



**USAID**  
FROM THE AMERICAN PEOPLE

# 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

people

share achieve

success

PARTICIPANT'S REFERENCE MATERIALS



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# BEHAVIOUR CENTERED PROGRAMMING: An Approach to Effective Behaviour Change

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### 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.



# Health Promotion Definition

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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

# Best Practices For Behaviour Change Project

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The following list represents best practices for implementing behaviour change programming, based on successful interventions. It is not meant to be exhaustive, but rather used to stimulate thinking about the various elements upon which a successful intervention is built.

- Uses research to determine program strategy
- Tailors media messages including radio to specifically address barriers learned from formative research
- Uses appropriate and diverse channels for communication
- Present clear messages in a way that resonated with the target audience (confirmed by pretesting)
- Allows for participation of community and community ownership
- Allows for flexibility to ensure the promoted action was feasible for the target audience

# UNIT 2

Participant's Reference Materials



# Definition of “Behaviour” and “Strategy”

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A **Behaviour** is:

- An ACTION
- Is specific, concrete, and measurable.

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

# Health Problem & Ideal Behaviour Definitions

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## **HEALTH PROBLEM DEFINITION:**

A health problem definition must include specific information on the following elements of the problem:

- Health area: (e.g. Malaria, HIV/AIDS, WASH, Child Health)
- Description of the problem: (e.g. incidence of malaria each year, rate of HIV incidence, rate of diarrhoea incidence , prevalence of under nutrition)
- Audience group (mothers, kids, sex workers, truck drivers, etc...)

## **IDEAL BEHAVIOUR DEFINITION:**

An ideal behaviour is one that is determined by scientific study to have a direct 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.

# Target Audience Definition & Five Ways To Describe Your Priority Group

## Target Audience Definition:

- Priority Group = the group of people who will perform the positive behaviour
- Influencing Group = the group of people who influence the priority group, who can either support or prevent the priority group from adopting positive behaviours (e.g. fathers, older women, traditional healers, community and religious leaders)

## Five 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)

# Priority Group Graphic

For use with Unit 2, Module 2, Session 2, Activity 4



# Definition of Theory

For use with Unit 2, Module 3, Session 2, Activity 2

*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.

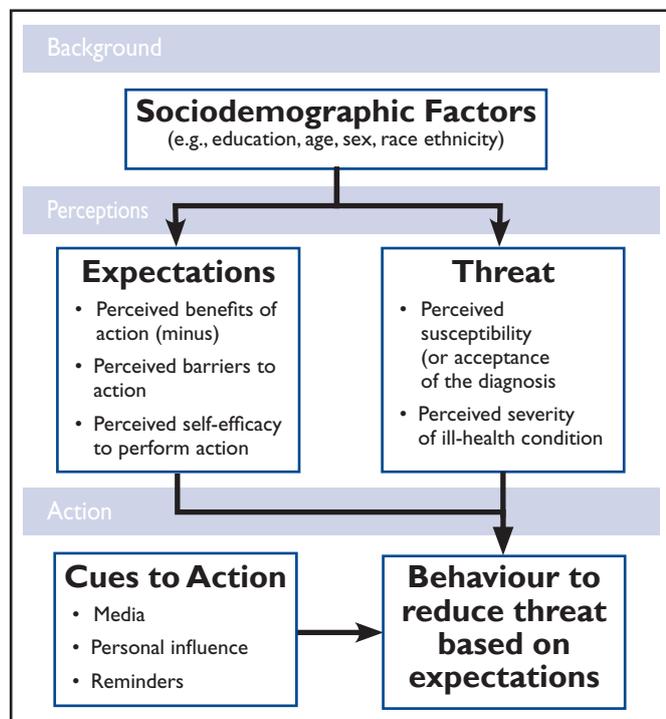
# Theories of Behaviour Change

For use with Unit 2, Module 3, Session 2, Activity 2

## Health Belief Model (HBM)<sup>1</sup>

The Health Belief Model (HBM) is a psychological model that attempts to explain and predict health behaviours by focusing on the attitudes and beliefs of individuals. The HBM was developed in the 1950s as part of an effort by social psychologists in the United States Public Health Service to explain the lack of public participation in health screening and prevention programs (e.g., a free and conveniently located tuberculosis screening project). Since then, the HBM has been adapted to explore a variety of long- and short-term health behaviours, including sexual risk behaviours and the transmission of HIV/AIDS. The key variables of the HBM are as

- **Perceived Threat:** Consists of two parts: perceived susceptibility and perceived severity of a health condition.



<sup>1</sup>Adapted from FHI and AIDSCAP's Behaviour Change: A summary of Four Major Theories <http://www.fhi.org/nt/rdonlyres/ei26vbslpsidmahhxc332vwo3g233xsqw22er3vofqvrjvubwyzclvqjcbdgexyl-3msu4mn6xv5j/bccsummaryfourmajortheories.pdf>

<sup>2</sup>Rosenstock, Strecher and Becker (1994). The Health Belief Model and HIV risk behavior change. In R. J. DiClemente and J.L. Petersopm, Preventing AIDS: Theories and methods of behavioral interventions. (pp. 5-24). New York: Plenum Press."

# Theories of Behaviour Change

For use with Unit 2, Module 3, Session 2, Activity 2

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- o **Perceived Susceptibility:** One's subjective perception of the risk of contracting a health condition,
- o **Perceived Severity:** Feelings concerning the seriousness of contracting an illness or of leaving it untreated (including evaluations of both medical and clinical consequences and possible social consequences).
- **Perceived Benefits:** The believed effectiveness of strategies designed to reduce the threat of illness.
- **Perceived Barriers:** The potential negative consequences that may result from taking particular health actions, including physical, psychological, and financial demands.
- **Cues to Action:** Events, either bodily (e.g., physical symptoms of a health condition) or environmental (e.g., media publicity) that motivate people to take action. Cues to action is an aspect of the HBM that has not been systematically studied.
- **Other Variables:** Diverse demographic, sociopsychological, and structural variables that affect an individual's perceptions and thus indirectly influence health-related behaviour.
- **Self-Efficacy:** The belief in being able to successfully execute the behaviour required to produce the desired outcomes.

## Limitations

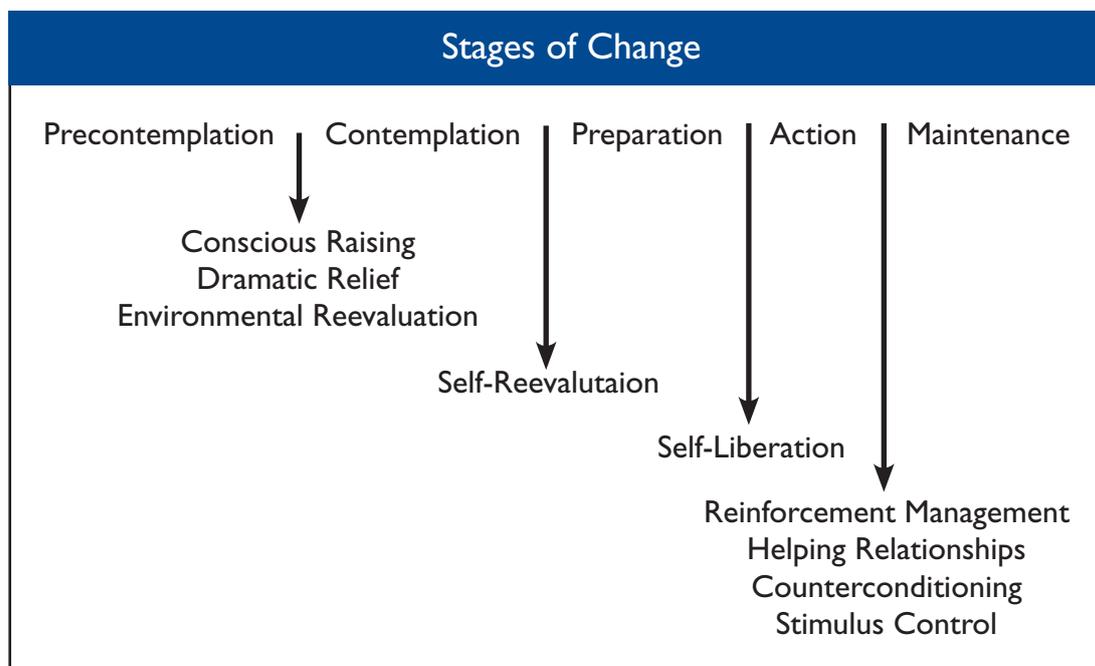
General limitations of the HBM include: a) most HBM-based research to date has incorporated only selected components of the HBM, thereby not testing the usefulness of the model as a whole; b) as a psychological model it does not take into consideration other factors, such as environmental or economic factors, that may influence health behaviours; and c) the model does not incorporate the influence of social norms and peer influences on people's decisions regarding their health behaviours.

# Theories of Behaviour Change

For use with Unit 2, Module 3, Session 2, Activity 2

## THE STAGES OF CHANGE THEORY

Psychologists developed the Stages of Change Theory in 1982 to compare smokers in therapy and self-changers along a behaviour change continuum. The rationale behind “staging” people, as such, was to tailor therapy to a person’s needs at his/her particular point in the change process. As a result, the four original components of the Stages of Change Theory (precontemplation, contemplation, action, and maintenance) were identified and presented as a linear process of change. Since then, a fifth stage (preparation) has been incorporated into the theory as well as ten processes that help predict and motivate individual movement across stages. In addition, the stages are no longer considered to be linear; rather, they are components of a cyclical process that varies for each individual. The stages and processes are listed below:



<sup>3</sup>Galavotti, C., Cabral, R., Grimley, D., Riley, G.E., and Prochaska, J.O. (1993). Measurement of condom and other contraceptive behaviour change among women at high risk of HIV infection and transmission. Paper presented at the IX International Conference on AIDS (Abstr PO-D38-4416), Berlin, Germany.

- **Precontemplation:** Individual has the problem (whether he/she recognizes it or not) and has no intention of changing.

**Processes:** Consciousness raising (information and knowledge) Dramatic relief (role playing) Environmental reevaluation (how problem affects physical environment)

- **Contemplation:** Individual recognizes the problem and is seriously thinking about changing.

**Processes:** Self-reevaluation (assessing one’s feelings regarding behaviour)

# Theories of Behaviour Change

For use with Unit 2, Module 3, Session 2, Activity 2

- **Preparation for Action:** Individual recognizes the problem and intends to change the behaviour within the next month. Some behaviour change efforts may be reported, such as inconsistent condom usage. However, the defined behaviour change criterion has not been reached (i.e., consistent condom usage).

**Processes:** Self-liberation (commitment or belief in ability to change)

- **Action:** Individual has enacted consistent behaviour change (i.e., consistent condom usage) for less than six months.

**Processes:** Reinforcement management (overt and covert rewards) Helping relationships (social support, self-help groups) Counterconditioning (alternatives for behaviour) Stimulus control (avoid high-risk cues)

- **Maintenance:** Individual maintains new behaviour for six months or more

## Example

A variety of behaviours, such as smoking cessation, weight control efforts and mammography screening, have been explored in U.S. populations using the Stages of Change Theory. More recently, this theory has been applied in research on sexual behaviours and HIV/AIDS. For example, the Centers for Disease Control and Prevention (CDC) is using the Stages of Change Theory in an HIV/AIDS Counseling and Testing Study at sexually transmitted disease (STD) clinics. Consequently, the counseling provided will be based on the client's particular stage. Populations for other stages of change research conducted in the U.S. consist of women, men who have sex with men but do not identify themselves as homosexual, intravenous drug users, prostitutes, couples, and youth. Preliminary results from these studies support the Stages of Change Theory as a method for characterizing individuals along a change continuum with the intent of enhancing the effectiveness of HIV/AIDS interventions. In addition, the theory offers a method for evaluating programs by measuring individual change.

## Limitations:

As a psychological theory, the stages of change focuses on the individual without assessing the role that structural and environmental issues may have on a person's ability to enact behaviour change. In addition, since the stages of change presents a descriptive rather than a causative explanation of behaviour, (meaning one stage does not result in the next stage occurring), the relationship between stages is not always clear. Finally, each of the stages may not be suitable for characterizing every population. For instance, a study of sex workers in Bolivia discovered that few study participant's were in the precontemplative, contemplative stages in regard to using condoms with their clients.

<sup>4</sup>Centers for Disease Control and Prevention. (1993). Distribution of STD clinic patients along a stages of behavioural change continuum -- selected sites, 1993. MMWR, 42,880-883.

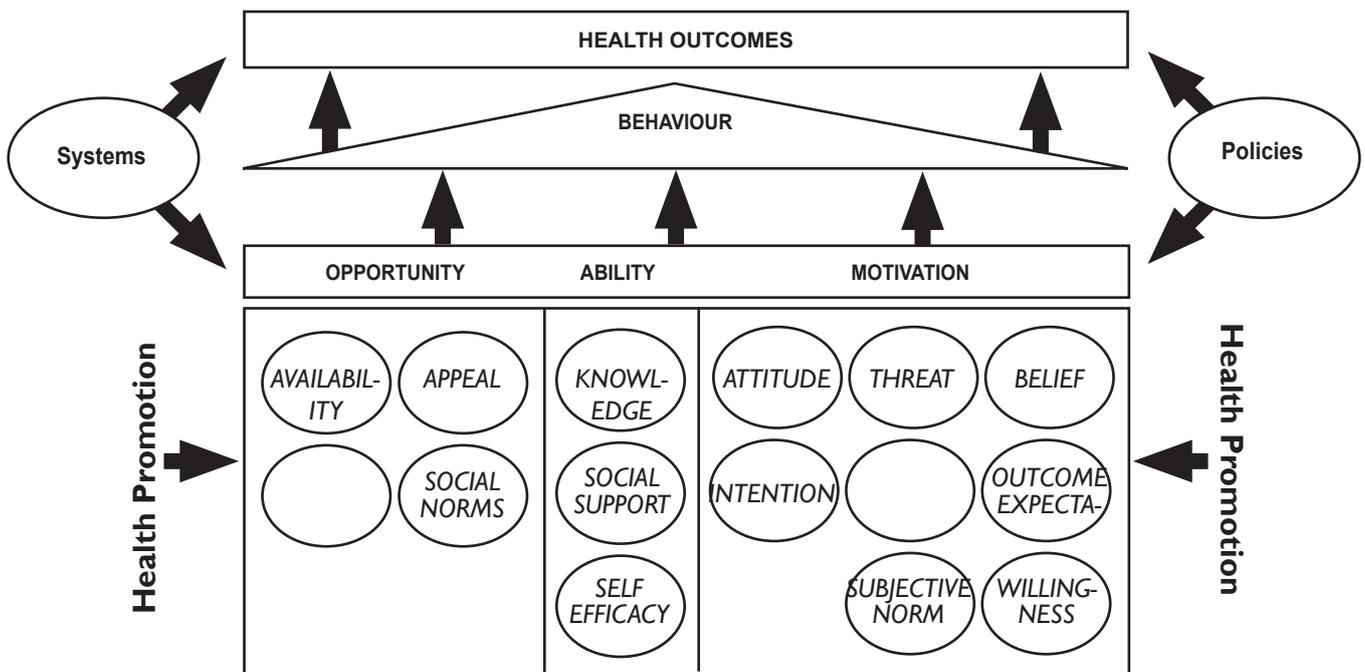
<sup>3</sup>Posner, J.K., and Higuera, G. (1995). Stages of Change in condom use adoption: The Bolivian Context. Paper presented by Proyecto Contra SIDA, USAID, La Paz, Bolivia, at the Tenth Latin American Congress on STDs/Fourth Pan American Conference on AIDS, Santiago, Chile.

# Theories of Behaviour Change

For use with Unit 2, Module 3, Session 2, Activity 2

## DETERMINANTS MODEL OF BEHAVIOUR & HEALTH PROMOTION

The following model takes various components of other theories, including pieces of the health belief model and the stages of change, and organizes them differently, adding to them and illustrating them in a model that really emphasizes determinants or the factors that directly influence behaviour. This model provides a specific and concrete way to analyze “barriers and motivations.” Each of the factors (in the bubbles in the bottom box) can be a barrier or a motivator, depending on the person. This model is based on the behaviour change model frequently used by Population Services International to develop and monitor social marketing programs, but has been modified slightly to apply to all kinds of health promotion activities.



Adopted from Population Services International's Bubbles Framework

The following model takes various components of other theories, including pieces of the health belief model and the stages of change, and organizes them differently, adding to them and illustrating them in a model that really emphasizes determinants or the factors that directly influence behaviour. This model provides a specific and concrete way to analyze “barriers and motivations.” Each of the factors (in the bubbles in the bottom box) can be a barrier or a motivator, depending on the person. This model is based on the behaviour change model frequently used by Population Services International to develop and monitor social marketing programs, but has been modified slightly to apply to all kinds of health promotion activities.

# Theories of Behaviour Change

For use with Unit 2, Module 3, Session 2, Activity 2

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It should also be noted, however, that the model also illustrates the role played by the health system and associated policies in impacting both a person's opportunity, ability and motivation to behave in a certain way as well as health outcomes directly. This relationship indicates that improving health is NOT just about behaviour. Promoting or encouraging healthy behaviours is essential, but other components of the health system (such as the existence of health centers, availability of drugs and training of staff) are also vital as are sound policies that establish the right priorities and provide necessary resources.

## Opportunity:

PSI defines opportunity as those institutional or structural factors that influence a behaviour.

- **Availability**

In this model, availability refers to whether or not external factors necessary to the behaviour are, in fact, available. This can refer to items, such as water treatment products, condoms, mosquito nets, or available variety and quantity of food, to infrastructure such as a facility in which to deliver a baby and/or services, such as immunization. The availability of these things is essential to whether or not a person has the opportunity to act. Without availability, no amount of health promotion can produce a result.

Availability can be objective (the item, infrastructure or service is actually not available) and subjective (the individual perceives there to be no availability).

- **Quality of Care**

Quality of care indicates the level of quality a person attaches to the process of doing the promoted behaviour. If one is encouraged to go for antenatal care, but is treated badly and made to wait for hours or hears about others who have had to, the perception of quality of care for that promoted behaviour will be low and the opportunity to perform the behaviour will be lessened.

- **Appeal**

Appeal is a factor that is most often relevant when a branded product or service is available. In such instances, the appeal refers to how much the brand attracts and invites customers. It can also be applied, however, to unbranded health items, such as birthing kits. If carrying a birthing kit held some kind of appeal for a pregnant woman, say for example, pride and honor within her community, this factor could also be relevant. Strong appeal works to establish opportunity for a behaviour to take place.

- **Social Norms**

Social norms are incredibly powerful factors in affecting the opportunity to perform the promoted behaviour. Social norms are defined as those behaviours that are regularly practiced in the community and held up as the standard. People tend to act in a way that is in line with how their neighbor acts. If the promoted behaviour is different than that held as standard in the community, social norms around the behaviour must change in order to create the opportunity for the promoted behaviour to take on.

# Theories of Behaviour Change

For use with Unit 2, Module 3, Session 2, Activity 2

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## Ability

Ability is defined as a person's capacity to act.

- **Knowledge**  
Knowledge is defined as the requisite information and facts needed to make a decision on performing the promoted behaviour or not.
- **Social Support**  
Social support is defined as the confirmation and encouragement, both emotionally and physically (a ride to a facility, for example) or, conversely, the resistance, a person encounters from his or her family and peers relating to performing the behaviour.
- **Self Efficacy**  
Self-efficacy is the perception of the individual as to their ability to perform the behaviour. It refers to whether or not that person feels capable to act.

## Motivation

Motivation refers to the individual's motivation or disinclination to perform the behaviour as a result of the following factors:

- **Attitude**  
Attitude is a value-laden opinion that an individual has towards the behaviour. It might be influenced by some of the other factors, including social norms, or knowledge, but ultimately it is the assessment of the behaviour in question, influenced however it was influenced, that determines motivation to perform a behaviour or not.
- **Threat**  
Threat refers to a person's perception of his or her susceptibility to negative outcomes should the behaviour not be performed and the severity of that outcome.
- **Belief**  
The beliefs a person holds regarding the promoted behaviour are also key to motivating him or her to act. A belief is different than empirical knowledge of facts, but is frequently just as important to a person's view of the behaviour.
- **Intention**  
Intention is a person's stated or un-stated plan to enact the behaviour. Many traditional behaviour change models identified intent to act as the very last step prior to action. Intentions can be hampered by many other factors and does not always lead to action, but likewise, without it action will certainly not occur.

# Theories of Behaviour Change

For use with Unit 2, Module 3, Session 2, Activity 2

- **Locus of Control**

Locus of control refers to a person's concept of fate and his or her ability to control events in life, including illness. It can be internal, meaning a person feels that outcomes are not inevitable and that they can be controlled, at least somewhat. A person with an external locus of control feels that someone or something else (God, a partner, a parent, fate or luck) is completely in control of the outcome and no decision made by that individual can have any impact. For those people with an external locus of control, motivation to act is mission.

For some people, there might be gradients of this factor, meaning that for some behaviours a person might feel that it is worth trying some behaviours because they might make a difference, but others will not.

- **Outcome Expectation**

Outcome expectation refers to whether or not a person believes that the promoted behaviour will actually have its intended consequence. If people are told to use condoms to prevent the transmission of HIV but do not believe that condoms will work, they are far less motivated to do the promoted behaviour or wear a condom.

- **Subjective Norm**

Subjective norms refer not to what other people are actually doing in a community, but rather what a person perceives others to be doing and by extension what a person feels they ought to be doing.

- **Willingness to Pay**

Willingness to pay refers to a person's willingness to absorb any cost associated with the behaviour being promoted, including transportation.

In developing materials and activities for health promotion, each of these factors should be explored in relation to each key behaviour in order to best determine where to focus health promotion efforts.

## Example of Filled in Behavioural Analysis

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

# Definition of Improved Sub-Behaviours

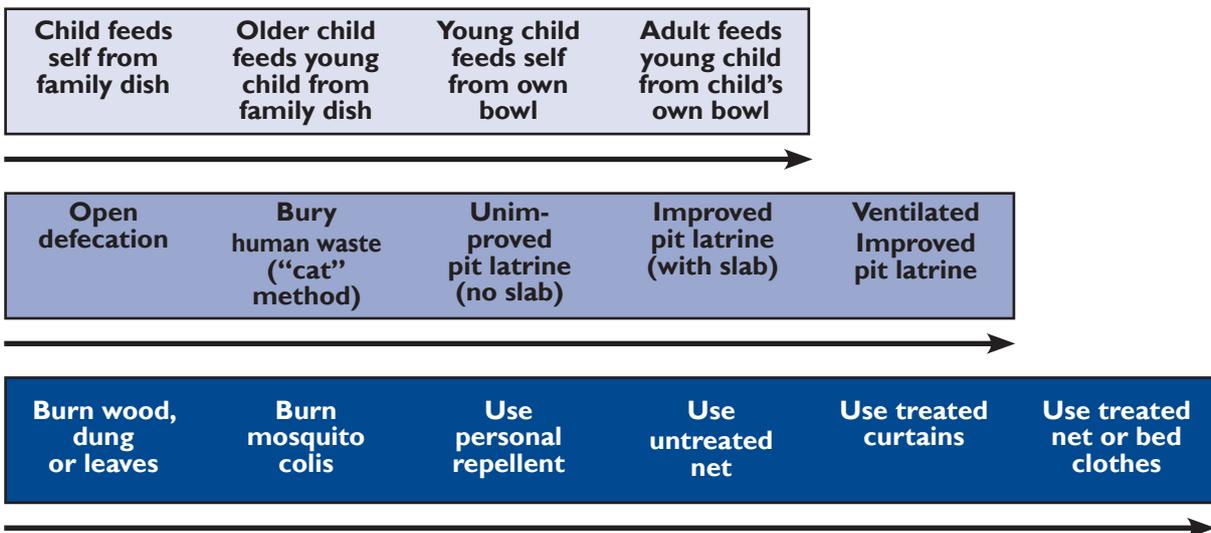
(small do-able actions)

## Improved sub-behaviours (small do-able actions) are:

- 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.
- Behaviours that, when practiced consistently and correctly, will lead to health improvement.
- 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.
- 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.
- It is effective – because it makes a difference to the household and the community

# Behavioural Ladders

Least Desirable  Most Desirable



# Definition and Goals of Formative Research

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## **FORMATIVE RESEARCH DEFINITION:**

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 existing (research) AND new research and the information is used to fill in the "Behavioural Analysis" portion of the Behaviour Centred Programming Strategy Matrix.

## **GOALS OF FORMATIVE RESEARCH:**

- Identify current behaviours
- Identify if key behaviours can be carried out by target audience
- Identify small, feasible improvements or alternatives to their key behaviours
- Identify motivators
- 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

# Possible Research Questions

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## 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 kind of motivators/supports exist to encourage the improved behaviours?
- What kind 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 socio-economic 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)

## Ability

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

## Motivation

- What motivates that behaviour?
- Is it something that the person wants to do or to have?
- Does the person feel that they have control over whether they can or cannot do the behaviour?
- Are there religious beliefs that may influence carrying out the behaviour?
- What is the person's attitude towards the behaviour?
- What beliefs influence the person to practice/not practice the behaviour?
- Is the person planning on doing the behaviour? Do they want to do it?
- Who makes the decision about the behaviour?
- How does the person feel about the behaviour?
- Is the person willing to pay for the good or services? Do they see a value to it?
- What perceived risks might influence someone to carry out the behaviour?
- What perceived consequences might influence someone to carry out the behaviour?
- 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?
- Does the person have the intention do carry out the behaviour?
- Do they believe that the desired outcome will be a result of practicing the behaviour?

# Sources for Programming Information and Research

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**USAID's Development Experience Clearinghouse** <http://dec.usaid.gov/index.cfm>

An on-line resource for USAID funded technical and program documentation currently making over 138,500 documents available for electronic download.

**Global Health Council** <http://globalhealth.org/sources>

Information on health-related web sites, publications and other media.

**Population and Health InfoShare** <http://www.phishare.org/>

An electronic library of material supplied by partner organizations working in reproductive and child health, HIV/AIDS, and population.

**World Health Organization** <http://www.who.int/publications/en/>

Guidance on program implementation spanning a range of health topics.

**World Health Organization/Africa Index Medicus** <http://indexmedicus.afro.who.int/>

Access to all African medical journals and other publications

**Zambia Ministry of Health** <http://www.moh.gov.zm/?q=node/129>

Action plans and occasional publications on service provision and programming.

**World Bank e-Library** <http://elibrary.worldbank.org/>

Certain health programming information, primarily on policy issues.

**C-Change Resource Center** <http://c-changeprogram.org/resources>

A site that allows users to search for C-Change publications by country, topic, or type.

**DHS Publications** <http://www.measuredhs.com/pubs/>

Demographic and Health Surveys.

**CDC** <http://www.cdc.gov/Publications/>

Publications from the Center of Disease Control

**Pub Med** <http://www.ncbi.nlm.nih.gov/pubmed/>

More than 20 million citations for biomedical literature from MEDLINE, life science journals, and online books.

**Medline** <http://www.nlm.nih.gov/bsd/pmresources.html>

MEDLINE® contains journal citations and abstracts for biomedical literature from around the world. PubMed® provides free access to MEDLINE and links to full text articles when possible.

# Sources for Programming Information and Research continue

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## DATA FOR DECISION MAKING

### **Demographic and Health Surveys** [www.measuredhs.com/accesssurveys](http://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](http://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).

### **WHO Statistical Information System** [www.who.int/whosis](http://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/](http://www.zamstats.gov.zm/)

A range of reports and statistics on Zambia.

### **Cochran Collaboration** [www.cochrane.org](http://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.

# Formative Research Methodologies

Quantitative Versus Qualitative Research	
<p><b>Quantitative Research</b> Examples of quantitative techniques include written surveys, KAP surveys, and structured interviews.</p>	<p><b>Qualitative Research</b> Examples of qualitative techniques include in depth interviews, focus group discussions, participant-observation, and exit interviews.</p>
<ul style="list-style-type: none"> <li>Answers questions of how many and how often. Documents differences that can be measured in numbers.</li> </ul>	<ul style="list-style-type: none"> <li>Answers questions of why and how.</li> </ul>
<ul style="list-style-type: none"> <li>Closed-ended questions. Uses a series of closed-ended questions that offer the respondent several choices when answering a question. For example: "Was your child immunized for tetanus? ___Yes___No___ Don't know." Closed-ended questions limit the kinds of responses that can be recorded, which keeps data organized but limits the ability to probe whatever response is given. For instance, you may not be able to ask participant's why they don't know if their child was immunized for tetanus.</li> </ul>	<ul style="list-style-type: none"> <li>Open-ended questions. Asks open-ended questions that allow respondents to give detailed answers, thus revealing their biases, the extent of their knowledge, and the gaps in their thinking. For example: "Why is immunization necessary?" might reveal a whole range of answers that can help you address the informational needs of your audience. Because responses from participant's will vary in content and length, a note-taker usually records responses on a blank sheet of paper and analyzes the data later.</li> </ul>
<ul style="list-style-type: none"> <li>Statistical. Provides a measurement of the audience's responses in numerical estimates. For example, 60 percent of mothers with children under 5 years of age reported that their children had received tetanus shots.</li> </ul>	<ul style="list-style-type: none"> <li>Anecdotal. Provides in-depth understanding about audience responses. For example, because a measles outbreak started the week after a national immunization day, mothers thought the polio vaccine caused the measles.</li> </ul>
<ul style="list-style-type: none"> <li>Measurable. Deals with objective, measurable behaviour, knowledge, and attitudes.</li> </ul>	<ul style="list-style-type: none"> <li>Contextual. Deals with the contextual and emotional aspects of human responses.</li> </ul>
<ul style="list-style-type: none"> <li>Process often pursues proof of a hypothesis.</li> </ul>	<ul style="list-style-type: none"> <li>Process is generally one of discovery.</li> </ul>
<ul style="list-style-type: none"> <li>Large sample size. Involves large numbers of participant's and interviewers, generally making this kind of research expensive.</li> </ul>	<ul style="list-style-type: none"> <li>Small sample size. Involves small numbers of participant's and interviewers, usually making this a less expensive form of research.</li> </ul>
<ul style="list-style-type: none"> <li>Straightforward analysis. Includes questions that are straightforward to ask and yields answers that are straightforward to analyze.</li> </ul>	<ul style="list-style-type: none"> <li>Thoughtful analysis. Yields results that are more difficult to analyze, requiring contemplation, organization, and interpretation. Rich with details, often providing answers to questions no one thought of asking.</li> </ul>
<ul style="list-style-type: none"> <li>Firm conclusions. Draws firm conclusions and results that can be generalized to the population at large. Data are presented as percentages and numbers of people who believe or do certain things. Counts the number of people fitting into different categories.</li> </ul>	<ul style="list-style-type: none"> <li>Insights. Provides insights into attitudes, beliefs, motives, concerns, and behaviours. Can be used to add deeper meaning and real-life examples to quantitative findings. Discloses clues about an audience's behaviours, fears, or doubts.</li> </ul>

Adapted from Debus M. Handbook for Excellence in Focus Group Research. HealthCom, Academy for Educational Development, Washington, DC 1988

# Formative Research Methodologies

RESEARCH TECHNIQUE	APPROPRIATE FOR
<p><b>In-depth interviews</b></p> <p><b>Observations (in conjunction with interviews)</b></p>	<p>To obtain individual information regarding abilities, beliefs, experiences, understandings, meanings, contexts and perceived constraints and supports to a practice.</p> <p><b>For example:</b> To discover health care providers' motivation and ability to provide effective counseling</p>
<p><b>Focus group discussions</b></p>	<p>To reveal actual behaviours</p> <p><b>For example:</b> To discover whether people actually carry out a particular practice or whether they merely say that they do.</p>
<p><b>Positive deviance inquiry</b></p> <p><b>Key informant interviews</b></p>	<p>To identify directions for exploratory research or areas that need focus in a community (e.g. what services are available, when might hours of a clinic be more suitable to people's schedules, what community needs are the most pressing)</p> <p>Teasing out a communications or perception's gap between groups or categories of people (e.g. groups of teachers might think differently than groups of parents about providing breakfast at school)</p> <p>To explore a social norms or social implications of a topic. (a group will react differently than individuals, so both individual interviews and focus groups could be used on the same subject to compare how the group reacted vs how the individual reacted.)</p>
<p><b>Trials of Improved Practices (TIPs)</b></p>	<p>To explore what practices are already working well, as well as the motivations and barriers for the feasible practices</p> <p><b>For example:</b> To learn what families with well-nourished children are doing differently than families with under-nourished children</p>
	<p>To check acceptability of the actions and messages among program personnel, implementers, or key influential people or to understand constraints and motivations for providers, program managers and community members in influencing key people, to get an idea what to ask during community interviews</p>
	<p>To identify if a proposed behaviour is realistic for the target audience to implement and what changes in the behaviour or optional behaviour make it more realistic for it to be implemented.</p>

Adapted from a toolbox for Building Health Communication Capacity

# Behavioural Objectives Characteristics

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*"An objective should be SMART"*

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

# List of Verbs for Formulating Learning Objectives\*

The following verbs have been found to be effective in formulating learning or educational objectives.

## 1. Those that communicate knowledge:

### Information

cite	identify	quote	relate	summarize	update
count	indicate	recite	repeat	tabulate	write
define	list	recognize	select	tell	
describe	name	record	state	trace	

### Comprehension

assess	contrast	distinguish	interpolate	restate	
associate	demonstrate	estimate	interpret	review	
classify	describe	explain	locate	translate	
compare	differentiate	express	predict		
compute	discuss	extrapolate	report		

### Application

apply	employ	match	relate	sketch	
calculate	examine	operate	report	solve	
choose	illustrate	order	restate	translate	
complete	interpolate	practice	review	treat	
demonstrate	Interpret	predict	schedule	use	
develop	locate	prescribe	select	utilize	

### Analysis

analyze	criticize	diagram	infer	question	
appraise	debate	differentiate	inspect	separate	
contract	deduce	distinguish	inventory	summarize	
contrast	detect	experiment	measure		

### Synthesis

arrange	construct	formulate	organize	produce	
assemble	create	generalize	plan	propose	
collect	design	integrate	prepare	specify	
combine	detect	manage	prescribe	validate	
compose	document				

### Evaluation

appraise	critique	evaluate	rank	score	
assess	decide	grade	rate	select	
choose	determine	judge	recommend	test	
compare	estimate	measure	revise		

## 2. Those that impart skills:

demonstrate	hold	massage	pass	visualize	
diagnose	integrate	measure	write		
diagram	internalize	operate	project		
empathize	listen	palpate	record		

## 3. Those that convey attitudes:

acquire	exemplify	plan	reflect	transfer	
consider	modify	realize	revise		

## Avoid using these verbs

appreciate	have faith in	know	learn		
understand	believe				

Note: These verbs are often used but are open to many interpretations and do not make a learning objective SMART

\* List developed by CORE Group Social Behaviour Change working group.

# Behavioural Change Strategic Activities

## Examples: Generic

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

# Behavioural Change Strategic Activities

## Examples: Safe Motherhood

4. Strategic Behaviour Change Activities				
Communication	Training	Community Mobilization/Collective Action	Commodity or Technology	Advocacy
<p><b>MASS MEDIA</b> 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 drama and radio spots</p> <p><b>COMMUNITY LEVEL</b> 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 leader's 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 CHW's on counseling for this topic</p> <p>Training of religious and traditional leaders 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 sacrifices for their children and to encourage them to be as safe as possible (including speeches by traditional healers and modern medicine practitioners to discuss how the various approaches can coexist)</p> <p>Safe mother savings groups (perhaps among the pregnant mother's groups—each mom pays a little bit in case any one of them needs emergency transport)</p>	<p>Clinic hours</p>	<p>Allowing for traditional practices to coexist with modern medicine, including permitting the woman to keep the placenta, labor in any position she wished and perform rituals immediately after birth.</p>

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

# Tips for Leveraging Technology Platforms for Behaviour Change Communications

There are many different kinds of mobile technology platforms that might be used to communicate with a target audience in a behaviour change intervention. The following table lists some of the most common and their applicability/purpose.

## Technology platforms in communications

Platform	Possible Use
Text messaging/SMS	Remind people to do something (e.g. it's time to take your child for his immunization)  Provide periodic pieces of information (e.g. in your 4th month of pregnancy, your baby is the size of a lemon and is starting to move around! You should eat an extra piece of fruit a day)
Interactive websites	To create a space for dialogue  To allow for feedback on a program  To provide continuously updated information  To allow for a deeper experience with the communication (e.g. an online "virtual reality" video game that is designed to communicate certain key messages through allowing the user to role play a character).
Friend applications/ social networking, etc...)	To mobilize people, especially youth, around a particular message or practice  To create social pressure for positive change  To establish an avenue for instant communication (e.g. one "friend" is actually a source of advice)
Mobile monitoring applications	To allow for instant monitoring of programs  To allow for easier monitoring (with mobile data entry)
Mobile video counseling cards	To use a more interesting and entertaining format for delivering counselling or initiating a conversation
Fundraising/money pooling/ insurance/ mobile payments	To leverage the existing mobile technology to provide banking, savings and collective management tools to members of the target audience groups.
Cell phone hotlines	To establish a free and easy way for members of the target audience to reach support and find necessary resources

# Considerations for Presenting Messages

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## THINKING ABOUT MYTHS

### Persistence of Myths Could Alter Public Policy Approach

By Shankar Vedantam  
Washington Post Staff Writer  
Tuesday, September 4, 2007; A03

The federal Centers for Disease Control and Prevention recently issued a flier to combat myths about the flu vaccine. It recited various commonly held views and labeled them either “true” or “false.” Among those identified as false were statements such as “The side effects are worse than the flu” and “Only older people need flu vaccine.”

When University of Michigan social psychologist Norbert Schwarz had volunteers read the CDC flier, however, he found that within 30 minutes, older people misremembered 28 percent of the false statements as true. Three days later, they remembered 40 percent of the myths as factual.

Younger people did better at first, but three days later they made as many errors as older people did after 30 minutes. Most troubling was that people of all ages now felt that the source of their false beliefs was the respected CDC.

The psychological insights yielded by the research, which has been confirmed in a number of peer-reviewed laboratory experiments, have broad implications for public policy. The conventional response to myths and urban legends is to counter bad information with accurate information. But the new psychological studies show that denials and clarifications, for all their intuitive appeal, can paradoxically contribute to the resiliency of popular myths.

This phenomenon may help explain why large numbers of Americans incorrectly think that Saddam Hussein was directly involved in planning the Sept 11, 2001, terrorist attacks, and that most of the Sept. 11 hijackers were Iraqi. While these beliefs likely arose because Bush administration officials have repeatedly tried to connect Iraq with Sept. 11, the experiments suggest that intelligence reports and other efforts to debunk this account may in fact help keep it alive.

Similarly, many in the Arab world are convinced that the destruction of the World Trade Center on Sept. 11 was not the work of Arab terrorists but was a controlled demolition; that 4,000 Jews working there had been warned to stay home that day; and that the Pentagon was struck by a missile rather than a plane.

Those notions remain widespread even though the federal government now runs Web sites in seven languages to challenge them. Karen Hughes, who runs the Bush administration's campaign to win hearts and minds in the fight against terrorism, recently painted a glowing report of the “digital outreach” teams working to counter misinformation and myths by challenging those ideas on Arabic blogs.

A report last year by the Pew Global Attitudes Project, however, found that the number of Muslims worldwide who do not believe that Arabs carried out the Sept. 11 attacks is soaring — to 59 percent of

## Thinking About Myths: Persistence of Myths Could Alter Public Policy Approach

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Turks and Egyptians, 65 percent of Indonesians, 53 percent of Jordanians, 41 percent of Pakistanis and even 56 percent of British Muslims.

Research on the difficulty of debunking myths has not been specifically tested on beliefs about Sept. 11 conspiracies or the Iraq war. But because the experiments illuminate basic properties of the human mind, psychologists such as Schwarz say the same phenomenon is probably implicated in the spread and persistence of a variety of political and social myths.

The research does not absolve those who are responsible for promoting myths in the first place. What the psychological studies highlight, however, is the potential paradox in trying to fight bad information with good information.

Schwarz's study was published this year in the journal *Advances in Experimental Social Psychology*, but the roots of the research go back decades. As early as 1945, psychologists Floyd Allport and Milton Lepkin found that the more often people heard false wartime rumors, the more likely they were to believe them.

The research is painting a broad new understanding of how the mind works. Contrary to the conventional notion that people absorb information in a deliberate manner, the studies show that the brain uses subconscious "rules of thumb" that can bias it into thinking that false information is true. Clever manipulators can take advantage of this tendency.

The experiments also highlight the difference between asking people whether they still believe a falsehood immediately after giving them the correct information, and asking them a few days later. Long-term memories matter most in public health campaigns or political ones, and they are the most susceptible to the bias of thinking that well-recalled false information is true.

The experiments do not show that denials are completely useless; if that were true, everyone would believe the myths. But the mind's bias does affect many people, especially those who want to believe the myth for their own reasons, or those who are only peripherally interested and are less likely to invest the time and effort needed to firmly grasp the facts.

The research also highlights the disturbing reality that once an idea has been implanted in people's minds, it can be difficult to dislodge. Denials inherently require repeating the bad information, which may be one reason they can paradoxically reinforce it.

Indeed, repetition seems to be a key culprit. Things that are repeated often become more accessible in memory, and one of the brain's subconscious rules of thumb is that easily recalled things are true.

Many easily remembered things, in fact, such as one's birthday or a pet's name, are indeed true. But someone trying to manipulate public opinion can take advantage of this aspect of brain functioning. In politics and elsewhere, this means that whoever makes the first assertion about something has a large advantage over everyone who denies it later.

Furthermore, a new experiment by Kimberlee Weaver at Virginia Polytechnic Institute and others shows

## Thinking About Myths: Persistence of Myths Could Alter Public Policy Approach

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that hearing the same thing over and over again from one source can have the same effect as hearing that thing from many different people -- the brain gets tricked into thinking it has heard a piece of information from multiple, independent sources, even when it has not. Weaver's study was published this year in the *Journal of Personality and Social Psychology*.

The experiments by Weaver, Schwarz and others illustrate another basic property of the mind — it is not good at remembering when and where a person first learned something. People are not good at keeping track of which information came from credible sources and which came from less trustworthy ones, or even remembering that some information came from the same untrustworthy source over and over again. Even if a person recognizes which sources are credible and which are not, repeated assertions and denials can have the effect of making the information more accessible in memory and thereby making it feel true, said Schwarz.

Experiments by Ruth Mayo, a cognitive social psychologist at Hebrew University in Jerusalem, also found that for a substantial chunk of people, the “negation tag” of a denial falls off with time. Mayo's findings were published in the *Journal of Experimental Social Psychology* in 2004.

“If someone says, ‘I did not harass her,’ I associate the idea of harassment with this person,” said Mayo, explaining why people who are accused of something but are later proved innocent find their reputations remain tarnished. “Even if he is innocent, this is what is activated when I hear this person's name again.

“If you think 9/11 and Iraq, this is your association, this is what comes in your mind,” she added. “Even if you say it is not true, you will eventually have this connection with Saddam Hussein and 9/11.”

Mayo found that rather than deny a false claim, it is better to make a completely new assertion that makes no reference to the original myth. Rather than say, as Sen. Mary Landrieu (D-La.) recently did during a marathon congressional debate, that “Saddam Hussein did not attack the United States; Osama bin Laden did,” Mayo said it would be better to say something like, “Osama bin Laden was the only person responsible for the Sept. 11 attacks” -- and not mention Hussein at all.

The psychologist acknowledged that such a statement might not be entirely accurate -- issuing a denial or keeping silent are sometimes the only real options.

So is silence the best way to deal with myths? Unfortunately, the answer to that question also seems to be no.

Another recent study found that when accusations or assertions are met with silence, they are more likely to feel true, said Peter Kim, an organizational psychologist at the University of Southern California. He published his study in the *Journal of Applied Psychology*.

Myth-busters, in other words, have the odds against them.

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# The Power of Fear-Based Messages: Do They Promote Behaviour Change?

## THINKING ABOUT FEAR

### The Power of Fear-Based Messages: Do They Promote Behaviour Change?

By Mahler, Hally R. & Flanagan, Donna R.; Family Health International AIDS Control and Prevention (AIDSCAP) Project

**Introduction:** Since the beginning of the AIDS epidemic, educators and communication professionals involved in HIV/AIDS prevention have used fear-based messages in an attempt to increase awareness of the epidemic and to provide individuals and communities into making changes in their behaviour and attitude.

Early fear-based materials had several limitations:

- They were created to inform people that AIDS exists, without providing important supporting information about how HIV/AIDS is transmitted;
- They promoted images and messages which were scary or unrealistic and thus failed to evoke the desired reaction;
- They rarely included action steps to help the audience avoid the “consequences” shown;
- They displayed images which inadvertently suggested that one can “recognize” someone who is HIV positive; and,
- They transferred fear of AIDS into fear of specific members of society, stigmatising certain groups of people.

Although Western health communications professionals have questioned the efficacy of fear-based messages for HIV/AIDS prevention, many African professionals continue to support and implement them. This study set out to examine why fear-based messages are still being used across the African continent, and the basis on which African health communications professionals design fear-based messages they feel are successful.

**METHODS:** 1) Fear-based messages and materials, currently in use in Africa, were selected for review. 2) Questionnaires and interviews were conducted with field-based communication experts in seven African countries to ascertain their opinions about these messages and materials. 3) Peer-reviewed and academic literature on fear-based communication was studied.

**RESULTS:** A majority of the African field-based IEC practitioners interviewed continue to believe in the efficacy and behaviour change potential of fear-based messages. The appropriateness of these messages may depend upon multiple factors such as the sociopolitical environment, folkloric traditions, and the current stage of the epidemic. In contrast, many non-African academic communication professionals remain skeptical of the effectiveness of fear-based messages.

## The Power of Fear-Based Messages: Do They Promote Behaviour Change?

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**DISCUSSION:** An analysis of the responses have led to the following recommendations for IED practitioners considering the use of fear-based messages.

- 1) Use appropriate cultural or subcultural contexts which root the messages or images in local beliefs;
- 2) Provide concrete actions steps which can be taken in order to avoid the negative consequences described;
- 3) Use images which support the negative consequences identified. Avoid using unrealistic images;
- 4) Segment messages to strictly defined target audiences during fear-based campaigns. If the message is only received by the target audience, it will help avoid stigmatization

Respondents indicated that long format media, such as video or radio are preferable to short format such as posters or billboards, since they allow IEC professionals the space to cover the four recommendations above.

**CONCLUSION:** Fear can be a powerful means to evoke an emotional response and help promote behaviour change. However, respondents indicated that fear can backfire and contribute to message avoidance if messages or images are too scary or culturally inappropriate. Communication professionals wishing to use fear-based messages should design their messages to meet the four recommendations outlined above.

# UNIT 3

## Participant's Reference Materials



# Creative Brief Definition and Examples

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## CREATIVE BRIEF DEFINITION:

- A document used by creative professionals and agencies to develop creative deliverables: visual design, copy, advertising, web sites, etc.
- Usually developed by the requestor ( the MOH health promotion, NAC, NMCC, or project staff) and approved by the creative team of designers, writers, and project managers.
- Consisting of a series of simple questions asked by the creative team and answered by the requestor.
- Is the guidepost for the development of the creative deliverable. If the project goes off track referring back to this mutually agreed upon document to see where the divergence began is helpful.
- Creative briefs can come in many flavors and are usually tailored to the agency or group that is developing the creative deliverable. They know which questions (and answers) are of paramount importance to them in order to deliver a high-quality creative execution. A creative brief may contain:

**Background** (What is the overall objective of the project? Where do these materials fit into the bigger picture? What is known about the target audience group and their relationship to the behaviour you are promoting?)

**Material** (what kind of material are you developing? Posters/billboards/radio spots/radio drama/TV spots/TV drama/stickers/etc...)

**Target Audience** (who do you want to reach with this communication?)

**Communication Objectives** (What will this communication make the audience feel, think, believe, remember or DO?)

**Obstacles** (What barriers exist to the audience thinking/feeling/believing or doing as you want them to?)

**Key Promise/Benefit?** (What is in it for the audience? Be single minded here—why would they do what you want them to?)

**Support Statement** (why does the key promise outweigh the obstacle?)

**Tone** (what feeling should the communication have?)

**Creative Considerations** (what other points need to be considered? Frequently things like low literacy, cultural sensitivities, etc... should be highlighted here).

**Mandatory elements** (mandatory elements such as the client's logo, address, phone number and so forth.)

**Deliverables** (What is to be used to give the audience the message? What is the best way or place to reach this audience?)

**Timeline** (How soon is this needed? When is it expected to be done? How many rounds of (revisions) will this project undergo?)

**Budget** (How much can be spent to get this developed? Is there any budget needed to publish/flight the creative?)

**Approvals** (Who needs to give the “okay”?)

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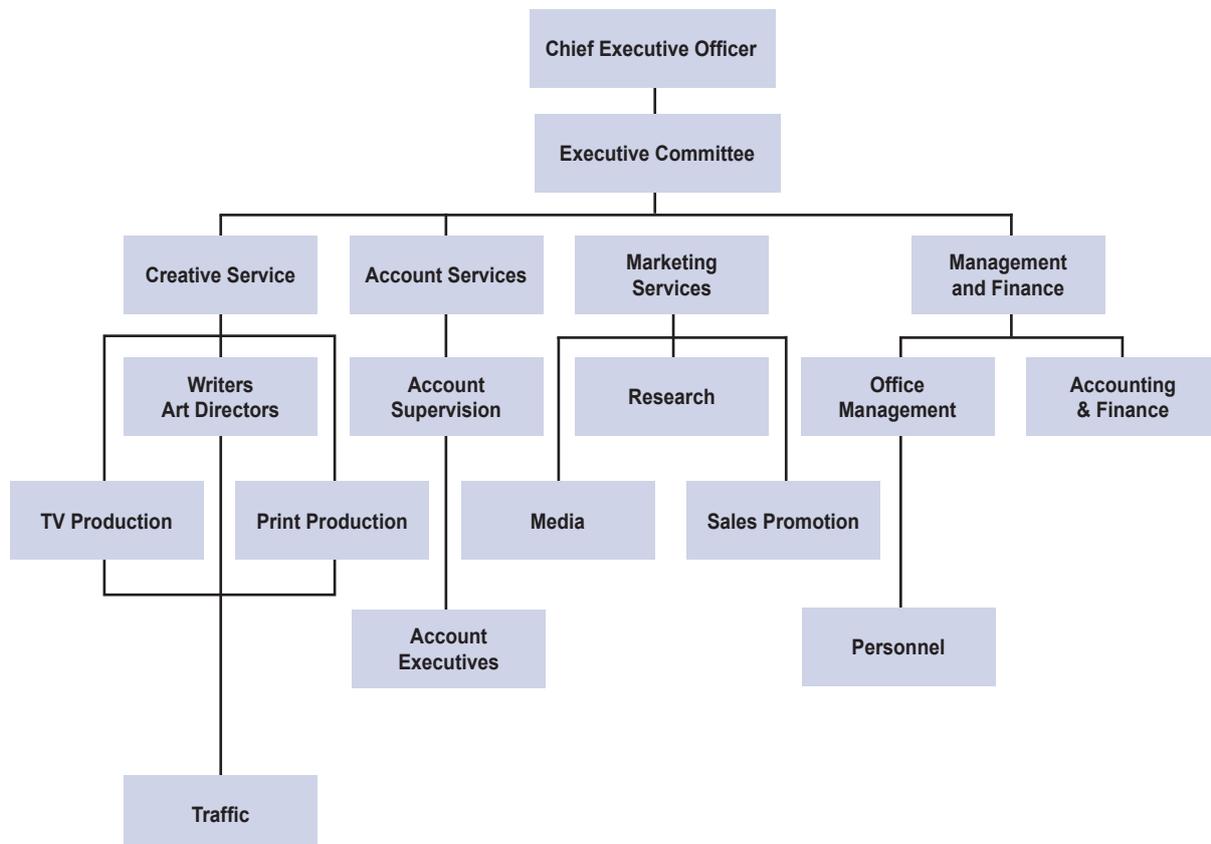
Adapted from Developing Materials On HIV/AIDS/STIs for Low-Literate Audiences FHI, PATH and USAID, 2002

# How an Agency Works

Advertising agencies are unique and may seem very different from your own organization. This section is designed to help guide your search for an agency and to familiarize you with the kinds of capabilities that ad agencies in your area are likely to offer.

## How Advertising Agencies Are Structured

Ad agencies are managed and staffed by communication professionals who have uniquely refined skills. Some agency professionals specialize in crafting and producing communication messages—the “creative” side of the business. Others are strategic planners with strong backgrounds in “marketing” products and services and who are instrumental in planning all aspects of a communication program. Other staff members may specialize in research, public relations, or sales promotion. The people who pull it all together are the “account executives” or account managers who manage the agency’s business with its clients. Still others deal with the management, personnel, and financial functions that are required by any organization.



# How an Agency Works

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## **The Creative Services Department**

the creative services department is run by the creative director, the person who has overall responsibility for all of the creative products produced by the agency. The creative department manager oversees the daily operations of the department, making sure that projects are assigned to the right people and that they get done. The people who create the agency's messages include: the copywriters who write the copy or text for messages and materials the art directors who conceptualize, develop, and draw the ideas for creative products; and the producers who translate the words and pictures into finished print and broadcast messages. These three professionals often work together as a group on client projects.

## **The Media Department**

The media department develops the plans for placing the client's advertising messages in the most appropriate print and broadcast media and makes sure that the media plan is implemented correctly. The media planner develops the media plan; the media buyer executes it. The media department job is to develop the best possible plan for meeting the communication campaign's objectives for reaching the intended audience. The agency—and the client—rely on the media department's expertise and knowledge about all of the available media, their coverage, and the media habits of the audiences the client is trying to reach.

## **The Research Department**

Some agencies have fully staffed research departments that can design and manage a wide array of market and communication research services to meet client needs. Others have more limited capability, with only a few researchers on staff who do not work within a research department per se, but are integrated into account teams. Many agencies do not have a research department of their own. Instead, they work with independent research companies.

## **The Account Services Department**

The account services department makes sure that the ad agency's resources are allocated to meet client needs. The account management supervisor oversees all agency accounts and reports directly to top management. The staff member responsible for servicing clients' day-to-day needs is the account executive. The account executive is the person who deals directly with the client, who coordinates all of the agency's planning, creative, media, and research activities for the communications program, and who obtains client approvals for the agency's work. Account executives usually report to an account supervisor who oversees and coordinates several agency accounts.

## **Account Planning**

Although the planning function may not be handled by a specific department most agencies provide communication campaign planning services to their clients. After reviewing essential background information about a client's product, service, or program, the agency will develop recommendations about the objectives and the strategy for a communication campaign. Some agencies form a "plan board" or an executive committee to develop and review the account team to do the job. Still others have individuals on staff who specialize in strategic planning and consumer behaviour. These planners bridge the gap between research, account team and by providing a thorough understanding of the client's audience to the group.

# How an Agency Works

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## Other Advertising-Related Organizations

The typical “full-service” ad agency performs a wide array of services for their clients. In many countries, smaller more specialized companies that provide advertising-related services are also available and may be hired directly by the ad agency to work on the communication program. Others may be hired directly by the client to supplement the ad agency’s capabilities.

- Companies that specialize in providing creative services are called “creative boutiques.” These companies focus solely on producing broadcast and print messages and materials for their clients.
- “Media buying services” are staffed by specialists in the media aspect of advertising.
- “Production companies” often are hired by an ad agency to provide the specialized services needed to produce the audiovisual messages that clients require.
- “Art Studios” produce the finished artwork needed for communication campaign messages and materials. Depending on the campaign’s creative strategy, the ad agency’s art director will select an artist to develop the campaign artwork. Typically, artists specialize in either ink drawings, watercolor drawings, oil paintings, or photography.
- “Research companies,” which are independent of the ad agency, may offer a wide range of research services or they may specialize in certain types of research. Some are expert in surveying public knowledge, attitudes, and behaviour, and studying the impact of communication campaigns. Some concentrate on conducting smaller scale focus group research. Others specialize in pretesting communication messages before they are finally produced and distributed.

## How Advertising Agencies Make Money

Many people believe that ad agencies make big profits. The reality is that agencies usually operate on slim profit margins. The reason for people’s misconceptions about agency profits is that agency billings include many costs that pass through their hands. When an agency claims total billings of \$1 million, that figure includes their “pass-through” costs for media placements and outside vendors.

The advertising agency business is a service business. Agencies do not manufacture goods or products. Rather they offer the talent and expertise of the people on their staff to create advertising messages and materials. Agencies charge for the services of these staff members in three basic ways: media commissions, mark-up, and fees.

## Media Commissions

The cost of buying time or space in advertising media accounts for the bulk of an agency’s pass-through costs. When an agency buys media time or space for its clients, it must pay the media outlet for the time or space and then bill the clients.

Ad agencies are often paid for their services through media commissions. Every country has a standard media commission fee, usually 15 percent, which the agency receives from the media, for time and space purchased on behalf of a client. For example, if a magazine charges \$100 for an ad, the agency pays the magazine \$85, charges the client the \$100 cost, and makes a \$15 commission on the ad placement.

# How an Agency Works

(continued)

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Usually, the commission is already built into the media costs. The agency pays the media outlet the cost of the ad less the 15 percent commission (net) and the client is billed the full amount (gross).

## **Mark-ups**

Production costs are another pass-through expense for ad agencies. Production costs may include the cost of printing, photography, illustration, TV production companies, or recording studios. Unlike the media costs, however, commissions are not already built into production costs. It is up to the agency to mark up these outside costs.

Most mark-ups on production costs range from 17.65 to 20 percent. The 17.65 percent mark-up is the equivalent of a 15 percent commission on the gross amount.

## **Agency Fees**

As with any service organization, an agency's profitability is determined by the amount of staff time compensated on each account. Media commissions and mark-ups may not cover the costs of all the services provided by the agency. Therefore, in addition to or instead of charging media commissions and mark-ups, an agency may charge hourly fees for the time spent by various staff members—especially account managers and creative staff. These fees usually include the cost of a staff member's base salary, benefits, and operating expenses (e.g., taxes, rent, equipment, etc.). and the hourly rates are agreed upon when the agency contract is negotiated.

Agency fees may be charged by project, based in the task at hand. If an agency charges hourly fees by task, a written estimate of each staff member's time is provided to the client for approval before work begins. Agency fees can also be charged through a monthly retainer. The retainer includes an estimates number of hours that each account team member will spend on the account.

Sometimes, especially when the amount of media or production activity is limited, agency fees are negotiated to cover all of the costs of doing business. In that case, an agency agrees not to mark up outside costs or collect media commissions. Instead, the agency fees cover these costs. Sometimes a combination of fees, commissions, and mark-ups makes the most sense.

After you consider factors such as the amount of your media placement budget, how much production activity is anticipated, and the breadth and scope of agency services required, you can sit down with the agency to work out which system of compensation is best and fairest to all parties.

# Tips on Working With an Agency

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## KEYS TO A SUCCESSFUL RELATIONSHIP

- **Be a partner.** Ask the group to think about what “partner” means to them. Ask for a volunteer to explain how they would see “partnership” between the MOH or a development organization or project and an ad agency. Add in (if not mentioned) that being a partner means ensuring a maximum level of collaboration and information sharing between the client (you) and the agency. It also requires respect, courtesy and candor—about timelines, deliverables, quality, process or anything else that comes up.
- **Be a member of the account team.** The agency is the expert in developing the creative, but you are the specialist in health and behaviour change, and you may well know the audience (if poor or low-literate) better than the agency. Participate in brainstorming sessions, observe focus groups or photography sessions. Be present and engaged.
- **Identify a single client contact point.** There might be lots of people involved from your end and the agency’s end, but there should be one person for each side that serves as the main point of communication between the two.
- **Do not micro-manage.** The agency was selected because of their staff’s ability to deliver what you are asking them to do. They should share their thinking and deliverables at various stages, but they should also have the freedom to do what they do best.
- **Ensure that the creative brief(s) is well-written and widely disseminated.** This brief is the foundation of the agency’s work. If you don’t share it during the proposal stage, make SURE you share it soon afterwards. The agency should follow the various criteria set out in the brief. If there are questions or disagreements, they should voice them so they can be resolved early on.
- **Be available.** You should build in review and revisions to the work plan both before and during pre-testing. The agency is being held to their timeline, which means you also have to stick to yours. If you have agreed on a 48-hour review period, then you must review it and return it in the agreed-upon time. Be realistic about who needs to review what at what stage and how much time the process will take, so the agency’s timeline can also be realistic.
- **Ensure they are fairly compensated.** The contract between your organization and the agency will dictate the terms of payment for the agency, but if things are held up or invoices are not paid, you might end up having to advocate on behalf of the agency. Determine billing procedures ahead of time (in the contract) and be sure they are followed! Additionally, consider other kinds of payment or reward, such as publically acknowledging their role (at a launch event for example).
- **Specify ownership rights in the contract.** Who owns the ideas the agency is working on for you? Even if they are not produced, can the agency re-use those ideas for a different client? Do you own the materials and the ideas behind them that are produced? What does your donor require? This needs to be explicit to avoid problems down the line.
- **Decide how you will monitor the activities and budget.** Do you want monthly reports? Weekly? How will you handle any changes that come up? How will you handle communications?

# Tips on Working With an Agency

## (continued)

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### **Some Things the Program Manager Should Know about Media Spending**

1. The decision on how much to spend on media is a strategic one; it relates directly to the media task.
2. The larger the task, the more it will cost to accomplish.
3. Mass media can only accomplish so much in terms of reaching the behaviour change goals—the other communications activities, including interpersonal communications play a major role in the process of behaviour change.
4. It will generally cost more to promote a new concept or behaviour or to change people's perceptions of a current behaviour than to sustain an established one.
5. Spending too little on media is as wasteful as spending too much.
6. It takes time for media to produce results; a minimum of six months is required for a reasonable media effort to succeed.

Media spending must work in concert with other elements of the program plan: for example, it is wasteful to spend on media before the services that are being promoted are fully up and running, or a product is fully available.

# Tips for Finding and Working With a Corporate Sponsor

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1. Make a list of potential sponsors and research information about them.
2. Be specific about what you are asking from a sponsor and how much money it will cost them BEFORE making the contact.
3. Develop a script of what to say when first making contact with the potential sponsor.

Some questions you need to answer before hand that might help convince the sponsor to work with you are:\*

- Why are they the logical sponsor?
- Who referred you to them?
- Who is your organization and what is its purpose?
- What is the date, time and location of the program?
- How many people will be exposed to the sponsor?
- How much money are you requesting?
- What will the money be used for?
- How much value will they be receiving for their investment?
- What is expected of the sponsor?
- What do they need to do?
- What exposure, recognition and marketing opportunity will be provided to the sponsor that benefits the sponsor?

## Examples of Exposure and Recognition for the Sponsorship

- Listing of company name and logo on materials
- Display signs and banners at events
- Recognition on the organization or project web site
- Certificate of participation
- Mention of sponsorship in press releases

4. Contact the potential sponsor and follow up.

Phone and/or set up a meeting to discuss the possibility of a sponsorship. Find out if anyone in your organization has a personal contact at the potential sponsor and get that person involved in making the contact or even attending the meeting.

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\*Questions taken and adapted from [speakerservices.com](http://speakerservices.com)

# Tips for Finding and Working with a Celebrity Spokesperson\*

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In many cases, celebrities will donate their time for Public Service Announcements or relief telethons, but this is often a favor to another celebrity or in a time of crisis the celebrity feels driven to help. Many celebrities are also eager to participate in giving back to society, but many also expect to be financially compensated for their time and association of their own brand with your campaign or program. There are a few tips you should keep in mind when approaching a celebrity:

- **Be sure you pick the right celebrity:** Just because someone is well-known and/or liked for their professional work does not mean they will be an ideal spokesperson for your cause. Someone non-controversial is best, to avoid the controversy of their professional or personal life spilling into your program. Likewise, you need to find someone who appeals to your target audience, but who is also a role-model for them.
- **Understand the celebrity or spokesperson's point of view:** Don't just assume that because a celebrity cares about your cause or issue that they will be willing to work with you for a discounted rate or for free. Targeting talent that has a genuine interest in your cause is critical, but you should be prepared to work out a contract that is beneficial to both sides. Understanding endorsements from the talent perspective and client perspective will help to build smart strategies for securing talent.
- **Don't assume a celebrity will be inexpensive if their calendar isn't booked:** "It's important to understand that celebrity schedules do not always revolve around their work and endorsements — they have personal lives too. This key piece of information will allow you to focus your energies on securing the right talent. Less famous celebrities or very famous celebrities who have been less publically active in recent times might or might not be willing to be a part of your campaign.
- **Research, research, research!** While some initial online research about a celebrity is important, there is a lot of outdated or inaccurate information online. Enlisting professional help in this area will help you to get a 360-degree view of what the celebrity is working on as well as upcoming projects. For example, if you're targeting a celebrity that just wrapped a media tour to promote a book, now probably isn't the best time to hire them for a campaign, since they've recently done the TV circuit.
- **Be honest about what is expected:** Many celebrities are surprised at how much time they need to allot to work effectively with a program. There is usually a lot of time involved between preparation, media interviews and events. Also, in many cases the celebrities will need to travel and those costs will need to be factored into what you pay them or your program costs. Be sure to consider extras such as flights, meals, hotel, on-the-ground transportation and special requests.
- **Don't be pushy.** As an NGO, we may expect a national spokesperson to fall all over us and our cause, but being pushy can backfire on you. Like any other relationship, you are required to give and take. Start off on the right foot with your spokesperson's publicist. Look for ways to work together.
- **Negotiate time and be respectful of a spokesperson's schedule.** A spokesperson's schedule is tight. One cannot assume just because they are your organization's spokesperson that they will just drop everything for you because they believe so much in your cause. Prioritize your lists of requests beginning with the most important items and go from there. Like any PR campaign, you want to get the biggest bang out of your bucks.

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\*<http://comprehension.prsa.org/?p=2069>

# Pretesting\*

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## 1. Determine the sample for those audience segments with whom the material is to be pretested.

**Same group characteristics.** The overall sample must have the same characteristics as the target audience to whom the materials being pretested are directed; for example, communities that are typical of the ethnic group or of the region or characteristic of the neighborhood (if the material is to be directed toward audiences living in suburban areas of cities). It is always advisable to select several sites having the same characteristics and not concentrate on a single site.

**Same individual characteristics.** Criteria should be established in accordance with the characteristics of the individuals to whom the material is to be directed. For example, in the case of a material on family planning aimed at rural women of reproductive age who already have several children, possible criteria might include being between 25 and 45 years old, married or in union, with at least two children, and having the intention of not getting pregnant again.

**Gatekeepers.** These intermediaries, such as program directors, secretaries, community outreach workers and health workers, who control the distribution channels for reaching your intended audience. If the gatekeepers do not like the material or do not believe it is credible or scientifically accurate, it may never reach the intended audience. These reviews with gatekeepers are not a substitute for pretesting the materials with the intended audience or for obtaining technical clearances from experts in the field covered by the material.

**Convenience sample.** One easy way to select people to be interviewed for pretesting is by sample of convenience. After the characteristics of the respondents have been defined, the interviewer goes to those sites where a large number of such individuals will presumably be found and selects individuals using screening questions.

Community stores, water sources, public washing places, health centers, hospitals, clinics, and markets are places where it is easy to find women and mothers. Bars, municipal offices, warehouses, factories at closing time, and fields are places where it is easy to find men to be interviewed.

**Size of sample.** Regarding the size of the sample, there actually is no preset formula. Things that can influence the sample size or number of rounds of pretesting that need to be done can include:

- The complexity of the material being developed (one poster versus a video). The more complex the material, typically the more people whose feedback you will need to gather, which usually implies more rounds of pretesting
- The complexity of the problem the material is addressing. Again, the more complex, the more people you might need to involve in the pretesting.
- 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.

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\*From A Toolbox for Building Health Communication Capacity. USAID, BASICS .1996

# Pretesting\*

## (continued)

### 2. Select the techniques to be used in the pretest

The pretest may be conducted individually or in groups, depending on the nature of the material, which suggests the type of technique to be used. The method should be chosen in a manner similar to that in which the methods for your formative research are chosen, but basic guidelines for focus groups include:

#### CONDUCT FOCUS GROUPS WHEN:

**Material being tested is for radio or television.** Focus group discussions can be a very efficient way to test rough drafts of radio and television programs/spots. In-depth interviews are often better for print materials, especially for materials aimed at low-literate audiences.

**Material is for group exposure/use/consumption.** One strong argument for using a focus group for pretesting is if the material you are producing is intended to be used in group circumstances or people are likely to be exposed to it in a group setting. In either case, if the overall characteristic of the material is its group use or consumption, then pretest it in focus groups. However, it is also useful to test materials that will be used by an individual. For in

**Difficulties doing individual interviews.** Circumstances or situations can arise where using an individual interview format is not possible. For instance, if you are pretesting television spots, it is not easy to carry a portable television set from house to house to interview people individually. The alternative is to invite your participant's to the nearby location where you have the video equipment and monitor and pretest in a focus group.

**The topic/theme/content is sensitive.** Many times you are dealing with a topic/theme/content that is culturally sensitive such as birth control or sex education. You have to be sure that the treatment is correct. The theme needs to be treated inside the social norms and its parameters used by the target audience. The vocabulary or images must not be offensive. Focus group discussions can often reveal truer feelings than individual interviews.

**The concept development is not clear.** Focus group interviews are especially useful in the concept development stage of the communication process. They provide insights into target audience beliefs and perceptions of message concepts, and they help trigger the creative thinking of communication professionals.

For example: You want to find out if mothers have any compelling feelings regarding the concept of vaccination to prevent deadly diseases. Will this rational concept move them to action or is it better to use the concept of "a responsible mother takes children to vaccination three times because that is what doctors recommend." Which concept will move mothers more? This situation is when focus groups give you the best indication of what message will be best suited to achieve the desired response from a particular audience.

### 3. Design the pretest guidelines and instruments for each technique

In accordance with the material and the specific techniques selected, design pretest focus group guidelines or individual interview instruments and the codes to be used for eventual encoding of the data chosen.

# Pretesting\*

(continued)

- 4. Select interviewers:** The technique for pretesting is more complicated than the technique involving research. There are two kinds of pretest implementers: those doing individual interviews and those conducting discussion or focus groups. A person conducting the pretest must be experienced. University students from communication or psychology faculties can be trained as interviewers. A skilled moderator is needed to lead focus group discussions.

**Note: It is advisable for those people who have produced the materials to have a role in their pretests. Their exposure to audience reaction to their material can be very persuasive in demonstrating the value of pretesting.**

- 5. Train interviewers:** Pretesting training should include the reasons the pretest is important. Make it clear to the interviewers that you have not done the drafts and will not be hurt by pretest results. Training should also include the creative brief for the material and the points in doubt as perceived by producers or the technical team.

The instrument to be used in the pretest should be explained to the interviewers. Instructions should be provided regarding the criteria for selecting those to be interviewed and the use of a screening questionnaire. Mechanics and procedures to be followed in conducting the pretest interview when done individually and when done in focus groups should be explained. Interviewers should practice first among themselves in training.

- 6. Test the pretest guidelines and instruments:** Just as research questionnaires have to be tested, it is also advisable that the pretest instruments be tested to assess whether the mechanics designed for conducting the interviews will achieve the pretest objectives and whether they are easy to implement. To test a pretest questionnaire, it will suffice for each interviewer to conduct three or four interviews and subsequently analyze the results with the person in charge. In the case of pretests with focus groups, it will be sufficient to form a single trial focus group to test both the guidelines and the proper implementation of that focus group.
- 7. Make the necessary logistical arrangements:** Assign a person to be in charge of logistics, such as transportation, meeting places, permits, and authorizations so that everything will be clearly understood before the initiation of field work.
- 8. Carry out pretest using selected methodology.** If you have hired an agency/consultant, they will do the pretesting. However, it is strongly advised that you observe some of the initial pretests to ensure that the technique is good and the quality of the data meets your standards.
- 9. Summarize the results.** If you have hired an agency/consultant, they will prepare the report summarizing the pretesting finding. There is no such thing as a perfect material. If the pre-testing results (especially in the first few rounds of pretesting) show that no changes were recommended, it is very likely that something went wrong with the pretesting!
- 10. Discuss the results and decide what changes to recommend based on them.** It is very important to have the creative team, the agency staff that conducted the pretesting and yourself work together

# Pretesting\*

## (continued)

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to decide how to modify the materials to reflect the pretesting findings. Note that data from pre-testing should be analyzed with an eye towards changes in:

- **FORM** (music, color, 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...).

# Sample Pretesting Guides

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## Sample Questions for Pretesting Print Materials

Ask these questions about each material, separating out images first and then text and then together:  
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?

# Sample Pretesting Guides

## (continued)

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### Sample Questions for Pretesting Radio and Video

(note, with television, you might consider playing the spot first without sound. If testing story boards, explain to the participant what they are seeing)

1. In your own words, what do you think is the message of this program?
2. Are there any words in the program whose meanings you did not understand? If yes, identify the word(s) and ask, What do you think (mention the word) might mean? Which word do you think should be used instead?
3. Can you hear and understand what they are saying? If no, what can't you hear or understand?
4. Are there any scenes in the program that you did not understand? If yes, explain.
5. Are the music, sound effects, visuals, and dialogue appropriate for this program?
6. Is there anything in the program that you think is not true? If yes, what? What about it seems untrue?
7. Does the program say anything that might offend anyone in your community? What?
8. What did you like most about the program?
9. Is there anything about the program that you do not like? If yes, what? How would you say it so that you would like it?
10. What do you think this program is asking you to do?
11. Are you willing to follow the advice given to you? What would cause you to be willing to follow the advice? What would discourage you?
12. To whom do you think this program is directed? What about it makes you think that?
13. Who are the people in the program? What were they doing?
14. Where do you think they were?
15. What do you think you will remember most about this program?
16. Do the people in the program talk the way people from here talk? Do they look like people from here? If not, what would you change?
17. In your opinion, what could be done to improve this program?

**Two versions being pretested:** If you have multiple versions of your spot or program, ask the above questions for each version, then ask:

### Comparison Questions:

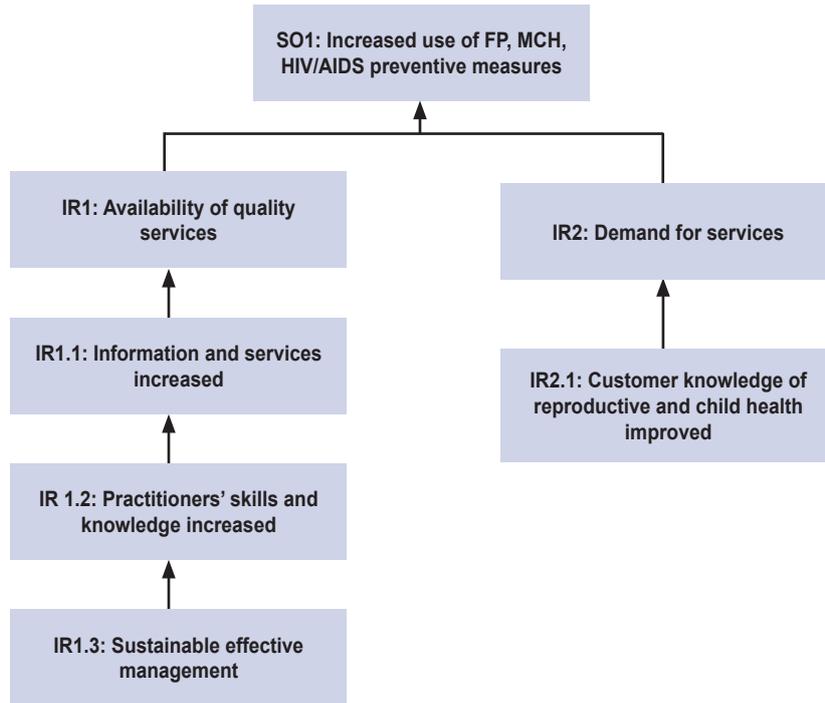
Which of the two programs do you like best? Why?

If you had to prepare a program containing the best parts of each version, what parts would you choose from each?

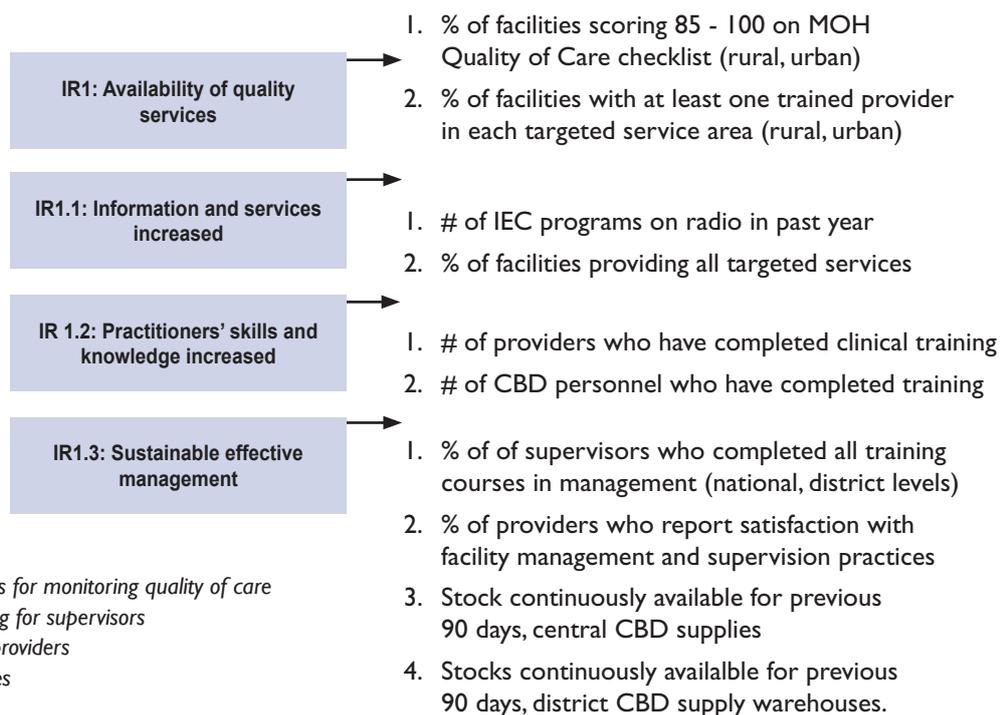


# Monitoring Plan Example I

## Strategic or Results Framework for Project A:



## Strategic or Results Framework with Indicators for Project A:



Interventions:

- Development of tools for monitoring quality of care
- Management training for supervisors
- Clinical training for providers
- CBD support/supplies
- IEC programs

## Monitoring Plan Example 2

**Logical Framework:**  
**Social Marketing for HIV/AIDS Prevention in the Dominican Republic, PSI 2005**

Results Hierarchy	Performance Indicators	M&E	Assumptions/ Risk
<p><b>Goal</b> Contribute to the reduction of STI and HIV incidence in the Dominican Republic</p>	Reduction of HIV prevalence rates among key target groups.	Ministry of Health sentinel survey	Intervention may contribute to reduction, in addition to activities of many other partner groups
<p><b>Purpose</b> Increased safer sexual practices among high risk groups</p>	<p>Commercial Sex Workers</p> <ol style="list-style-type: none"> <li>Maintain reported consistent use of condoms by CSW with paying clients at 88% or above</li> <li>Increase consistent use of condoms by CSW with non-paying partners "all the time" in last 12 months from 26.1% to 35%</li> <li>Decrease use of oil-based lubricants in last week from X% to X%.</li> </ol> <p>Batey Residents</p> <ol style="list-style-type: none"> <li>Decrease number of partners in last 12 months from X% to X%</li> <li>Increase use of condoms in last sex act from X% to X%</li> </ol> <p>Youth</p> <ol style="list-style-type: none"> <li>Decrease proportion of youth between 13-16 years of age reporting that they are sexually active by 5%</li> <li>Increase reported use of condoms in last sex act with regular partner from 32% to 37%</li> </ol>	<p>1-2. FHI BSS (2004 &amp; 2007 data)</p> <p>3. CSW TRaC Surveys (2006 &amp; 2008)</p> <p>4-5. Batey TRaC Surveys (2005 &amp; 2008)</p> <p>6-7. PSI Youth KAP 2004 &amp; 2007</p>	Other HIV/AIDS prevention activities implemented by NGO partners continue at current or increased capacity.

## Monitoring Plan Example 2

(continued)

Results Hierarchy	Performance Indicators	M&E	Assumptions/ Risk
<b>Outcomes</b> 1. Improved access to condoms and lubricants among high-risk groups	1.1 Maintain the proportion of commercial sex establishments distributing condoms at 90% or above	1.1 – 1.3 PSI CSW MAP Surveys (2006 & 2008)	Distribution of public sector condoms will be targeted to appropriate income groups with necessary controls on distribution, and will not compete or interfere with Pante distribution network and sales points  Current 6 Pante NGO partners will continue to participate actively in the project  COPRE-SIDA or DIGECITSS will donate or procure 3.5 million no-logo condoms for PSI for distribution to the bateyes.
	1.2 Increase the proportion of pay-by-the-hour motels distributing condoms to 80% or above	1.4 PSI MIS reports	
	1.3 Increase the proportion of grocery stores in areas with high rates of commercial sex work distributing condoms to 70% or above	1.5 PSI Batey MAP Surveys (2005 & 2008)	
	1.4 Increase the number of Pante direct sales points in commercial sex establishments and motels from 620 to 950	1.6-1.7 PSI Batey TRaC Surveys (2005 & 2008)	
	No-Logo Condoms for Bateyes	1.8-2.0 PSI CSW TRaC Surveys (2006 & 2008)	
	1.5 Increase proportion of batey communities with at least one condom sales outlet (CBD or grocery stores) from X to X%	2.1-2.2 Training attendance lists and certificates strategic plans	
	1.6 Increase proportion of batey residents stating that they have access to condoms within 15 minutes of their residence from X to X%		
	1.7 Increase batey residents who state that they feel condoms are affordable from X to X%		
	Lubricants for Commercial Sex Workers		
	1.8 Increase CSWs who have heard of water-based lubricants from less than 20% to more than 60%		
	1.9 Increase proportion of CSWs who know where to purchase water-based lubricants from less than 20% to more than 50%*		
	2.0 Increase proportion of CSWs who have used water-based lubricants from less than 20% to more than 50%		
	2.1 Increase number of trained and certified NGO sales agents (CSW and Bateyes) from 87 to 150.		
2.2 Increase number of sales persons from NGO partners having received training in lubricant sales including program income and sales projections, from 0 to 5			

## Monitoring Plan Example 2

(continued)

Results Hierarchy	Performance Indicators	M&E	Assumptions/ Risk
<p><b>Outcomes</b></p> <p>3. Increase the total condom market in the Dominican Republic</p> <p>4. Strengthened Behaviour Change Communication capacity</p> <p>5. Increase preventive knowledge and attitudes, particularly in factors related to motivation and ability to implement desired behaviours</p>	<p>2.4 Annual marketing plans developed by project supervisors at 5 of the NGO partners</p> <p>2.5 Ensure that 4 of the NGO partners achieve sufficient sales levels by March 2007 to pay salary of project supervisor with program income and fully cover all associated project costs.</p> <p>2.6 All NGO partners comply with established standards for warehouse conditions and procedures, maintenance of sales receipts and financial records</p> <p>2.8 Train NGO partners in MAP and TRaC research and data collection techniques. Integrate NGO partners into MAP/TRaC data collection for practical training</p> <p>2.9 Train 18 CHAYN/Tertulia youth in social marketing and sales techniques</p> <p>3.1 Total condom market increases to 23.5 million units in 2007 calendar year</p> <p>3.2 PROFAMILIA and commercial brands together account for more than 22% of market share.</p> <p>3.3 Create national condom strategy and policy in collaboration with COPRESIDA and newly formed national condom committee</p> <p>4.1 Batey NGO health personnel trained in BCC messages and strategies</p> <p>4.2 BCC guides produced and distributed to Batey NGOs</p> <p>4.3 Idea Youth Café (IYC) youth trained in BCC as peer educators</p> <p>5.1 Increase proportion of batey residents who perceive HIV/AIDS as a real threat to their lives from X% to X%</p> <p>5.2 Increase proportion of batey residents who believe condoms effectively prevent HIV/AIDS from X to X%</p>	<p>2.4 NGO Marketing plans</p> <p>2.5 Final project report</p> <p>2.6 PSI NGO "audit" reports</p> <p>2.7 – 2.9 Training attendance lists and certificates</p> <p>3.1-3.2 Sales volume as reported by all condom distributors, and validated by store audit results</p> <p>4.1, 4.3 Training attendance lists and certificates</p> <p>4.2 BCC guides produced and distributed (PSI Marketing Reports)</p>	<p>MODEMU and CEPRO-SH will integrate messages regarding advantages of water-based lubricants into their educational activities. CSW peer educators and Pante sales force will distribute lubricants directly to CSW, to sex establishments, and to motels.</p> <p>The current 6 NGO (CSW) partners will continue to participate actively in the Pante condom social marketing project.</p> <p>The 4 new NGO (Batey) partners will participate actively in condom social marketing activities and designate appropriate staff for these ends.</p>

## Monitoring Plan Example 2

(continued)

Results Hierarchy	Performance Indicators	M&E	Assumptions/ Risk
	<p>5.3 Increase proportion of batey residents who believe that the more partners they have, the greater their risk of HIV/AIDS from X to X%</p> <p>5.4 Increase the proportion of youth who believe that condoms are not just for casual partners from 21.1% to 30%</p> <p>5.5 Decrease the proportion of youth who believe that being a virgin means being “uncool” from 43% to 38%</p>	<p>5.1-5.3 PSI TRaC Surveys (2005 &amp; 2008)</p> <p>5.4-5.5 PSI Youth KAP Survey (2004 &amp; 2007)</p>	<p>PROFAMIL-IA is willing to collaborate with PSI and invest in building brand awareness.</p> <p>COPRESIDA provides appropriate follow-up to national condom strategy committee.</p>

# Monitoring Plan Example 2

(continued)

Activities	Inputs /Assumptions
<p><b>Improved access to condoms &amp; lubricants among high-risk groups</b></p> <ul style="list-style-type: none"> <li>• Procure 24 million Pante condoms</li> <li>• Procure 150,000 sachets and 30,000 tubes of lubricants</li> <li>• Produce packaging for all condoms and lubricants</li> <li>• Hire MODEMU CSWs to pack condoms &amp; lubricants</li> <li>• Produce point of sale and promotional materials through sales agents and promotional activities</li> <li>• Conduct 200 educational &amp; promotional activities to promote condom &amp; lubricant use among CSW</li> <li>• Sell average of 1 million condoms per month</li> <li>• Sell total of 300,000 sachets and 75,000 tubes by end of project</li> </ul> <p><b>Capacity Building in Social Marketing</b></p> <ul style="list-style-type: none"> <li>• Hold quarterly Pante sales committee meetings and Batey committee meetings</li> <li>• Provide 6 refresher training courses to NGO sales force</li> <li>• Conduct 12 training sessions with NGO sales force in use of and sale of lubricants</li> <li>• Conduct or sponsor annual training courses for NGO social marketing project supervisors</li> <li>• Cover salaries of NGO project supervisors through September, 2007</li> <li>• Support development of marketing plans and strategic social marketing plans</li> </ul> <p><b>Increase Total Condom Market</b></p> <ul style="list-style-type: none"> <li>• Lobby COPRESIDA to effectively coordinate national condom strategy and policy committees</li> <li>• Lobby COPRESIDA to support, in writing, exemption of import duties for all condoms imported to the DR</li> <li>• Integrate additional condom brand into MUDE and ADOPLAFAM distribution networks to Grocery stores</li> </ul>	<p>\$572,000 USD from USAID for operations and activities</p> <p>Donation of 9 million Pante condoms from USAID</p> <p>Donation of 3.5 million no-logo condoms from COPRESIDA</p> <p>KfW contributions for operations and activities, purchase of Pante condoms and lubricants</p> <p><b>Assumptions</b></p> <p>COPRESIDA is willing to take action and put guidelines and commitments in writing</p> <p>Grocery stores will be interested in another higher-end brand of condoms</p> <p>PROFAMILIA agrees to invest funds (subcontract) wisely in their condom brands and dedicates more time to brand promotion</p> <p>Tertulia and CHAYN will continue to function in DR even once GTZ withdraws most support from the country</p> <p><b>Inputs</b></p> <p>\$95,000 from UNICEF for delayed debut campaign development</p> <p>\$500,000 in donations of free airtime from local radio and television stations</p>

# Monitoring Plan Example 2

(continued)

Activities	Inputs /Assumptions
<ul style="list-style-type: none"> <li>• Support PROFAMILIA (subcontract) in producing additional materials to boost their brand awareness and increase demand</li> </ul> <p><b>Strengthen Behaviour Change Communication Capacity</b></p> <ul style="list-style-type: none"> <li>• Conduct training sessions in social marketing for NGO personnel</li> <li>• Support NGOs in developing annual sales projections</li> <li>• Train 40 batey NGO in BCC techniques with support from PSI/Haiti BCC team</li> <li>• Train NGOs in MAP and TRaC research methodologies</li> <li>• Train NGOs in use of on-line MIS database</li> <li>• Assess existing BCC materials in bateyes and NGO needs</li> <li>• Produce BCC printed materials (flipcharts, discussion guides, booklets, brochures) and reproduce PSI/Haiti audiovisual and radio programs where relevant</li> <li>• Assess existing BCC materials for CSW and NGO needs</li> <li>• Train national AIDS hotline counselors to address issues related to delayed sexual onset and parent communication</li> <li>• Create youth website to support campaign materials and provide links and references to other sites</li> <li>• Train Tertulia and CHAYN members in BCC</li> </ul> <p><b>Increase Preventive Knowledge and Attitudes</b></p> <ul style="list-style-type: none"> <li>• Conduct 200 IPC BCC activities in 50 bateyes</li> <li>• Produce and disseminate radio program in Creole</li> <li>• Adapt and disseminate condom use BCC spots</li> <li>• Produce and disseminate delayed debut campaign</li> <li>• Produce and disseminate campaign for youth 15-24 regarding trust, cross-generational or transactional sex</li> </ul>	

# Research Methods Overview

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## Definition of Research

Research is the systematic process of collecting, analyzing, and interpreting information (data) in order to increase our understanding of the phenomenon about which we are interested or concerned. Research methods are either “quantitative” or “qualitative.”

## Quantitative Research

Quantitative methods help us understand “what” is happening: how many people believe or behave a certain way, which characteristics are related to each other, etc. Quantitative research is generally conducted through surveys, record-keeping, counts, experiments, secondary data analysis and uses closed-ended questions and larger sample sizes.

## Qualitative Research

Qualitative methods help to understand the “why” of an issue, getting to information that is “beneath the surface” of an answer. They produce in-depth, descriptive information and are generally conducted through: observations, focus-groups and in-depth interviews. Qualitative research methodologies primarily use open-ended questions and have small sample sizes.

## Deciding on a method

An important step in determining which method(s) to use is to link the research methods with the program indicators. Based on what you want to measure, what you want to see change, different methods will be more appropriate than others. If, for example, specific indicators measure numbers or percent (e.g. # of training sessions or % of people reached by radio spots), then qualitative methods cannot be used. Other indicators that are defined more qualitatively (e.g. radio spots are clearly understood by target audience) can be measured either quantitatively (through a survey asking the target audience about the meaning of radio spots) or qualitatively (through focus groups or in-depth interviews).

## Types of Methods: Monitoring

Methods that may be used to monitor programme implementation include the following:

- Periodic review of programme documents (such as work plans, monthly/quarterly reports, etc.).
- Regular audits of materials at representative distribution points to find out quantities of materials issued, who gets the materials, the purpose to which the materials are put and the comments users make on the materials, if any.
- Spot checks at public places and places where members of the target audiences are found to see if audiences remember hearing or seeing messages in the media, on notice boards, etc.
- Central-location intercept interviews to ask about target audiences' perceptions (of campaign slogans or tag lines.)
- Regular field trips to demonstration sites to check on availability of products or supplies.
- Observations at service points, points of sale and in counseling or training sessions.

# Research Methods Overview

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Key methods to monitor specific aspects of communication include the following:

### Monitoring implementation schedules

This activity is undertaken to answer the following questions:

- Are planned programme activities being implemented according to set schedules?
- If no, why not?
- Are materials distributed and used as planned?

Methods that can be used to monitor this programme area include:

- Regular progress reports from the field.
- Regular audits of materials at representative points.
- Observation (especially supervision visits) to find out how materials are used

### Monitoring electronic media broadcasts and materials in print media

This answers the following questions:

- Are planned media broadcasts and print material schedules being met?
- What other related materials have been broadcast or published as a result of the program publicity?

Monitoring mass media broadcasts and print material schedules is a challenging activity. Staff are not always at home to listen to radio and TV, nor do they always buy all the many newspapers and magazines in which material could appear.

Options for collecting the necessary information include the following:

- Relying on the joint effort of staff who may hear the materials (this is unscientific and unreliable, but a commonly used method in many programmes).
- Assigning a person (or persons) to listen to all important radio/TV stations and make press cuttings (a little more reliable, but unlikely to catch all materials).
- Recruiting volunteers to monitor key media channels.
- Hiring a media monitoring company to monitor, collect and analyze materials. Using the services of a media monitoring company is by far the most reliable monitoring method. In addition, subscribing to a media monitoring service has other advantages. Some groups, for example, provide regular information on audience stratification and characteristics. Subscribing to the services of a media monitoring company may be expensive, but it is worthwhile if the budget allows.

### Monitoring the quality of interpersonal communication

Monitoring interpersonal communication activities seeks to answer the following questions:

- Are interpersonal communication activities being carried out at the different points (such as service delivery points) as planned?
- How is the quality of interpersonal communication between clients and workers (such as information disseminators, service providers)? Are clients satisfied and interacting well?
- Are clients receiving the key information that they should receive during interpersonal interactions?
- How is the quality of interpersonal communication between communication trainers and trainees?

# Research Methods Overview

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### Methods that can be used to obtain the needed information include:

- Observation at points of interpersonal interaction (immunization points, during home visits, etc.).
- Exit interviews at service centres such as clinics or mobile health posts.
- Group discussion with appropriate audience categories.

### Monitoring traditional and local media

It is important to find out the following about traditional or local media:

- How many local groups are involved in disseminating information?
- Are there other groups that could be involved in disseminating information?
- What types of groups are they?
- What areas do they serve?
- How are they managed?
- How are they viewed and received in the community?
- What is the interim impact of the messages they disseminate?

### Methods to obtain the needed information include:

- Discussion with other programme facilitators at the national and regional level.
- Visits to observe performances/groups' meetings.
- Small group discussions with sections of the audience after performances/meetings.
- Intercept interviews with the people leaving performances/meetings.

### Monitoring interim effects of programme interventions

As communication activities continue, programme managers will be anxious to have answers to questions such as the following:

- What do people think about the messages they are getting from the programme?
- Do they understand the messages?
- Do they accept or reject the messages?
- Do they find it possible or impossible to implement the action being proposed in the messages? If impossible, what help/support can help them to act positively on the messages?
- Are any changes taking place in knowledge, attitudes or behaviour among the target audiences? If yes, what kind of changes are taking place? Are they negative or positive?
- Are our interventions making any gains?

### Methods that may be used to elicit the needed information include:

- Central-location intercept interviews seeking people's perception of programme slogans.
- FGDs to investigate the impact of messages and detect possible confusion or negative reactions.
- Observation at service delivery points and other suitable points.

# Research Methods Overview

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### Types of Methods: Evaluation

Outcome Evaluation	Impact Evaluation
<p>Studies short- or medium-term achievements and effects of a program. It answers questions such as:</p> <ul style="list-style-type: none"> <li>• Is there change (e.g. in KAPB)?</li> <li>• Was change caused by the intervention?</li> </ul> <p>Outcome evaluation is usually statistical and usually uses a pre and post research design (which compares the situation before and after the intervention or compares behaviour/results at a given clinic during the same time period before, during and after intervention).</p>	<p>In many ways, impact evaluation is similar to outcome evaluation and uses similar statistical research methods.</p> <p>Major differences are that impact evaluation:</p> <ul style="list-style-type: none"> <li>• Studies long-term, population effects of a programme, such as change in mortality and morbidity, change in health status, change in quality of life, change in hunger and unemployment, etc.</li> <li>• Uses comparative designs (which compare the situation before and use controls as well).</li> </ul>

As a brief introduction to evaluation design, the best approach to evaluate, or measure change, is to do a baseline and periodic follow-up data collection. It is common in program evaluation, to collect the same data at three points in time within the communities involved in the intervention: 1) baseline (before the beginning of the program), 2) halfway during the program (midline) and 3) at the end of the program (endline). This design allows program implementers to determine the changes that have taken place in their community during the time that they have been carrying out the program. However, this design cannot clearly show that the changes observed over time are a result of the program. Perhaps these changes would have occurred anyway over time.

One way to more clearly show that changes are a result of a program, is to have a comparison to an outside group (often called a control group) that have not been exposed to the program. Data is collected from both the intervention communities and outside groups at the different points in time, and later analyzed to examine differences between the two groups over time. With this design, we can see if the program contributed to changes within the intervention community but not in the comparison community. A slightly different design is to have a comparison group from within the same intervention community, specifically those that have not been exposed to the intervention.

#### Challenges for BCC evaluation designs:

- 1) Finding an adequate comparison group (that are similar to the intervention group except for exposure to the program);
- 2) 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.
- 3) 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;

# Research Methods Overview

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- 4) Can be difficult to measure exposure to a program 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/c characteristics of program.
- 5) 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).

There are alternative and innovative evaluation designs that are being used more and more to evaluate the impact of BCC programs, including the use of advanced statistical methods, such as propensity score analysis. Though the evaluation of BCC programs generally rely on measuring change through quantitative methods, in particular through surveys of the target audience, qualitative methods should be used to complement and strengthen the evaluation findings.