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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

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believe motivation

opportunity

strength support

trust

people

share achieve

success

TRAINING HANDOUTS



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SEPTEMBER 2011

This publication was produced for review by the United States Agency for International Development. It was prepared by Chemonics International Inc.

BEHAVIOUR CENTERED PROGRAMMING: An Approach to Effective Behaviour Change

TRAINING HANDOUTS

ACKNOWLEDGEMENTS

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.

Day One

Unit #	Module #	Session #	Session Title	Duration	Time Frame
			Opening/Introductions (Preliminary Activities)	60 minutes	9:00 – 10:00
			Pre-test		
UNIT 1: Introduction					
1	1	1	What is Behaviour Change	60 minutes	10:00 – 11:00
BREAK				15 minutes	11:00 – 11:15
1	1	2	Case Studies of Successful Programs	90 minutes	11:15 – 12:45
LUNCH				60 minutes	12:45 – 13:45
UNIT 2: Applying a Strategic Framework					
2	1	1	Behaviour Centered Programming Overview	60 minutes	13:45 – 14:45
2	2	1	What is a situational assessment?	20 minutes	14:45 – 15:05
BREAK				15 minutes	15:05 – 15:20
2	2	1	Health Problem Identification, Ideal Behaviours & Audiences	1 hour 45 minutes	15:20 – 16:55
			Evaluation of the day	5 minutes	16:55 – 17:00

Day Two

Unit #	Module #	Session #	Session Title	Duration	Time Frame
			Review of Concepts from Day 1	10 min	9:00 – 9:10
UNIT 2: Applying a Strategic Framework (continued)					
2	3	1	Overview of Behavioural Analysis	60 min	9:10 – 10:10
2	3	2	Conducting Research, Activities 1, 2 and 3	1 hour	10:10 – 11:10
BREAK				20 min	11:10 – 11:30
2	3	2	Conducting Research, Activities 4 and 5	60 minutes	11:30 – 12:30
Lunch				60 minutes	12:30 – 13:30
2	3	2	Conducting Research, Activity 6 (small group work)	2 hours	13:30 – 15:30
BREAK				15 minutes	15:30 – 15:45
2	3	2	Conducting Research, Activity 7 (presentations)	1 hour 30 minutes	15:45 – 17:15
			Evaluation of the day	5 minutes	17:15 – 17:30

Day Three

Unit #	Module #	Session #	Session Title	Duration	Time Frame
			Review of Concepts from Day 2	60 minutes	9:00 – 10:00
UNIT 2: Applying a Strategic Framework (continued)					
2	3	4	Defining Behavioural Objectives	15 minutes	10:00 – 10:15
2	4	1	Strategic Behavior Change Activities Development	45 minutes	10:15 – 11:00
BREAK				15 min	11:00 – 11:15
2	4	1	Small Group Work: Behavioral objectives, audience groups and behavior change activities	60 minutes	11:15 – 12:15
2	4	1	Presentations: Behavioral objectives, audience groups and behavior change activities	45 minutes	12:15– 13:00
LUNCH				60 minutes	13:00 – 14:00
2	4	2	Communications Planning	60 minutes	14:00 – 15:00
2	4	2	Small Group Work: Communication plan	60 minutes	15:00 – 16:00
BREAK				15 min	16:00 – 16:15
2	4	2	Presentations: Communications plans	45 minutes	16:15 – 17:00
2	4	3	Summary	30 minutes	17:00 – 17:30
			Evaluation of the day	5 min	17:30 – 17:35

Day Four

Unit #	Module #	Session #	Session Title	Duration	Time Frame
			Review of Concepts from Day 3	30 min	8:30 – 9:00
UNIT 3: Implementation					
3	I	1	Overview of Issues in Implementation	60 min	9:00 – 10:00
3	I	2	Partnerships for Implementation	30 min	10:00 – 10:30
BREAK				15 min	11:00 – 11:15
3	I	3	Pretesting	2 hours	11:15 – 13:15
LUNCH				60 minutes	13:15 – 14:15
UNIT 4: M&E for BCC					
4	I	1	What is M&E for BCC	30 min	14:15 – 14:45
4	I	2	Development of an M&E plan	30 minutes	14:45 – 15:15
4	I	3	Indicators	30 minutes	15:15 – 15:45
BREAK				15 min	15:45 – 16:00
4	I	4	Methods Overview	30 minutes	16:00 – 16:30
4	I	5	Using the Data	30 minutes	16:30 – 17:00
C	I	1	Post-test	15 minutes	17:00 – 17:15
C	2	2	Evaluation of the day	5 minutes	17:15 – 17:20
C	3	3	Preparation and practice for training practice	On own through end of day	

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 about 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

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 Behavior for Focus: Appropriate Complementary Feeding from age 6 months to 2 years

Complementary Feeding includes a number of behaviors:

- 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 % to 53 %, according to the 2007 DHS, 45 percent of children under five are stunted and 21 percent are severely stunted. Stunting is apparent even among children less than 6 months of age (18 percent). Wasting is also somewhat of a problem, with a national average of 5% of <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%), there is no need for an emergency feeding program.

Duration of breast feeding is strongly associated with the linear growth 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 percent) of children are breastfed; this occurs regardless of background characteristic. More than half (57 percent) of infants were put to the breast within one hour of birth and 93 percent started breastfeeding within the first day. 61 percent of infants below six months of age are exclusively breast fed, but younger children are more likely to be exclusively breast fed. Eighty-six percent of infants below two months are exclusively breast fed, compared with 35 percent of infants aged 4-5 months. The median length of breastfeeding in Zambia is 4 months . As many as 24% of children aged 2-3 months and 62% of children aged 4-5 months are receiving food supplements in addition to breast milk.

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)

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 Organization (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.

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 percent eat foods made from grains, and 68 percent eat fruits and vegetables rich in vitamin A. Overall, a relatively small proportion of children consume cheese, yogurt, and other milk products (4 percent). 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.

In most cases (70%), 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%) in the sitting area of the family house with the

⁵ Zambia DHS-2007

⁶ Zambia Child Health Situation Analysis (2004)

⁷ Formative 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)

child held on the mother/caretaker's lap. Verbal encouragement is frequently observed (up to 75% 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 28-53%. Further, Vitamin-A fortified sugar is only regularly purchased by 58.5% of caregivers, so other fortification vehicles such as maize meal should be explored.

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 neighborhood health committee: individual and group counseling, community education, micro nutrient 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

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

⁹ Zambia DHS-2007

¹⁰ TIPs for Improved Rainy Season Infant and Child Feeding

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

¹³ Modification of Complementary Foods in Zambia: <http://fex.enonline.net/25/modification.aspx>

¹⁴ Complementary Foods of Infants and Children Aged 6-18 Months Old in Lusaka, Zambia

¹⁵ Assessment 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 diarrhea disease in Zambia.

Key Behavior 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% 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 percent of children die from diarrhea-related causes each year. Even in urban areas, such as Lusaka, diarrhea remains a significant challenge. Diarrhea is reported to be amongst the top five 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 do to acute diarrhea, the rate of diarrhea cases has, unfortunately, not decreased.

It has been proven that one of the best ways to fight diarrhea 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 diarrhea 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 fecal-borne diseases that cause diarrhea, especially in those most susceptible—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 diarrhea-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 behavior with regards to handwashing at all critical times is poor. For example, one study showed that while 80 percent 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 behavior 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%.¹⁷

Research Summary Diarrhea/Handwashing

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

In many places, however, access to water is indeed 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 percent of people have access to a nearby supply of clean water¹⁸. The average walk to a water source taken by a woman is 45 minutes¹⁹. Without access to water, proper handwashing practices are difficult—if not impossible—to perform, leading to increased likelihood of diarrhea and diarrheal related deaths in infants.

To help stretch water supplies, 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% 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 percent of the population—lack the funds to buy soap⁷. At the same time, however, almost all households had soap available for bathing and laundry, it was just not used 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%¹⁹) 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 fecal 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 fecal 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 percent 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 percent 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

Research Summary Diarrhea/Handwashing

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

the area. For example, the Government Basic School in Choma has helped the surrounding area, 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 behavior 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

Instructions for Small Group Work on Behavioural Analysis

- Fill in Behavioural Analysis matrix (from info in the case study 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 Behaviours	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 Behaviours	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 Barriers	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 home and cannot express milk • Some proteins, such as fish and dairy products, are not seen as acceptable for young children 	<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).

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 	<p>Handwashing with soap before</p> <ul style="list-style-type: none"> • 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 thought 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 st it up at the handwashing station

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 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

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 effect 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 labor in private or with one female family representative until she reaches the very end of labor, when a traditional attendant and the woman's female relatives join her to help urge the baby out. Women usually labor 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 labor becomes prolonged, her female relatives assist the labor by pushing on her stomach to aid in the delivery. Hemorrhage 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

More than 50% of women in CountryX 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 labor 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 labor 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 Behaviours	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 Barriers	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"> • Services of midwives are expensive/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

Completed Program Definition Matrix for Safe Motherhood

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

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		
Program Goal	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:
 - Define final list of behaviours as behavioural objectives
 - Re-examine choice of primary and influencer audience groups and finalize their choices.
 - 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.

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.

“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</p> <p>Secondary</p> <ul style="list-style-type: none"> Fathers Mothers of older children Grandmothers and Health workers

“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 fortifies 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/Communication Objective	Primary Message	Secondary Measures	Who/How will material be used?
Radio spot and radio drama	Scripts for 8 15- minute radio “soap opera” episodes and 2 reminder spots 8 recorded soap opera episodes and 2 reminder spots	Caregivers Household members	Mothers know which local foods to feed their children Mothers are taught (via the drama) and then reminded (via the spots) of easy feeding tips such as adding oil to porridge and sitting with their baby to feed them, rather than letting a sibling do it.	Little ones have little stomachs! They need to eat 5 times a day. Proper feeding is not hard—just add in a bit more oil to your child’s porridge and give them a banana or avocado in between meals. Avoid giving your child cookies or crackers from a package—it is expensive and doesn’t give your child anything good.	Mom’s need support from the community to ensure the littlest community members get what they need Nutrition means doing the best with what is available—you don’t have to look much beyond your garden to make sure your baby gets what he/she needs to grow big and strong. Wait until 6 months to start feeding your baby. Until then, breastmilk is all he or she needs.	Scheduled broadcasting on community & commercial radio stations 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/ Communication Objective	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 HW station) • Visual aids on HW • 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 HW</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 HW in households and have tippy taps with soap as models at health posts</p> <p>Getting NGO's to promote HW</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/ Communication Objective	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 & de- velop 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 diarrhea & the fewer episodes of diarrhea, the better your child will grow and learn (& less money spent on medicine/doctors)	Air one epi- sode 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/Communication Objective	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/Communication Objective	Primary Message	Secondary Message	Who/How will material be used?
Community theatre	Script for community theatre 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

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		

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:

- 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

- 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

- 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

- 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

Sample Material for Pretesting

Material: Poster

Target Audience: Men and women age 20-45

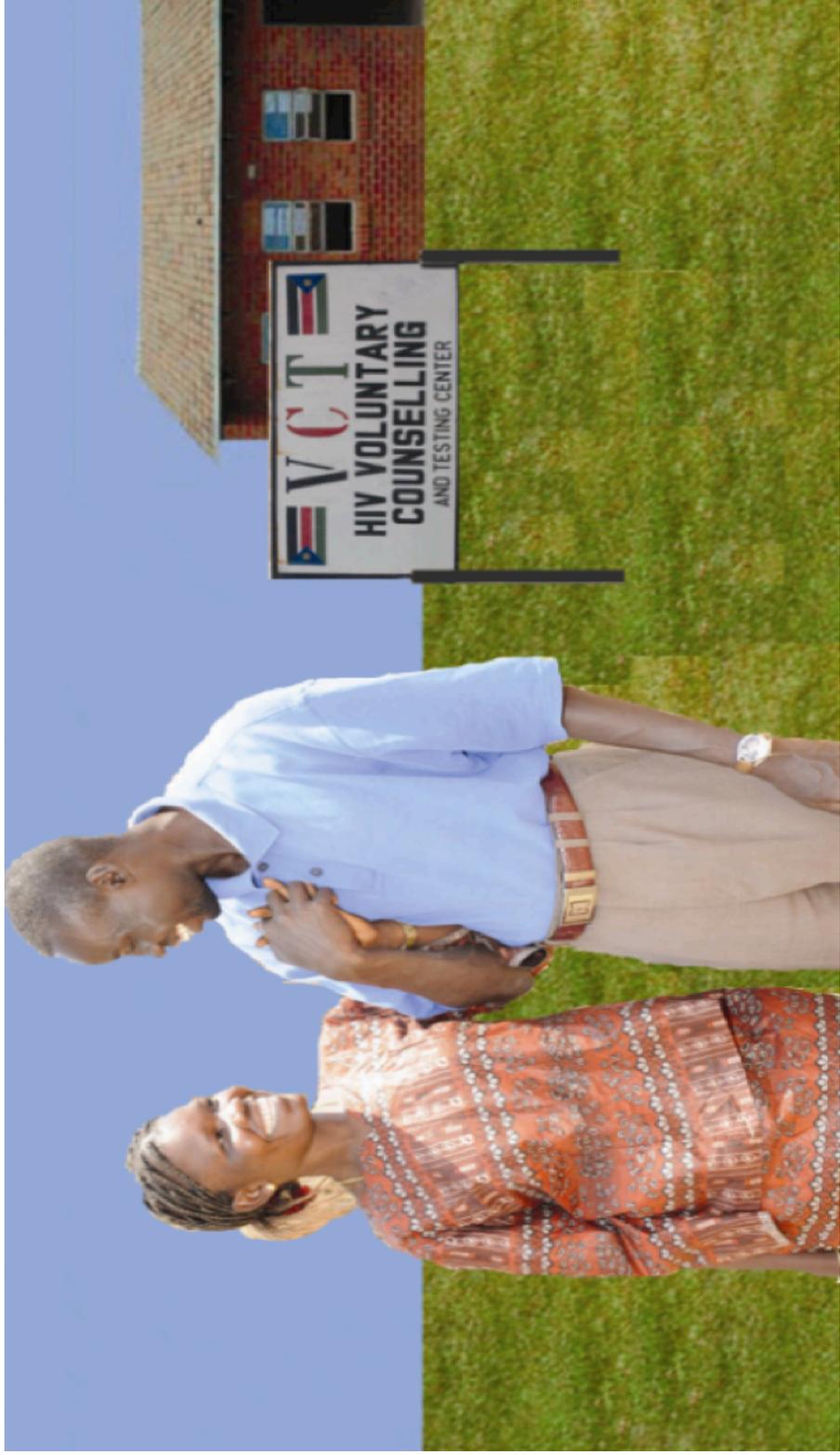
Behavioral Objective: To increase rates of couples seeking voluntary testing for HIV

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?

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 behaviors 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 behavior, as specified in the behavior change objectives, are a final program outcome. Such changes are generally preceded by intermediate changes, or precursors to behavior 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.

Indicators

For use with Unit 4, Session 3, Activity 1

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 three 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.
- % 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: Behavior

- % 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.