work closely with the research team to ensure that the questions being asked will get at the data you are seeking.
- o Select and train interviewers. Typically you are not involved in doing this if you have contracted pre-testing out to an agency/consultant group. However, you need to discuss with them what criteria they are using in selecting interviewers and how they will train them.
- o Test the pre-test guidelines and instruments. It can be very helpful to observe when the guidelines/instruments are being tested or to meet with the interviewers soon after they have tested them to learn what worked/did not work. You should be involved in helping decide what changes to make to the instruments based on their pretesting results.
- o Make the necessary logistical arrangements. If you have hired an agency/consultant, they usually make all the arrangements.
- o Do the pre-testing. If you have hired an agency/consultant, they will do the pre-testing. However, it is strongly advised that you observe some of the initial pre-tests to ensure that the technique is good and the quality of the data meets your standards and that the artist/production staff is a part of the team (even if they are not in charge of organizing the pre-testing).
- o Summarize the results. If you have hired an agency/consultant, they will prepare the report summarizing the pre-testing findings. There is no such thing as a perfect material. If the pre-testing results (especially in the first few rounds of pre-testing) show that no changes were recommended, it is very likely that something went wrong with the pre-testing!
- o It is very important to have the creative team, the agency staff that conducted the pre-testing, and yourself work together to decide how to modify the materials to reflect the pretesting findings. Note that data from pre-testing should be analysed with an eye towards changes in both:
 - FORM (music, colour, tone, typeface, attention distractors, more accurate representation of people or things, text placement, etc.)
 - CONTENT (word choice, call-to-action, multiple messages, too abstract a concept, confusing technical terms, how appealing the behaviour seems, etc.)
 When you get to the discussion on corporate sponsors/donors, and bringing in celebrity spokespeople, refer the participants to Participants' Reference Material #3-4 and 3-5 to let them know they have more information and tips for going about this.

Session 3: Pretesting

(Continued)

Activity 3: Pre-testing Different Kinds of Media (10 minutes)

- Now discuss what is different about pre-testing different kinds of media. Show the next slide and go through each kind of media.

| Media | Special considerations for pre-testing |
|------------|--|
| Print | <ul style="list-style-type: none"> • Purpose—will it be interpreted on its own or is it more of a job aide? Make sure it is tested with user and audience if it is a job aide. • Test images/photos drawings separately from text at first |
| Radio | <ul style="list-style-type: none"> • Best if you can do a draft recording of material (such as with amateurs reading the parts) with accompanying sound effects rather than just reading it • Best to play it twice and then do a series of questions. If long, break it into listening segments and ask questions after each segment. • Good idea to pre-test in groups since often radio is heard with others around or used in listening groups – or if short spot, can do individual pretesting |
| Television | <ul style="list-style-type: none"> • Similar to radio, but must also evaluate visuals—test visuals separately from audio and then together. • Consider testing story boards to get feedback on concepts, sequencing, types of images that will be used before producing rough drafts to pre-test • Must also ask questions about pacing, ability to understand what is going on, whether or not the scene appeals to the audience, if it is realistic, attractive, captivating, etc. |
| Mobile | <ul style="list-style-type: none"> • Acceptability of getting information via mobile device—whose device does it go to? What format should it arrive in? Are there privacy concerns? |

- Ask the group what their own experience has been in doing pre-testing with different types of media, if any. Tell them that trying to set up the pre-testing so that the audience encounters it in as realistic a way as possible is key, but with more complicated media like radio or video, it is very expensive to create mock ups. Therefore, careful use of storyboards and rough recordings are important to ensure the ideas are on track. You might even consider having members of the target audience form a review committee and be present on set to give input and respond to issues immediately.

Session 3: Pretesting

(Continued)

Activity 4: Brainstorm & Role Play: Guide Development, Pre-testing (40 minutes)

- Pass out Training Handout #3-2. Read aloud the description of the material to the group and explain who the target audience for it is.
- Now ask the group to brainstorm how they might start developing a guide to pre-test such a material. Ask:
 - Which methodology would they select? (for a poster, one-on-one interviews are effective)
 - What questions would they ask? Go through each area below and ask the group to generate questions that would measure it. Use Training Handout #3-3 for support in guiding the participants.
 - Comprehension- clarity of content and presentation
 - Attractiveness- elements that make people want to see/hear the material
 - Acceptance- audience feels they can accept it – not offensive, is believable, does not trigger disagreement
 - Involvement- audience can identify with the materials and recognizes that message is meant for them
 - Call to action- most materials asks, motivates or induces audience to carry out a particular action.
- Once the questionnaire is developed, have a volunteer come to the front and assume the role of the person being interviewed. Have another volunteer be the interviewer. Using the questionnaire they just developed (or Training Handout #3-3 if necessary), have the interviewer role play interviewing the volunteer.
- After the role play, distribute copies of Training Handout #3-3 as reference.

Activity 4: Processing role play (10 minutes)

- After the role play, ask the participants to describe what they saw. How did the interview go? What did they learn about their material? Did the volunteer understand it? Find it attractive? Accept it? Know it is meant for them? Respond or identify a call to action?
- What would they change about this material?
- What would be the next steps in its production? (If they only did one interview, more interviews! If the results were a summary of multiple interviews, they would make the changes, pre-test again and then move towards finalization).

Sample Material for Pre-testing

Material: Poster

Target Audience: Men and women age 20-45

Behavioural Objective: To increase rates of couples seeking voluntary testing for HIV

Purpose of Material:

- To serve as a reminder that VCT is available
- To promote the ease of getting a test
- To promote the sense of trust and security between a man and woman after going through VCT

Sample Material for Pretesting

Anyone in Southern Sudan can get HIV. Everyone can prevent HIV.



“By learning our status, we can prevent HIV.”

Sample Questionnaire for Pretesting

Fold or cover material so only the illustration shows:

1. What does the illustration show?
2. What do you like about the illustration?
3. What do you dislike?
4. Do the people in the illustration seem like people you would know?
5. What does the illustration make you think of?

Fold or cover material so only the text shows. Have the participant read the text if they can, otherwise read it to them:

6. What does the text mean, in your own words?
7. Are there any words in the text you do not understand? Which ones? If so, explain the meaning and ask respondents to suggest other words that can be used to convey that meaning.
8. Are there any words that you think others might have trouble reading or understanding? Again, ask for alternatives.
9. Are there sentences or ideas that are not clear? If so, have respondents show you what they are. After explaining the intended message, ask the group to discuss better ways to convey the idea.
10. Is there anything on this page that you like? What?
11. Is there anything on this page that you don't like? What?
12. Is there anything on this page that is confusing? What?
13. Is there anything about the pictures or the writing that might offend or embarrass some people? What? Ask for alternatives.

Show the illustration and the text together. Ask these questions about the entire material:

14. Do the words match the picture on the page? Why or why not?
15. What information is this page trying to convey?
16. Do you think the material is asking you to do anything in particular? What?
17. What do you think this material is saying overall?
18. Do you think the material is meant for people like yourself? Why?
19. What can be done to make this material better?

Trainer's Manual

UNIT 4



empower

act

honor

people

inspiration

teamwork

educate

strength

trust

believe

motivation

support

share

achieve

inform dreams

challenges

change

desire

enable

learn

create

behaviour

courage

own

opportunity

goals

motivation

success

share

UNIT 4: Monitoring and Evaluation for BCC

| | |
|---|-----|
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| Session 2: Development of an M&E Plan | 138 |
| Session 3: Indicators | 140 |
| Session 4: Methods Overview | 145 |
| Session 5: Using the Data | 148 |

Session I: What is Monitoring? What is Evaluation

| | |
|----------------------------|--|
| Time | 30 minutes |
| Learning Objectives | <ul style="list-style-type: none"> • Define the terms monitoring and evaluation • Identify the differences between monitoring and evaluation • Explain the importance of monitoring and evaluation and where it fits in a program |
| Preparation | <ul style="list-style-type: none"> • Read the session carefully • Review accompanying PowerPoint slides |
| Materials | <ul style="list-style-type: none"> • Flipchart paper • Markers |
| Methodologies | <ul style="list-style-type: none"> • Brainstorm • Discussion |

Activity 1: Defining the Terms: Brainstorm (10 minutes)

- Present slide titled: “Learning Objectives” from the Unit 4, M&E accompanying power points.
- Now ask the group to consider the first objective—to define M&E. Have the group brainstorm possible a possible definition for monitoring. Write responses on a flip chart. Ask them to do the same for evaluation.
- Ask the group to consider the two side by side. How are they different? How are they the same? Where are the overlaps?
- Now present slides “Quote from Macro Pierre White” through “Monitoring and Evaluation Pipeline” to illustrate the definition and difference between the two terms. Hand out the “monitoring and evaluation definition” handout, Training Handout #5-1.
- Move to slide titled “Monitoring and Evaluation” and emphasize to the group that M&E is a continuous process that should occur throughout the life of a program. Planning for M&E should be part of the design of any BCC program, right from the beginning. M&E is not a separate component of BCC programs but is an integral part. Experience shows that M&E is often ignored until the final stage of the project, but it is much more useful if it is incorporated from the beginning.

Activity 2: Importance of M&E (10 minutes)

- Now ask the group to think about the importance of M&E. Show slide starting with “Is the importance of M&E to...” and read it aloud, asking the hypothetical questions: Is the importance of M&E to...
 - o Criticize your colleagues and their work?
 - o Please international donors (and spend lots of their money)?
 - o Exert power – keep other people running around, compiling tables, writing up reports?
- Show slide containing “The real importance of M&E” and have a volunteer read aloud the points it contains on the real importance of M&E:
 - o Helps make informed decisions regarding on-going programs: determine whether a program is right on track and where changes need to be considered

Session I: What is Monitoring?

What is Evaluation (Continued)

- o Facilitates effective and efficient use of resources
 - o Provides information for planning future activities
 - o Helps to understand if and to what extent a program worked
 - o Documents project accomplishments, thus contributing to institutional memory
 - o Enables you to meet organizational reporting and other requirements and to convince donors that their investments have been worthwhile or that alternative approaches should be considered
- Summarize the activity by showing and reading aloud slide starting:
We invest in M&E in order to:
 - Strengthen program design, improve implementation
 - Justify allocation of limited resources
 - Improve use of allocated resources (thereby increasing cost-effectiveness)
 - Generate knowledge:
 - Identify factors (individual, community, programmatic) that influence health outcomes
 - Meet an organizational requirement

Activity 3: What to monitor/evaluate? (10 minutes)

- Now tell the group that the next step is to figure out what exactly to monitor. Show slide titled “What to monitor or evaluate” and note that, in BCC, we can monitor any and all of the different communication activities of a program, including:
 - o Mass media campaigns
 - o Print materials
 - o Counselling
 - o Entertainment-education activities
 - o Group presentations
 - o Community mobilization
- Say that you can monitor and/or evaluate behaviour change among all the various audience groups involved in your campaign or activities. Ask the group to offer some of the audience groups that they previously identified in their behaviour change strategies (can include men and women of reproductive age; providers and/or clients of health services; youth; PLHA; most at-risk populations [MARPs,] pregnant women). Show slide titled “Target Audience” to summarize the possible kinds of audiences.
- Tell them that in the same way that they designed and delivered communications specifically for each of those audiences, they will also plan and execute monitoring and evaluation exercises for each group.
- Show slide titled “Segmentation in M&E” and tell the group that lastly, just as the audience was segmented in part according to geographical location, the M&E activities will also need to be segmented. Examples of possible geographic focus to M&E activities can include:
 - o Select rural communities
 - o Clinics and urban health centres
 - o Schools
 - o Entire country

Session 2: Development of a Monitoring and Evaluation Plan

| | |
|----------------------------|--|
| Time | 30 minutes |
| Learning Objectives | <ul style="list-style-type: none"> • Describe the inputs to a M&E plan • Explain how M&E differs for different kinds of projects • Describe the construction of an M&E plan • Determine key points when BCC specialists should and the M&E team should collaborate |
| Preparation | <ul style="list-style-type: none"> • Read the session carefully • Review Accompanying PowerPoint slides |
| Materials | <ul style="list-style-type: none"> • Flipchart paper • Markers |
| Methodologies | <ul style="list-style-type: none"> • Discussion • Brainstorm • Case study analysis |

Activity 1: What goes into a plan? (15 minutes)

- Present the learning objectives for the session (slide titled “learning objectives”, Unit 4 accompanying PowerPoints)
- Tell the group that in this session, they will look in detail at the M&E plan.
- Show slide titled “M&E Plan: Definition,” and have a volunteer read the definition out loud. Every communication program should have an M&E plan that is developed at the same time as the BCC strategy.
- Now present and read aloud slide titled “the function of an M&E plan.” Emphasize that just as with a communication plan, this document serves as the roadmap to M&E.
- Present slide titled: the various elements of an M&E plan:
 - I. Introduction
 - II. Description of the Program - including problem statement and framework(s)
 - III. Indicators - including data sources and indicator reference sheets
 - IV. Data Collection, Reporting Systems
 - V. Monitoring Plan
 - VI. Evaluation Plan
 - VII. Plans for Dissemination and Use of Information
 - VIII. Capacity and Needs for M&E Plan Implementation
 - IX. Mechanism for M&E Plan Update
- Tell participants that the point isn't necessarily to have a document that follows this list exactly—it can be in different formats or styles, using different frameworks. The point is to somehow capture all of this information.

Session 2: Development of a Monitoring and Evaluation Plan (Continued)

- Tell the group that in the Participants' Reference Materials, they have examples of two different results frameworks/monitoring plans. (Participants' Reference Materials #4-1 and 4-2). Ask the participants to spend some time looking at these examples during a break or in the evening and tell them that you are available if they have any questions.
- Tell the group that they will not be responsible for creating such a plan, but rather for working with the M&E experts to be sure the appropriate pieces of the program are being measured and for defining how the program will change in response to regular monitoring data.

Activity 2: BCC programmers' role in M&E (15 minutes)

- Now ask the group to think about their role in M&E. Show slide containing the questions below to lead a short discussion:
 - How do they usually work with the M&E team?
 - When do they usually engage with the M&E process?
 - How do they usually get data from the monitoring process? Do they get it?
 - If so, how do they use the data to adjust their program?
 - What ideas do they have as to how the process could be improved?
- Emphasize that it is important for them, the BCC experts, to work closely with the M&E experts from the very beginning of the process. Brainstorm the stages or points in the M&E process where the two teams should work with each other. Show slide titled, "Stages or points BCC can be involved the M&E process" and ensure that the list includes the following:
 - Topics for research (such as baseline line/end line) are being identified
 - Research instruments (such as survey questionnaires or focus group discussion guidelines) are being developed
 - Data are being used to analyse how to improve/modify project activities

Session 3: Indicators

| | |
|----------------------------|---|
| Time | 30 minutes |
| Learning Objectives | <ul style="list-style-type: none"> • Define “indicator” • Distinguish between kinds of indicators and what they are used to measure |
| Preparation | <ul style="list-style-type: none"> • Read session carefully • Review accompanying PowerPoint slides |
| Materials | <ul style="list-style-type: none"> • Photocopies Training Handout #4-1 • Flipchart paper • Markers |
| Methodologies | <ul style="list-style-type: none"> • Presentation • Discussion |

Activity 1: Kinds of indicators (30 minutes)

- Tell the group that, as they saw, one of the most critical components of an M&E plan is selecting appropriate indicators that will be used to monitor program implementation and gauge achievement of the program’s objectives.
- Show slide containing the learning objectives for this session and read it aloud.
- Next, show slide titled, “What is an Indicator?” and have a volunteer from the audience read aloud the definition of an indicator:

*a variable
that measures
one aspect of a program/project*

*An appropriate set of indicators will include at least one for each
significant element of the program or project (i.e. at least one per box
in an M&E framework)*

- Now show slide titled, “What is an indicator cont...” and tell the group that indicators can either be quantitative or qualitative. Quantitative indicators are presented as numbers or percentages. Qualitative indicators are descriptive observations and can be used on their own or to supplement the numbers and percentages provided by quantitative indicators. Indicators should be consistent with international standards and other reporting requirements, as appropriate. The process of selecting the indicators can be fairly straightforward if the program objectives are “SMART.” A complete and appropriate set of indicators for a given program should include at least one indicator for each significant aspect of the program’s activities.

Session 3: Indicators

(Continued)

- Ask the group to think again about the kinds of things that could be measured in a program. Show slide containing list below as a reminder and highlight a few of the items on the list:
 - Distribution of print materials
 - Broadcast of communications (mass media or mobile)
 - Reach of communications
 - Trainings held
 - Visits made to households
 - Service utilization
 - Product distribution
 - Product utilization
 - Practices/behaviours
 - Beliefs
 - Attitudes
 - Knowledge
 - Systems improvements (technology, logistics, reporting, procurement, budgeting, human resource allocation, etc...)
- Tell the group that each of these kinds of things requires a certain kind of indicator. Show slide titled, “Types of Indicators,” as you discuss the three types of indicators: (1) output or process, (2) outcome, and (3) impact indicators. In general output/process indicators are most often used for monitoring and outcome and impact indicators are used for evaluation. However, there are times when your monitoring should also be looking at outcome and impact.
- Pass out the “Indicators” handout (training handout #4-1). Ask for a volunteer to read the description of output/process indicators and the list of examples. Ask the group which of the items they listed that could be measured in a program would be considered an output/process indicator.
- Ask for a different volunteer to read the description and examples of outcome and impact indicators. Ask the group to again think about the list of things to be monitored or evaluated (using appropriate slide). Which of those things would be measured using an outcome indicator? Do we have any that would be considered impact?
- Tell the group that in the last session of this unit, they will have a chance to decide on indicators for the strategy they developed. For now, however, show slide containing list below and remind participants that selecting indicators is subject to some careful considerations, including that they:
 - Be SMART
 - Have utility for program decision making
 - Are consistent with international standards or other reporting requirements
 - Follow/mirror existing indicators and data sources if available
 - Fill information gaps, determine feasible new indicators

Session 3: Indicators

- Finally, present slide showing the pitfalls of selecting indicators and tell participants to keep these in mind as they start the exercise of selecting their own indicators in a few sessions. Explain that monitoring becomes difficult when you have:
 - o Poorly defined indicators;
 - o Too many indicators;
 - o Indicators that do not currently exist and cannot realistically be collected;
 - o Process indicators to measure outcomes and impacts;
 - o Outcome and Impact indicators only;
 - o Indicators that are not very sensitive to change

- Ask if the participants have any questions and conclude the session.

Indicators

(For use with Unit 4, Session 3, Activity 1)

Process Indicators (sometimes called Output Indicators)

Output indicators are used in monitoring and measure what the program is actually doing – the immediate results obtained by the program. They essentially count what the program did or perhaps, what the population did.

Example of output indicators:

- # of training sessions
- # of radio spots aired
- # of materials produced
- # of materials distributed
- # of people trained
- # of people reached
- % of people who have seen/heard/read the program's materials

BCC output indicators may also include quality indicators, such as:

- % of audience who comprehend the messages of the radio program
- % of trained health providers that provide accurate information six months after the training

Outcome and Impact Indicators

Evaluation indicators can be separated into outcome and impact indicators. Outcome indicators measure changes in knowledge, attitudes and behaviours in the audience while impact determines impact on health indicators (e.g. HIV prevalence, mortality, etc.). Impact evaluations require special studies with wide coverage. Most programs do not have the resources to evaluate impact and therefore focus mainly on outcomes.

Observable changes in behaviour, as specified in the behaviour change objectives, are a final program outcome. Such changes are generally preceded by intermediate changes, or precursors to behaviour change, which may include: knowledge, attitudes, interpersonal communication, self-efficacy, intention, etc. BCC outcome indicators should include both the intermediate and long-term outcomes because the intermediate ones may be impacted first and may also provide evidence of changes occurring in the audiences.

Example of outcome indicators:

Intermediate outcome indicators: Knowledge, Attitudes, and Intentions

- % mothers /caretakers with correct knowledge of ITN to prevent malaria
- % mothers/caretakers with approval to use ITN to prevent malaria
- % mothers/caretakers with intention to use ITN to prevent malaria
- % of surveyed population that know 3 primary warning/danger signs during pregnancy
- % of women aged 15-49 who desire not to have additional children
- % of pregnant women who intend to give birth with the assistance of a skilled attendant
- % of young people who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission.

Indicators

(For use with Unit 4, Session 3, Activity I— Continued)

- % of males and females expressing accepting attitudes towards PLWA
- % youth intending to maintain their abstinence
- % of population who intend to seek VCT

Long-term outcome indicators: Behaviour

- % of pregnant women who slept under and ITN the previous night
- % of women who received IPT to prevent malaria during their last pregnancy
- % of births attended by a skilled health personnel
- % of children 12-23 months fully immunized
- Median age at first sex among young men and women ages 15-24
- % of women and men aged 15-49 who had sex with more than one partner in the last 12 months, of all people aged 15-49
- % of women and men aged 15-49 receiving HIV test results in the last 12 months.

Session 4: Methods Overview

| | |
|----------------------------|--|
| Time | 30 minutes |
| Learning Objectives | <ul style="list-style-type: none"> • List possible methodologies for conducting M&E • Determine which methodologies are appropriate for which situations and projects • Determine the most appropriate entity for conducting M&E (external or internal evaluator) • Recognize the necessary budget allocation for M&E • List ways to maximize/stretch M&E budgets |
| Preparation | <ul style="list-style-type: none"> • Read the session carefully • Review PowerPoint slides |
| Materials | <ul style="list-style-type: none"> • Flipchart paper • Markers |
| Methodologies | <ul style="list-style-type: none"> • Presentation • Discussion |

Activity 1: Introduction to methods for M&E (20 minutes)

- Show slide containing unit's "Learning Objectives." Read them aloud.
- Tell the group that although it is unlikely that they will ever have to actually conduct the monitoring and evaluation exercises themselves, since this is typically done by M&E experts, it is important that they understand the process and purpose sufficiently to closely work with the M&E team.
- Tell the group that for either monitoring or evaluation, they will rely on research tools. This session will briefly cover some of those methods and when they are best applied.
- Now show slide titled "Overview of M&E Techniques" and have a volunteer read it aloud. Tell the group that this list represents the various ways data might be obtained. Some of them are more relevant for specific kinds of monitoring.
- Go through slides "Methods to monitor program implementation" through "Monitoring interim effects of programme interventions," emphasizing the different considerations and questions for each kind of program monitoring:
 - o Program activities
 - o Media implementation
 - o Interpersonal communication
 - o Traditional media
 - o Intermediate program effects/impact
- Show slide titled, "Types of Methods for Evaluation" and describe the difference between Outcome Evaluation and Impact Evaluation.
- Tell the group that in both monitoring and evaluation, it is advisable to combine both quantitative and qualitative methods in both monitoring and evaluation, as appropriate, to gain a deeper understanding of an issue.

Session 4: Methods Overview

(Continued)

- Now show slide titled, “Challenges for BCC Evaluation Designs” and read it aloud to the group adding in the further contextual information below:
 - o Finding an adequate comparison group (that are similar to the intervention group except for exposure to the program)
 - o Multiple programs are implemented at the same time and often work together to bring about change. It is therefore difficult to attribute change to a specific program
 - o Mass media is often used, as well as implemented at the national level, making it difficult to have a comparison group that has not been exposed to the program
 - o Measuring exposure to a program can be difficult and therefore determine who was and who was not exposed. Need to have a specific set of questions about the intervention to adequately measure exposure. Asking audience members if they heard a specific a program is not enough; exposure can be examined through, for example: spontaneous recall of the program, spontaneous knowledge of program’s messages, spontaneous knowledge of characters and specific events/ characteristics of program
 - o A program needs to be implemented consistently for a long period of time, at least 9 – 12 months, for changes to take place. Changes in intermediate outcomes (such as knowledge, attitudes, and intentions) may occur more quickly, but changes in behaviour may take longer (sometimes as long as 2 years of consistent program implementation)

- Tell the group that resolving these issues frequently takes careful planning and coordination with the M&E experts from the very beginning—yet another reason to closely collaborate right from the start of a project.

- Tell the group that since the purpose of this session is just to provide an overview of the kinds of considerations that go into choosing and working with various methods, tell the group that you will end here, but that they have additional information on M&E research in Participants’ Reference Material #4-3.

Session 4: Methods Overview

(Continued)

Activity 2: Who should conduct M&E? (5 minutes)

- Now tell the group that now they have reviewed the basic components of M&E, you want to briefly discuss who should conduct M&E. Frequently, projects will have people on staff who are responsible for M&E, but these individuals are not always the best suited to actually DO the data collection and analysis.
- Ask the group to think about external evaluators vs. internal evaluators. What would be benefits of external evaluators (hiring an outside agency)? What would be the benefit of internal evaluators? Show slide explaining external evaluators and read it aloud, comparing it to the discussion just had:

External evaluators are:

More neutral regarding the results of the evaluation
Perceived as having greater credibility and objectivity
More likely to be frank about negative results
The indicated choice when internal evaluation capacity does not exist, is limited because staff lacks the skills, or because not enough staff are available to carry out the tasks

Internal evaluators are:

More likely to work closely with the people in charge of the program and have a greater and better understanding of the program
More likely to immediately apply results to improve the program or interventions
In better position to use the acquired data and to know why and how the intervention had or did not have an effect

Activity 3: How much does M&E cost? (5 minutes)

- Now show slide titled, “How much does M&E cost?” Tell the group that M&E typically makes up at least 10% of the overall program budget, but there are some ways to maximize the M&E budget, including:
 - o Using routine administrative data and continuous surveys to reduce evaluation costs. Questions related to communication interventions can be added to national surveys, for example, to assess a program's reach and impact.
 - o Collaborating with other organizations to evaluate programs can provide important benefits.

Session 5: Using the Data

| | |
|----------------------------|---|
| Time | 30 minutes |
| Learning Objectives | <ul style="list-style-type: none"> • Identify challenges for use of M&E data in programming • Determine key strategies for improving use of data • Choose appropriate indicators for a program, how they will be measured, by whom, and when |
| Preparation | <ul style="list-style-type: none"> • Read the session carefully • Review Accompanying PowerPoint slides |
| Materials | <ul style="list-style-type: none"> • Flipchart paper • Markers |
| Methodologies | <ul style="list-style-type: none"> • Discussion • Brainstorm • Case study analysis |

Activity 1: How to use the data (30 minutes)

- Tell the group that you want them to start thinking again about the programs that they have designed in this workshop to address the problems of stunting and diarrhoeal disease in young children in Zambia.
- Show Learning Objectives slide for this session and read the objectives aloud.
- Turn to slide containing quote, “Involvement Brings Commitment,” and read the quote aloud. Emphasize to the group that this statement is meant to serve as a reminder that the program staff and the M&E team must work closely together at all stages—both must OWN the program and have a stake in its outcome.
- Now show slide titled “Purpose of M&E/The Big Picture!” and conduct a brainstorming exercise. Ask the group to think about examples from their previous work. Use the following questions to guide a short discussion:
 - o How do you use your M&E information?
 - o Specifically, whom do you share your M&E information with?
 - o In your information sharing processes, what are your feedback mechanisms?
 - o What have been some barriers to using the M&E information?
 - o How can we overcome these barriers?

Ensure the following points are raised as ways to ensure use of M&E information:

- o Involve program staff in defining outcome measures and data collection
- o Provide timely reports, with information that is reliable, specific and well understood
- o Clearly link results to decisions that need to be made by developing realistic, specific recommendations for program improvement
- o Continuously remind decision makers of findings and recommendations
- o Share findings and recommendations with broad audiences
- o Assign evaluation staff to assist in implementing recommendations
- o Explore multiple uses of study data

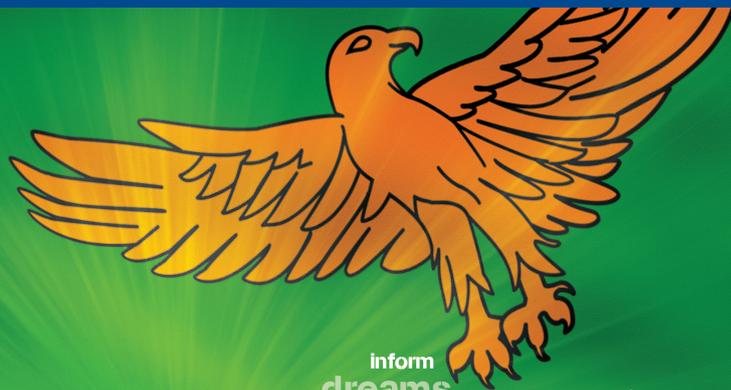
Session 5: Using the Data

(Continued)

- Now show slide titled, “M&E information is only useful if it is:” and briefly explain the difference between data and information:
 - Data often refers to raw data, unprocessed information.
 - Information usually refers to processed data, or data presented in some sort of context
- Show next slide also titled, “M&E information is only useful if it is:” and remind the group that the purpose of M&E is to improve programs. Then flip to slide titled, “Dissemination” and tell the group that M&E information is only as useful if it is:
 - manageable and timely
 - presented according to the audience’s
 - interest
 - capacity to understand and analyse
 - time, competing demands on time
 - transparent
 - focused on activities, results of interest
 - focused on meaning and direction for action
- Now move to slide titled, “Utilization,” and note that M&E information must ALSO be:
 - Disseminated
 - Utilized
 - Contains a feedback mechanism
- Show slide titled “Feedback” and discuss dissemination of information.
- Show slide titled “Remember” and discuss utilization. Tell the group that utilization of monitoring data is sometimes difficult. Lead a discussion about how to use data. Ask:
 - What about a program can you change? Once you have produced communications materials, making changes is difficult, so you want to make sure your materials are as good as possible the first time. But you might be able to change how they are used, where they are used, when they are used. You might be able to add training on their use or couple them with increased interpersonal communication.
 - When should you make changes? You should not be wildly reactionary to monitoring data— if attendance at one community drama is low, it does not mean that community drama is useless. Look for trends and the big picture. At the same time, you should not be afraid to make changes once you see these trends emerge.
- Now emphasize that monitoring information should be cyclical and there should be a way to share what has been learned with stakeholder groups and others who have been a part of the process.
- Remind the group that M&E information needs to be used to be helpful!
- Ask the group if they have any questions and if not, conclude the session.

Trainer's Manual

CONCLUDING ACTIVITIES



empower act

enable inspiration learn create teamwork own courage educate goals strength trust achieve

inform dreams challenges change desire

believe motivation support share

honor people success

Concluding Activities

| | |
|----------------------------------|-----|
| Post-Test | 151 |
| Action Planning/Discussion | 152 |
| Workshop Close..... | 155 |

Post Test

- Distribute the Post-test copies (Training Handout C-1) and have each participant fill it out and return it to you when they are finished.

Session C-2: What Now? Action Planning and Discussion

NOTE: IF conducting a Train-the-Trainer workshop, please complete the Train-the-Trainer Module (separate document) PRIOR to doing this action planning session.

| | |
|----------------------------|--|
| Time | 30 minutes |
| Learning Objectives | <ul style="list-style-type: none"> • Determine concrete next steps for integrating the learning into their daily work • Plan for next level of trainings • Close workshop |
| Preparation | <ul style="list-style-type: none"> • Read the session carefully |
| Materials | <ul style="list-style-type: none"> • Blank pieces of paper |
| Methodologies | <ul style="list-style-type: none"> • Brainstorm • Small group work |

Activity 1: Personal planning (15 minutes)

- Ask the group to reflect on the training as a whole. Ask for several volunteers to name what they find to be the two most standout take-aways, i.e. the two most interesting, relevant, or otherwise important ideas that they learned.
- Now ask the group to consider how feasible it will be to integrate the learning into their daily work life. Ask what will be the challenges? What can they do ahead of time to overcome the challenges?
- Responses could include better link with the research/M&E teams from the beginning to integrate everything; hold exploratory meetings with other programs to understand mobile technology communications better; stay up to date on research findings and participate in meetings and discussions about how to solve health problems in Zambia; train others to adopt this same model of thinking.
- On blank pieces of paper, have each person list 5 things he or she will do immediately upon return to the office to ensure that this training takes root for themselves.

Activity 2: Institutional Planning (15 minutes)

- Now have the participants consider how they will spread this training and methodology to others as well as use it in their activities.
- Pass out Training Handout C-2, “Capacity Building Worksheet” and Training Handout C-3 “Provincial level BCC Activities Planning.” Tell the group that the first worksheet is pretty self-explanatory. For the second one, they can put down any activities they think they would like to initiate in their province—this should include training (so some of the columns might repeat information they just wrote down on the first worksheet), but they can also list other activities like holding a briefing and presenting their plans, conducting research, producing province-specific materials for a particular topic, or really anything. This might reflect some of what they included in their action plans for 2012, but this is an opportunity to really think through what is possible and what they need help with accomplishing.

Session C-2: What Now? Action Planning and Discussion (Continued)

- Have the participants fill these worksheets out individually and make yourself available for support.
- Give the group 20 minutes to fill out the worksheet and then take 10 minutes to discuss them, especially inviting volunteers to discuss the items they have identified as challenges to successful roll out.
- Collect the worksheets, make copies, and then return them. Tell the group that you will be in touch with them soon to support implementation of this plan.
- Ask if anyone has any further questions or concerns.
- Tell the group that the workshop has now concluded.

Activity 3: Close of Workshop (10 minutes)

- Officially close the workshop. Thank the participants for their active participation and contribution. Distribute certificates and have a dignitary, if possible, offer words of encouragement to the participants as they leave the workshop to begin implementing their new skills.

Activity 4: Daily Evaluation: DAY 4 (5 min)

- Distribute the training evaluation for Day 4 and ask that each person complete it and hand it back to you before leaving for the evening. Conclude for the day.

Session C-I: Post Test

Capacity Building Planning Worksheet

Province:

Who needs capacity building in BCC? (List all possible within province)

Approximate total number of potential participants:

What are the primary responsibilities of these participants in health promotion?

What level of capacity do they currently have in health promotion/BCC?

Is the entire BCP workshop applicable? If not, which parts are applicable?

Who can be trained (besides you) to serve as the training team in the province?

When would you like to hold a provincial-level workshop on BCP?

Can this workshop be planned as part of the 2012 work-planning cycle?

What challenges will you face in holding this workshop? (And what support will you require from national level counterparts and CSH?)

BCC Activities Planning Worksheet

| Activity | Timeframe/Deadline | Resources Required | Responsible Person | Partners |
|----------|--------------------|--------------------|--------------------|----------|
| | | | | |
| | | | | |
| | | | | |