Social and Behavior Change for Family Planning

How to Develop Behavior Change Strategies for Integrating Family Planning into Maternal and Child Health Programs

An "Off-the-Shelf" Facilitator's Guide for Conducting a 2.5 Day Training for NGO and Civil Society Staff in Low-Resource Settings

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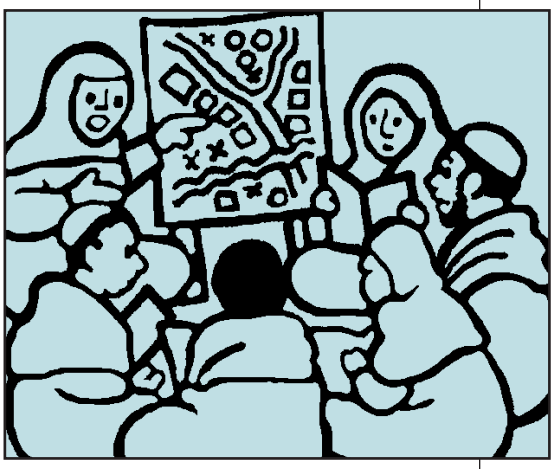

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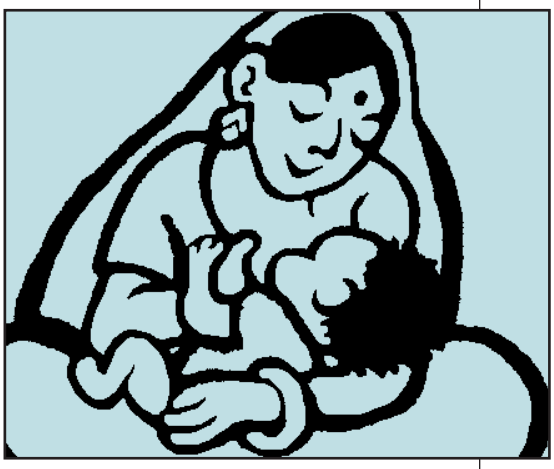

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Abstract

Many maternal and child health programs want to add family planning (counseling, referrals or even services) into their programs. One way to get started is through social and behavior change. That means learning about the community's family planning knowledge, attitudes and practices, and then creating strategies based on what is learned. Many health program and government staff would like to get the skills needed for this process—but time and resources are not available for a week(s) long training.

This curriculum can share these useful skills without requiring a lot of time or resources. It is designed to be used "off-the-shelf"—which means it is not necessary to bring in an outside trainer. A local staff person or team can use this guide to run a 2.5 day training course that teaches the basics of "designing for behavior change." This can serve as an energizing starting point for addressing family planning by building skills and helping staff get started in social and behavior change. The concepts and tools can actually be applied to other topics as well, including maternal and child health, nutrition, infectious disease care and control, sanitation, and more.

Recommended citation

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CORE Group emerged organically, in 1997, when a group of health program professionals from non-governmental development organizations realized the value of sharing knowledge, leveraging partnerships, and creating best practices for child survival and related issues. Fifteen years later, we have evolved into an independent non-profit organization with 75+ Member NGOs, Associate Organizations and Individual Associates. This group works collectively in 180 countries, reaching over 720 million people every year—one tenth of the world's population.

Much of our dynamism is generated through our lively *Community Health Network*. CORE Group builds on the energy and knowledge of the Network to take on additional efforts: we run a Practitioner Academy for Community Health, design and administer community health grant programs, advocate for community health approaches, and develop technical guidance and tools—like this report. Learn more, and access our free resources and webinars at www.coregroup.org.

Contents

Acknowledgements

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The task force was led by ICF Macro and included representatives of ADRA, CARE, Save the Children, Food for the Hungry, CORE Group, and two of CORE Group's Working Groups: Social and Behavior Change, led by Mitzi Hanold, Marilyn Patton and Beth Outterson, and Safe Motherhood/ Reproductive Health led by Judy Lewis, Abdelhadi Eltahir, Sadia Parveen and Lindsay Grenier.

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Gwen Glesmann

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Sources

In keeping with our belief that there is never any need to reinvent the wheel, we would like to acknowledge these excellent source materials, which were invaluable to the development of this guide. We recommend going straight to them to learn more.

Social and Behavior Change

Designing for Behavior Change. CORE Group, http://www.coregroup.org/storage/documents/Workingpapers/dbc_curriculum_final_2008.pdf

Designing for Behavior Change Workshop Report, January 22–26, 2007 Bamako, Mali, CORE Group

One-Day DBC Course (unpublished, graciously provided by Bonnie Kittle)

Gill K, Emah E, Fua I. A Guide to Participatory Monitoring of Behavior Change Communication for HIV/AIDS: Getting the Community and Program Staff Involved in Assessing and Improving Programs. Washington, DC: PATH; 2005.

Formative Research

Comparing Doers and Non-Doers: A Rapid Assessment Tool for Social Marketing Programs. Academy for Educational Development, Washington, DC, 1998.

Qualitative Research for Program Development, PATH/World Bank, 1990.

Family Planning

Anthony Kouyate, R and Nash-Mercado, A. 2010. *A Guide for Developing Family Planning Messages for Women in the First Year Postpartum*. ACCESS-FP: Baltimore, Maryland. http://www.shopsproject.org/resource-center/a-guide-for-developing-family-planning-messages-for-women-in-the-first-year-postpart or http://www.shopsproject.org/sites/default/files/resources/PPFP%20Message%20Guide.pdf

Anthony K. Mbonye, MD. Delivering Family Planning Messages through Prenatal Care Clinics in Kumi District, Uganda. The International Electronic Journal of Health Education, 2003; 6:34–40

Basics of Community-Based Family Planning Training Curriculum, Facilitators Guide. Child Survival Technical Support Plus (CSTS+) Project at Macro International, with funds from the Office of Population Reproductive Health Flexible Fund, April 2009.

Ringheim, K. Better Together: Linking Family Planning and Community Health for Health Equity and Impact. CORE Group, April 2012

Family Planning Integration: Overcoming Barriers to NGO Programming. CORE Group, September 2010

Unmet Need for Family Planning: Recent Trends and Their Implications for Programs by Lori Ashford, February 2003, Population Reference Bureau, http://www.prb.org/pdf/UnmetNeedFamPlan-Eng.pdf

Community Mobilization

Demystifying Community Mobilization: An Effective Strategy to Improve Maternal and Newborn Health, http://www.accesstohealth.org/toolres/pdfs/ACCESS_DemystCM.pdf

Facilitator's Guide: Pandemic Influenza Community Planning and Response Curriculum for District and Community Leaders. Health Technical Working Group of the Humanitarian Pandemic Preparedness Initiative (H2P) and was funded by the US Agency for International Development (USAID), July 2009.

International Federation of Red Cross/Red Crescent Societies, Community-Based First Aid materials.

Acronyms

CBFP	community-based family planning
DBC	Designing for Behavior Change
D/ND	doer/non-doer
FP	family planning
FP101	Basics of Community-based Family Planning (curriculum)
HO	handout
MCH	maternal and child health
NGO	nongovernmental organization
PDME	Project Design, Monitoring and Evaluation
SBC	social and behavior change
SMRH	safe motherhood/reproductive health
TA	training aid
USAID	United States Agency for International Development

Introduction

Family planning and maternal and child health programs are a natural pair. More and more, maternal and child health (MCH) programs are recognizing the synergies created by linking the two, and adding family planning (FP) components to their portfolios. Still, despite years of experience addressing MCH issues, programs are often not sure how to understand and change beliefs and behaviors around family planning. They want to help women, men, and couples successfully use modern family planning methods but don't know how to design and run community mobilization activities to do so.

What is this training module for?

This training module is designed to help NGOs and civil society organizations learn how to conduct audience research to develop social and behavior change (SBC) activities. This module focuses on SBC that can be used to add family planning to existing maternal and child health programming, with a focus on community level work. Staff of such organizations can learn first to conduct very targeted audience research, and then to use their findings to develop effective social and behavior change strategies. This module can be adapted for training public sector employees, community health volunteers, and others.

Conduct audience research about family planning: What do people think, feel, know, do about family planning? (You might be surprised by what you learn.)	→	**Translate findings into a social and behavior change strategy** to improve family planning knowledge, attitudes, practices and/or access.	→	**Implement the strategy**	→	**Assess and refine the strategy, as needed**

This module can be used to design a new project or program, or to incorporate or strengthen social and behavior change efforts for family planning within existing maternal and child health work.

Why is this called an "off-the-shelf" tool?

Many programs want to expand and improve their programs, but don't have the budget to bring in a trainer to teach them the skills needed to do so. In response, **this module is intended for use "off the shelf," which means that staff within an office can pick it up "off the shelf," read through it, and plan and implement the complete training, all without outside help.** The designated "trainers" need not be skilled in behavior change—just willing to work through this module, following the directions, step by step.

This model not only builds the trainers' and trainees' capacities for social and behavior change, but at the same time offers the "trainers" an opportunity to build leadership, training and facilitation skills.

How much time do we need to run this training?

About two days, plus time for fieldwork. Overall, this training curriculum includes up to 16 hours of training time, and time is also needed in the middle to go into the community to conduct research (that may take a few hours to a whole day, depending on logistics). Planners can work with their staff to set aside the time over a few days to work through the content. One key to success is keeping careful control over the time it takes to complete each activity, sticking to the recommended times as much as possible. Another key is working with staff to clear schedules in advance in order to allow full attention and participation.

Is this the same as the full training known as Designing for Behavior Change? (DBC)

Yes, but not exactly. This is an abbreviated version of the DBC manual adapted for field workers in family planning. For deeper understanding and skill building, users are encouraged to explore and connect to more extensive resources, including the six-day Designing for Behavior Change curriculum published by CORE Group's *Social and Behavior Change Working Group*, from which this adapted. Also recommended are *Barrier Analysis* resources.

If staff have already taken the DBC training, this will serve as a refresher for what they've learned. Staff who haven't yet had DBC training will be well prepared by this training to one day undergo the longer DBC training, if possible.

Background

CORE Group believes in the power of teamwork. That's why our mission statement is to "foster collaborative action and learning to improve and expand community-focused public health practices." Started in 1997 as a informal group of global health program staff who realized they all benefited from working together, CORE Group has since evolved into an independent not-for-profit organization, and home of the *Community Health Network*. This *Network* brings together CORE Group member organizations, scholars, advocates and donors to support the health of underserved mothers, children and communities around the world. CORE Group is also helping launch the *Food Security and Nutrition Network*.

In response to the needs of local settings, CORE Group Member NGOs and Associate Organizations are constantly innovating in the field. Their field experience gives them first-hand knowledge of what works, what doesn't and how best to move forward. They implement and adapt new methodologies and tools (like this one), and collect data and lessons learned. CORE Group works to meet implementer's needs for regular access to state-of-the-art information and ideas, and practical, field-appropriate tools.

In 2010, CORE Group's *Safe Motherhood and Reproductive Health Working Group* surveyed Members to find out more about integration of community-based family planning services into maternal and child health programs. Participants included recipients from grants from USAID's Flexible Fund and Child Survival Health Grants Program.

Based on the survey results and follow-up work within the *Community Health Network*, a key recommendation was to simplify the existing *Basics of Community-based Family Planning* (FP101) and *Project Design, Monitoring and Evaluation* (PDME) training curricula, making their content more easily available to NGO staff worldwide who face the everyday challenges of FP/MCH program implementation. Specifically, CORE Group was charged with **adapting existing content** to produce stand-alone modules that make the information, tools and skills more accessible and applicable to program staff for use, by topic, as needed. This is the first module created in response to that "unmet need."

Why focus on social and behavior change strategies?

We often make the mistake of believing that simply providing a useful product or service is all that is needed to get "customers." Unfortunately, that usually is not the case. Companies spend billions trying to understand what products people will want, designing products accordingly, advertising the product, getting people to try the product (by giving free samples, for instance), and telling people how much better the product makes them or makes their life now that they are using it. (Think: cell phones and energy drinks.)

When it comes to family planning, women and men might want to have fewer children, more years between births, or delay first birth, but that does not mean that they will automatically adopt family planning once highly effective methods become available. Using modern family planning requires new behaviors—taking pills, using condoms consistently, getting a surgical procedure, or even counting the days between menstrual cycles.

How do we help people who would like to have more control over their fertility to change their behavior from non-use of family planning to use of family planning? For this, we need a behavior change strategy—a set of actions, based on a good understanding of the target audiences—that will help them overcome obstacles to behavior change. **This module will help participants understand what goes into a behavior change strategy and how to develop, implement, and assess implementation of a behavior change strategy.**

The behavior change strategy that trainees will create must go well beyond simply providing information to target audiences. To be effective, it must help create an environment that enables the desired behavior change, and supports the people who want to adopt or facilitate the change. This could include making the service more accessible, having respected leaders voice support for and model the change, getting special interest groups involved, training service providers, and more—*depending on what the research tells you*. Taking a holistic, well-informed view can go far in helping in plotting out steps to creating a thoughtful, strategic and effective plan (even if everything cannot be implemented at once.)

How does behavior change fit into your maternal and child health work or overall program?

If you are considering using this module, you are probably involved in a program that provides maternal and child health services and is interested (and maybe even experienced) in offering family planning services as well. You may know many pregnant women and caregivers of young children. You may have found these clients or community members ready and willing to take your health advice and use the medications given or recommended to them. You may also have worked with such clients who do not follow the advice or use the medication (properly or at all). In both cases, you will have identified an issue, partnered with them to do something about it, told them how doing it will help, showed them how to do it or have done it for them, and encouraged them to do it. You and your program are already involved in behavior change! This module is designed to help you expand your capacities to use very targeted audience research to expand and improve your behavior change efforts into the realm of family planning.

Special considerations for family planning behavior change

In many settings, family planning is considered a personal, sensitive and even controversial topic. Some things to consider when learning about your community's family planning knowledge, attitudes and practices:

- How do the staff themselves, and one's own organization, feel about family planning?

- Many cultures maintain a tradition of having many children. What messages and activities can successfully convey the benefits of spacing pregnancies and the option of having fewer but healthier children?
- Family planning often involves joint decision-making by couples—how might program planners and service providers consider gender roles in the particular community where the behavior change intervention will take place? For example, will accessing FP information or services put women at risk for violence or separation from their husbands, parents or families?
- Discussing family planning means discussing sex and sexuality—subjects that may be taboo in some societies. How can the program overcome or work within such taboos (and avoid backlash) and teach men, women, and adolescents about reproduction and health?
- Rumors and misconceptions about modern FP methods are common. Modern methods can also have side effects and complications. Programs providing or promoting FP must understand and respond effectively to myths and rumors and reduce the risk of negative side effects and serious complications. What rumors exist in your setting?
- Family planning can even be a political issue. Programs introducing FP should seek the support of policymakers and political leaders. Who might be likely and influential supporters?
- As with any ongoing health intervention, a plan for reliable, uninterrupted supplies and services is crucial not only to maintaining behavior change but also to encouraging people to try and continue the new behavior. Can you count on that? If not, how might that gap be corrected?

These are just a few common considerations. We suggest you list at least three other issues or ideas specific to family planning in your communities.

Using this module

Who should use this module?

This module is aimed primarily at trainers and managers working for NGOs that deliver maternal and child health services in low- and middle-income countries. While it is intended for use with staff of such NGOs, it can also be modified for use with volunteers, public sector staff, and others as needed.

What are the overall workshop objectives?

At the end of this training, participants should:

- Be able to design and conduct *formative research*.
- Be able to develop an evidence-based, targeted *behavior change strategy* to help willing clients adopt family planning.
- Have skills and tools needed to *plan for implementation of and assess the success* of the behavior change strategy

How is the module organized?

This training module is organized around 10 steps to develop, implement, and assess a behavior change strategy. It can be used alone or as part of a larger workshop. It includes suggestions on how to divide the module into shorter training segments in case full days are not available. Each step contains an **overview page** with time allotted, objectives, activities, suggestions for adaptation, and materials and preparation needed. Each **activity** contains instructions, references to handouts and training aids, and notes to the trainer. **Notes to the trainer** contain tips, suggestions, or sample responses participants might give.

Step and Activity	Duration	Participants should have or should be able to:
Welcome and Introduction		
Activity 1 – Opening	20 minutes	State the overall training objectives
Activity 2 – Pre-Test (optional)	10 minutes	Determine pre-training knowledge about developing BC strategies
Activity 3 – Integrating FP into MCH services	15 minutes	State at least two good reasons for integrating FP into MCH services Describe at least two challenges to integrating FP into MCH
Step 1 – Understand Behavior Change		
Activity 1 – Making a Change	30 minutes	Shared experiences about a change they have made Reflected on what it takes to change a behavior
Activity 2 – Stages of Change	15 minutes	Describe the five Stages of Change and relate them to the steps in the Process of Planned Change.
Activity 3 – Identifying the Steps in the Change Process, Our Roles, and the Community's Role	30 minutes	List at least five steps of the Process of Planned Change[1] in the correct order. Identify the actions of the community in at least five of the steps in the Process of Planned Change. Identify the roles of a change agent in at least five of the steps in the Process of Planned Change.
Activity 4 – Being a Change Agent	10 minutes	Describe their role as change agents with regard to family planning.
Step 2 – Develop a Framework for the Behavior Change Strategy		
Activity – Behavior Change Strategy Overview	40 minutes	Identify the key elements of a behavior change strategy. List at least four of the six principles of developing an evidence-based behavior change strategy.
Step 3 – Define the Priority Group and Behavior		
Activity 1 – "Exercise" Exercise	45 minutes	Demonstrated that one's behaviors do not always match what one knows or believes. State at least one reason why raising awareness or increasing knowledge often is not enough to achieve behavior change. Be able to state at least one reason why it is important to use formative research to design a behavior change strategy.
Activity 2 – Selecting Priority and Influencing Groups	45 minutes	Describe why it is important to focus on the points of view of the priority and influencing groups. Describe a priority and influencing group in five ways. Describe how priority and influencing group characteristics influence the choice of behavior change strategies.
Activity 3 – Defining the Behavior You Will Promote	45 minutes	Write at least two well-defined FP behavior statements.
Activity 4 – Things that Drive Behavior	30 minutes	Describe what are "things that drive behavior". List the three most powerful things that drive behavior.
Activity 5 –Key Benefits and Obstacles	20 minutes	Write benefit and obstacle statements.

Step 4 – Learn More about the Priority Group and Influencing Group		
Activity 1 – Doer/Non-Doer Analysis Overview	45–60 minutes	Describe the purpose of Doer/Non-Doer Analysis. Cite the main reason it is necessary to interview at least 45 doers and at least 45 non-doers.
Activity 2 – Adapting the Doer/ Non-Doer Survey Questionnaire	45–60 minutes	Adapted the Doer/Non-Doer survey questionnaire to their priority group and desired behavior. Describe the type of information each question is designed to get.
Step 5 – Field Test the Doer/Non-Doer Survey		
Activity 1 – Discussion and Optional Demonstration	15 minutes	Cite at least two reasons it is important to use good interviewing techniques when conducting a survey. List at least four good interviewing techniques. Demonstrate good interviewing techniques.
Activity 2 – Role Play	50–60 minutes	Accurately complete Doer/Non-Doer interview questionnaires. Define "probe" in the context of interviews.
Activity 3 – Field Practice and Questionnaire Pre-Test	2+ hours	Appropriately solicit respondents for Doer/Non-Doer interviews. Conduct Doer/Non-Doer interviews.
Activity 4 – Tabulating the Results	60 minutes	Tabulate the responses of doers and non-doers.
Activity 5 – Making Sense of the Results	30 minutes	Examine data from the Doer/Non-Doer survey. Compare doers and non-doers. Based on the data, identify which benefits and obstacles are the most important.
Step 6 – Plan and Conduct a Doer/Non-Doer Survey		
Activity – Parameters for Conducting the Survey	30 minutes plus one or more days to conduct survey	Describe how the Doer/Non-Doer survey will be conducted. Describe their own role and responsibilities in the survey. Interview the required number of doers and non-doers.
Step 7 – Analyze Data Collected in the Field		
Activity 1 – Tabulating the Results	2+ hours	Tabulate the responses of doers and non-doers.
Activity 2 – Making Sense of the Results	2+ hours	Compare doers and non-doers. Examine data from the Doer/Non-Doer survey. Based on the data, identify which drivers of behavior are the most important.
Step 8 – Develop your Behavior Change Strategy		
Activity 1 – Identifying Implications of Big Differences	1 hour	Say what the big differences mean for their behavior change strategy.
Activity 2 – Identifying Appropriate Activities	1 hour and 30 minutes	Identify 3–4 activities that relate to the most important benefits and obstacles as identified through the Doer/ Non-Doer survey. Give 3 reasons it is important to go beyond awareness raising. Develop an effective behavior change strategy.

Step 9 – Implement Your Evidence-Based Strategy		
Activity – Developing an Implementation Plan and Budget	30 minutes	Identify potential risks and obstacles to implementing their new behavior change strategies. Develop an implementation plan.
Step 10 – Assess and Adjust Your Strategy		
Activity – Monitor, Evaluate, and Tweak	30 minutes	Cite at least two reasons assessing a behavior change strategy is important. Identify at least one method of monitoring and evaluation that is feasible for your program to use.
Closing		
Activity 1 – Post-Test (optional)	10 minutes	Determine post-training knowledge about developing BC strategies.
Activity 2 – Workshop Evaluation	10 minutes	Expressed their views on the training workshop.
Activity 3 – Closure	10 minutes	

What parts of this package need to be adapted to the setting where they will be used?

- Most of the steps have special guidance for what needs to be adapted. Give yourself time to prepare the session following that guidance.
- You need to know who your trainees will be, how much experience they have, what they will be asked to do with what they learn in the training, and how much time you have. Whenever time permits, try to change relatively passive (one way) activities into activities that fully engage participants. For example, instead of reviewing a handout to explain a concept, create an exercise where participants come up with the answers or explanations. Similarly, if you give one example to help explain something, ask participants to give other examples. This involves them and allows trainers to check what participants understand.
- While this module might be too complex for many community-level volunteers, in certain settings it may be possible. If training community-level volunteers, consider which specific aspects of strategy development you expect them to perform. Will they conduct the survey and develop the strategy, or both? Do they need to participate in development of the questionnaire or just in pretesting it? Also simplify language as appropriate.
- If needed, all handouts and survey questionnaires should be translated and presented in the local language(s). Finding the right translator is very important to be sure that materials are translated properly. Translators should be carefully chosen. The best translators aim for translation of ideas and concepts—not just a word-for-word translation. Use common, simple words, and culturally understandable terms and ideas. A "style sheet" that offers consistent language, terminology, and style should be developed. For survey questionnaires especially, short, clear sentences that are sensitive to issues of culture, gender, and age are best.[2]
- Be creative! Look for chances to make the materials as familiar and memorable as possible. For example, the "Exercise" Exercise can be changed to a topic more relevant to the community, such as hand washing with soap, paying taxes, or even road safety.

How do we adapt the training sessions, messages, and educational materials for local use?

- Make the materials and activities understandable to the trainees—whatever it takes. This may mean translating the materials into one or more local languages, adapting the way materials look, changing the words or graphics so that participants understand them correctly. Keep materials as

clear and simple as possible. Field-test all questionnaires with representatives of the actual people who would use them before making the final version.

- Adapting the handouts is important. They should be as clear and basic as possible, using local language, terms, ideas, resources, and referrals. Any graphics (tables, drawings, etc.) should be easy to understand and appropriate.

Training Tips

Surroundings

- Create a comfortable learning environment: with plenty of space—yet everyone can hear the speakers, in comfortable seating, and the right temperature.
- Break regularly, and provide food if possible.

Learning atmosphere

- Set a friendly tone that encourages learning: open, relaxed, caring.
- Encourage trainees to ask questions, hold active discussions, and fully participate.
- Be sure the training is right for the literacy level, learning level, and language of the trainees.

Teaching techniques

- People learn best through a variety of techniques. Use words, pictures, songs, demonstrations, drama, stories, parables, and other interactive activities. Appeal to all of the senses.
- People learn less when they sit silently, listening to someone talking. They need to practice with the content. Lectures don't assure that learners really understand, don't imprint the memory well, and can be boring.
- Allow and encourage participants to figure things out for themselves, rather than giving them all the answers. This will increase their retention of the information.
- Encourage participants to share their knowledge and experience and to link or apply what they already know to what they are learning. This should increase ownership, confidence, **and** retention.
- As often as possible, give participants a chance to practice using the material, using techniques like small group work, role-plays, field practice, and more.
- At the end of each activity or day, pose the objectives as questions to help assess participant learning.
- At the beginning of each day, assign a pair of participants to summarize the main things learned that day, for presentation the following morning. One way to keep the summaries focused is to give participants a format to follow. Here is one possible format, with example:

Date and Team: _____

Activity/Key Learning	**Implications for BC Strategy**
Integrating FP into MCH Services	We need to find out what makes it easy or difficult for our clients to use FP.
Understanding Behavior Change	Strategy must take into account the roles of the client, influencers, and change agents.

Measure if it's working

Use pre- and post-tests to measure success. If time is short, think of simple ways to make sure participants understand the content, such as a show of hands for those who feel they need more help to develop or implement surveys. If participants are not learning what you are trying to teach, ask them for ideas about what is wrong, and how to improve. Get expert help too. Change the module to make it work.

> Tell me, I will forget,
> Show me, I will remember,
> Involve me, I will learn.
>
> — *Native American proverb*

Welcome and Introduction

Total Suggested Time
30-45 minutes

LEARNING OBJECTIVES

By the end of this introductory session, participants should be able to:

1. State the overall training objectives.
2. Determine pre-workshop knowledge about developing BC strategies.
3. State at least two good reasons for integrating FP into MCH services.
4. Describe at least two challenges to integrating FP into MCH.

Training Methods

Discussion, test, role play

What Might Need Adaptation

- If workshop participants come from different organizations and do not all know each other, allow extra time to have them introduce themselves and say why they are participating.
- If your facility already provides FP services, you will need to adjust the questions in Activity 3 to reflect the facility's experience with integration thus far, bringing out what advantages, challenges, and successes there have been.
- If appropriate and time permits, introduce one or more of the FP integration case studies and have small groups explore how what those organizations did applies to what your organization is trying to do. What can be learned from the experiences of others?

Materials and Supplies Needed

- Flipchart, markers, tape
- HO – Pre/Post-Test
- TA – Pre/Post-Test Key
- HO – Workshop Schedule
- HO – Ten Steps to Developing a Behavior Change Strategy
- TA – FP Integration Role Play Scenarios
- Baby doll or something to be the six-month old baby during the role play

Preparation Needed

- Flipchart with training title, duration, and overall training objectives: Participants will:
- Be able to conduct formative research.
- Be able to develop an evidence-based behavior change strategy to help willing clients adopt family planning.
- Have skills and tools needed to plan for and assess the success of a BC strategy

- Flipchart with learning objectives
- If doing the role play, write the scenario on a card to give to the participant(s) performing the role play so they understand what they are supposed to do.
- Depending on how formal you need to be, prepare a sign-in sheet for participants. Have them sign in and receive a training packet (manual, pen, pencil, notebook, name card, etc.).

Activity 1 Opening

15–20 minutes

1. Greet participants in a friendly way. (People learn better when they feel comfortable and valued.) Introduce yourself if this is not an internal training where everyone knows everyone. If there is anyone new to the group, have them introduce themselves and say that you hope you will all get to know each other better during this day together.
2. Using prepared flipcharts, tell participants the workshop title, purpose, objectives, and length.
3. Ask participants what, if any, experience they have developing or implementing behavior change activities or behavior change strategies. During the workshop, try to bring these experiences into the discussion as relevant.
4. Ask participants what they expect to gain from the workshop. Summarize their expectations on a flipchart to review at the end of the workshop. Let them know if any of the listed expectations are unlikely to be met during the workshop.
5. Ask participants to offer and agree to workshop norms that will allow the group to accomplish everything that must be accomplished in the short time you have together.
6. Emphasize that this is an action-focused workshop where they will learn from each other, practice what they learn, and later do the work needed to develop and implement an effective behavior change strategy. Therefore, they must be active participants, share their experience, and ask questions when they have them.

Activity 2 Pre-Test (optional)

10 minutes

1. Tell participants they are being asked to complete a brief pre-test to help measure the effectiveness of the training. They will have 10 minutes and should all begin at the same time. Anyone with a question should raise his or her hand, and you will come to him or her.
2. Tell them that they should not be concerned if they do not know many of the answers. They should expect to do better on the post-test, after all of the workshop material has been covered.
3. Tell participants to write their name or other identifier (animal, color, number, etc.) at the top of the pretest and later at the top of the post-test so that they can be compared..
4. Distribute the pre-test and tell participants to begin. After 10 minutes, collect the pre-tests for marking during a break.

Activity 3 Integrating FP into MCH services

15 minutes

The purpose of this activity is to get participants thinking about some of the advantages and challenges of integrating family planning into MCH services. This should help set the stage for the rest of the workshop.

1. With a co-trainer or participant, perform a 3-minute role play where the mother of a 6-month old-child wants to delay having another child for a few years. She has come to the clinic to have the child vaccinated and brings up the subject of birth spacing. In the role play, you must ask her to go to a different clinic on another day to seek FP counseling and services. The mother complains about the time and distance involved and says she will try to return but is not sure when it will be possible.

> **TRAINERS NOTE**
>
> *Trainers should feel free to change the topic to an FP integration issue that the group is more likely to have experienced.*

2. Process the role play by asking participants questions such as those below. Optional: Record on a flipchart the challenges mentioned (and participants' proposed solutions) for use in future FP integration planning and problem solving. They might also be useful in Step 8, Develop Your Evidence-Based Strategy as long as strong emphasis is placed on what the data show rather than on what participants think are the priority and influencing groups' challenges and potential solutions.
   a. What do you think of what just happened?
   b. What would or did you do in a similar situation?
   c. What are some reasons for having FP services available when mothers come to the clinic to get help for their children?

> **TRAINERS NOTE**
>
> *Some reasons might be:*
>
> - *To spark their interest in family planning at a time when they might be wanting to delay another pregnancy*
> - *To avoid them having to take time (and other resources) to return another day*

   d. What do you think needs to be done (and needs to be in place) in order to make this change?
   e. What are some challenges the MCH clinic/staff might face?

TRAINERS NOTE

Possible challenges might include:

- *Having a waiting room full of mothers and children and no staff dedicated to FP*
- *The need for staff to be trained and equipped to provide FP counseling and services*
- *The need for job aides and client materials describing FP methods*
- *Lack of community outreach/demand generation activities*
- *Having only one examination room*
- *Having an effective referral system for any FP services the clinic cannot offer*
- *Stigma around FP use (especially during the postpartum period)*
- *Lack of funding for FP services*
- *Lack of privacy (open consultation room, injections or pills given publicly)*

f. Aside from being asked to go to another location for FP on another day, what are some other challenges that could prevent a woman seeking MCH services from also seeking or receiving family planning services?

3. Summarize this exercise by pointing out that, in addition to having FP commodities, appropriate training and materials, time, and other such things, it is important to understand and prepare for what people in the community and at health facilities do about family planning and why, as this might be very different and more complex than the reasons they get prenatal care or immunization (for example). How to get and effectively use such information is the core of this training.
4. Phrase each session objective as a question and seek responses from participants to ensure that session objectives have been met.
5. Transition to the next step by saying that we will now move on to the 10 steps to develop, implement, and assess a behavior change strategy to help our community take advantage of family planning services available to them. Distribute and briefly review the workshop schedule and 10 Steps to Developing a Behavior Change Strategy to show how you will attain the workshop objectives.

H0 – Pre/Post-Test

The pretest will help facilitators tailor the discussions to what participants know and don't know. The post-test will help participants and facilitators measure how much learning took place during the workshop.

Please circle the ONE best answer.

1. What elements must be considered in order to design effective behavior change strategies?
    a. Priority group, benefits and obstacles, evaluation methods
    b. Priority group, influencing groups, benefits and obstacles, activities, indicators
    c. Behavior, priority group, influencing groups, the most powerful drivers of behavior, benefits and obstacles, and activities
2. What do we most need to know about the priority and influencing groups?
    a. Demographics, what they like to do, what they want, whether they are at the beginning or the end of the stages of change cycle
    b. Profession, age, marital status, family size, income, aspirations, readiness to adopt the behavior
    c. What they do, their common desires, readiness to adopt the behavior, what keeps them from doing the behavior, demographics
3. Which of the following is a clear, well-defined family planning behavior statement?
    a. Husbands start to come to the clinic with their wives for family planning counseling.
    b. More women use family planning.
    c. Women of reproductive age visiting the MCH clinic report they are currently using at least one [modern] family planning/pregnancy prevention methods.
4. What is a Doer/Non-Doer survey used for?
    a. To learn what obstacles are keeping the doers and non-doers from doing the behavior.
    b. To identify which people are able to do the behavior and which cannot.
    c. To show what are the most influential things in motivating or preventing people from doing a certain behavior.
5. What is the connection between drivers of behavior and the selection of an activity?
    a. Selection of an activity should be based on how likely it is that the activity will address all of the things that drive the FP-related behavior of the priority group.
    b. The drivers of behavior may help us identify which activities will be sustainable at the community level.
    c. Activities should be selected that will directly address the things that most powerfully drive behavior according to where individuals are in the stages of change.

Adapted from *Designing for Behavior Change*, 2011

TA – Pre/Post-Test Key

The pretest will help facilitators tailor the discussions to what participants know and don't know. The post-test will help participants and facilitators measure how much learning took place during the workshop.

Please circle the ONE best answer.

1. What elements must be considered in order to design effective behavior change strategies?
   a. Priority group, benefits and obstacles, evaluation methods
   b. Priority group, influencing groups, benefits and obstacles, activities, indicators
   c. *Behavior, priority group, influencing groups, the most powerful drivers of behavior, benefits and obstacles, and activities*
2. What do we most need to know about the priority and influencing groups?
   a. Demographics, what they like to do, what they want, whether they are at the beginning or the end of the stages of change cycle
   b. Profession, age, marital status, family size, income, aspirations, readiness to adopt the behavior
   c. *What they do, their common desires, readiness to adopt the behavior, what keeps them from doing the behavior, demographics*
3. Which of the following is a clear, well-defined family planning behavior statement?
   a. Husbands start to come to the clinic with their wives for family planning counseling.
   b. More women use family planning.
   c. *Women of reproductive age visiting the MCH clinic report they are currently using at least one [modern] family planning/pregnancy prevention methods.*
4. What is a Doer/Non-Doer survey used for?
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   b. The drivers of behavior may help us identify which activities will be sustainable at the community level.
   c. *Activities should be selected that will directly address the things that most powerfully drive behavior according to where individuals are in the stages of change.*

Adapted from *Designing for Behavior Change, 2011*

HO – Workshop Schedule

Step and Activity	Duration	Time
DAY 1		
Welcome and Introduction	45 minutes	8:30 – 9:15
Step 1 – Understand Behavior Change		
Activity 1 – Making a Change	30 minutes	9:15 – 9:45
Activity 2 – Stages of Change	15 minutes	9:45 – 10:00
Activity 3 – Identifying the Steps in the Change Process, Our Roles, and the Community's Role	30 minutes	10:00 – 10:30
Activity 4 – Being a Change Agent	15 minutes	10:30 – 10:45
BREAK		10:45 – 11:00
Step 2 – Develop a Framework for the Behavior Change Strategy		
Activity – Behavior Change Strategy Overview	40 minutes	11:00 – 11:40
Step 3 – Define the Priority Group and Behavior		
Activity 1 – "Exercise" Exercise	45 minutes	11:40 – 12:25
Activity 2 – Selecting Priority and Influencing Groups	45 minutes	12:25 – 1:10
LUNCH		1:10 – 2:10
Activity 3 – Defining the Behavior You Will Promote	45 minutes	2:10 – 2:55
Activity 4 – Things that Drive Behavior	30 minutes	2:55 – 3:25
Activity 5 – Benefits and Obstacles	20 minutes	3:25 – 3:40
BREAK		3:40 – 3:50
Step 4 – Learn More about the Priority Group and Influencing Group		
Activity 1 – Doer/Non-Doer Analysis Overview	45 minutes	3:50 – 4:35
Activity 2 – Adapting the Doer/Non-Doer Survey Questionnaire	45 minutes	4:35 – 5:20
DAY 2		
Recap	5 minutes	8:30 – 8:35
Step 5 – Field Test the Doer/Non-Doer Survey		
Activity 1 – Discussion and Optional Demonstration	15 minutes	8:35 – 8:50
Activity 2 – Role Play	50 minutes	8:50 – 9:40
Activity 3 – Field Practice and Questionnaire Pre-test	2 hours	9:40 – 11:40
LUNCH		11:40 – 12:40

Activity 4 – Tabulating the Results	60 minutes	12:40 – 1:40
Activity 5 – Making Sense of the Results	30 minutes	1:40 – 2:10
Step 6 – Plan and Conduct a Doer/Non-Doer Survey		
Activity – Parameters for Conducting the Survey	30 minutes	2:10 – 2:40
Participants return to work and to conduct survey		
DAY 3 (following conduct of full survey)		
Step 7 – Analyze Data Collected in the Field		
Welcome Back and Recap of Field Experience		8:30 – 8:45
Activity 1 – Tabulating the Results	2 hours	8:45 – 10:45
BREAK		10:45 – 11:00
Activity 2 – Making Sense of the Results	2 hours	11:00 – 1:00
LUNCH		1:00 – 2:00
Step 8 – Develop your Behavior Change Strategy		
Activity 1 – Identifying Implications of Big Differences	45 minutes	2:00 – 2:45
Activity 2 – Identifying Appropriate Activities	1 hour, 30 min.	2:45 – 4:15
Step 9 – Implement Your Evidence-Based Strategy		
Activity – Developing an Implementation Plan and Budget	30 minutes	4:15 – 4:45
Step 10 – Assess and Adjust Your Strategy		
Activity – Monitor, Evaluate, and Tweak	30 minutes	4:45 – 5:15
Closing	30 minutes	5:15 – 5:45

HO – Ten Steps to Developing a Behavior Change Strategy

Step 1 – Understand Behavior Change

This step helps you explore what behavior change is and how difficult it can be to change. It also looks at steps in the behavior change process and the roles various people play.

Step 2 – Develop a Framework for the Behavior Change Strategy

Here we decide what types of information will go into our behavior change strategy.

Step 3 – Define the Priority Group and Behavior

To develop a solid strategy and know if the desired change has taken place, it is important to be clear about exactly who we want to adopt the new behavior and what conditions encourage or prevent behavior change. It is equally necessary to clearly define the desired behavior. We learn here how to identify and describe the priority group and how to write a clear behavior statement.

Step 4 – Learn More about the Priority Group and Influencing Group

We know a lot about the groups to whom we provide health care, but we often don't know everything we need to know about what motivates them to adopt a particular behavior and what are the most important obstacles to behavior change. In this step, we learn about one way to discover these things about our priority groups. We also adapt a questionnaire that will help us get the information we need to develop a targeted, evidence-based behavior change strategy.

Step 5 – Field Test the Doer/Non-Doer Survey

In this step, we practice conducting a survey to learn what motivates our priority or influencing group and what prevents them from making the desired change. We also field-test the survey questionnaire and practice analyzing the findings.

Step 6 – Plan and Conduct the Doer/Non-Doer Survey

The team will agree on how and in what timeframe to conduct the actual survey – and then do it.

Step 7 – Analyze Data Collected in the Field

Now that we have collected information, we must analyze it and decide what is potentially important for our behavior change strategy.

Step 8 – Develop your Behavior Change Strategy

This is where we bring it all together. We will think about what the key Doer/Non-Doer survey findings mean for behavior change strategy development and identify activities—based solidly on our research—to achieve the desired behavior change.

Step 9 – Implement Your Evidence-Based Strategy

Here, we develop an implementation plan (including timeline, resources, persons responsible, and other elements) and budget.

Step 10 – Assess and Adjust Your Strategy

To know if the behavior change strategy is succeeding, you need to decide what you will measure, how you will measure it, and how often. You will also need to figure out how to use what you learn to improve the strategy itself or how it is implemented.

TA – FP Integration Role Play Scenarios

Option 1

Client: You are the mother of a 6-month-old child. You have come to the clinic to have the child vaccinated. You want to delay having another child for a few years, so you say this to the health worker. When you learn that FP counseling and services are not available there, you complain about the time and distance involved and say you will try to return but are not sure when it will be possible.

Health worker: Your clinic does not provide FP services. You must ask the client to go to a different clinic on another day to seek FP counseling and services.

Option 2

Client: You are the mother of a 9-month-old child. You have walked for an hour and thirty minutes to bring your child to the clinic for her measles vaccination. You want to delay having another child for a few years, so you say this to the health worker. When you learn that FP counseling and services are not available that day, you complain about the time and distance involved and say you will try to return but are not sure when it will be possible.

Health worker: It is Monday, and your clinic provides FP services on Wednesdays. You must ask the client to go to return to seek FP counseling and services.

Option 3

Create a scenario that highlights a problem the program has had with FP integration or the inability to provide FP counseling and services.

STEP 1

Understand Behavior Change

Total Suggested Time
1 hour, 30 minutes

This step helps you explore what behavior change is and how difficult it can be to change. It also looks at steps in the behavior change process and the roles various people play.

LEARNING OBJECTIVES

By the end of this step, participants should:

1. Have shared experiences about a change they have made.
2. Have reflected on what it takes to change a behavior.
3. Be able to describe the five Stages of Change.
4. Be able to list at least five steps of the Process of Planned Change in a logical order.
5. Be able to identify the actions of the community in at least five of the steps in the Process of Planned Change.
6. Be able to identify the roles of a change agent in at least five of the steps in the Process of Planned Change.
7. Be able to describe their role as change agents with regard to family planning.

Supplies Needed

- Flipchart, markers, tape
- Stages of Change on flipchart
- TA – Stages of Change Cards (one set)
- TA – Process of Planned Change Cards (as many sets as there will be small groups)
- HO – Understanding Behavior Change (optional)

Preparation Needed (see activities for details)

- Flipchart titled "Doing Something New" with the suggested questions
- Flipcharts titled "obstacles to change" and "facilitators of change"
- Prepare one set of Stages of Change cards.
- Prepare enough sets of the "Process of Planned Change" cards to have one complete set for each small group. Mix up each set of cards so they are not in the right order.
- Write the stages of change with brief descriptions of each on a flipchart.
- Prepare flipchart with the Role of a Family Planning Change Agent.
- Find out what the demand or unmet need (the number of women who want to delay their next pregnancy but are not using a family planning method[3]) for family planning is in your country or area.

Activity 1 Making a Change

30 minutes

LEARNING OBJECTIVES

By the end of this activity, participants should:

1. Have shared experiences about a change they have made.
2. Have reflected on what it takes to change a behavior.

Training Methods

Small group work

Supplies Needed

Flipchart, markers, tape

Preparation Needed

- Flipchart titled "Doing Something New" with the questions:
  1. What was the change you made (or tried to make)?
  2. What did you do to make the change? What were the steps you took?
  3. Were there things that made it easier or harder? What were they?
  4. What did you have to do to keep it up?
  5. How successful were you?
- Flipcharts titled "obstacles to change" and "facilitators of change"

1. Introduce this activity by saying that in order to develop an effective behavior change strategy, we must understand what behavior change is and the types of things it requires.
2. If there are six or more participants, divide them into small groups. Group members will think about and discuss a change they have made—or tried to make—in their personal life (e.g., quit smoking, lose weight, exercise regularly, spend more time with their children, curb spending, etc.). Tell them to discuss what the change was, what was required to make the change, whether they succeeded, and what it took to keep doing it. As a reminder, post the flipchart "Doing Something New" where all the groups will be able to see it. If participants need it, give an example, such as drinking one cup of coffee every day instead of three cups. Tell them they have 10 minutes to discuss in their groups, but give them 15 minutes.
3. After 10 minutes, ask if they need more time. After 15 minutes, bring the full group back together.
4. Ask what were some of the things that made the changes they discussed easier or harder. List several of their responses on flipcharts marked 'Obstacles to Change" and "Facilitators/Benefits of Change."
5. Point out (or let them point out) any common themes that arise, such as family members encouraging or discouraging the change, having a plan, availability of things needed to make the change, length of time doing things another way, etc.). Tell participants to keep these in mind, as you will come back to this concept of obstacles and facilitators/benefits.
6. Transition to the next activity by saying that in order to successfully integrate FP into our program, we need a plan for helping people adopt FP. This means we must recognize where community members are in the change process and developing a plan that meets them there and addresses the things most likely to get them to change.

Activity 2 Stages of Change

15 minutes

LEARNING OBJECTIVES

By the end of this activity, participants should be able to describe the five Stages of Change.

Training Methods

Discussion

What Might Need Adaptation

- If participants already know the stages of behavior change, just have them quickly described
- If your organization uses a different behavior change model, use that model instead of the Stages of Change model.

Supplies Needed

- Stages of Change on flipchart
- TA – Stages of Change Cards (one set, printed on card stock if possible)
- Flipchart, markers, tape

Preparation Needed

- Write the stages of change with brief descriptions of each on a flipchart.
- Prepare one set of Stages of Change cards.

1. Using a prepared flipchart, list the five stages of change and ask participants to say what they think each means. Also ask for an example of each, related to a family planning behavior.

> TRAINERS NOTE
>
> *Stages of Change*
>
> - ***Pre-Awareness**: The person is not aware of the behavior [ex., has never heard of family planning].*
> - ***Awareness**: The person is aware of the behavior but needs more information about it [ex., has heard of FP and "the pill" but doesn't know much about the benefits of using FP or how to use oral contraceptive pills (OCPs)].*
> - ***Preparation**: The person gets ready to try the behavior [ex., gets counseling and a month's supply of OCPs].*
> - ***Action**: The person tries the behavior [ex., begins taking an OCP daily].*
> - ***Maintenance**: The person continues doing the behavior. [ex., takes an OCP daily as instructed and returns for resupply].*

2. Explain that we need to be aware of the stage of change the community is in so that we can design an effective behavior change strategy to meet their needs. For example, if the community is already well aware of the benefits of family planning, we don't need to spend a lot of resource raising awareness about FP benefits.

3. Tape the cards to the wall. In the next activity, participants will place the process of change cards where they fit best in relation to the stages of change.

> **TRAINERS NOTE**
>
> *If possible, leave this set of cards or the Stages of Change flipchart taped to the wall for the entire training so it can be referred to easily.*

4. Transition to the next activity by saying that now we will look at a change process that takes into account the five stages of change.

Activity 3 Identifying the Steps in the Change Process, Our Roles, and the Community's Role

30 minutes, (longer if there are more than 10-12 participants)

LEARNING OBJECTIVES

By the end of this activity, participants should be able to:

1. List at least five steps of the Process of Planned Change[4] in a logical order.
2. Identify the actions of the community in at least five of the steps in the Process of Planned Change.
3. Identify the roles of a change agent in at least five of the steps in the Process of Planned Change.

Training Methods

Matching game

What Might Need Adaptation

If your organization uses a different behavior change model, adapt this exercise to fit that model

Supplies Needed

- TA – Process of Planned Change Cards (as many sets as there will be small groups, printed or pasted on card stock if possible)
- Flipchart, markers, tape

Preparation Needed

Prepare enough sets of the Process of Planned Change Cards to have one complete set for each small group. Mix up each set of cards so they are not in the commonly accepted order.

1. Tell participants they will now do an exercise where they must put cards in the best order.
2. Divide participants into small groups of 5-6 people each. (If you have six or fewer participants, you can do this as a full group exercise.) Give each group the first set of cards—the cards with the behavior change steps. Tell them to tape the cards under the stages of change cards in the order that makes sense to the group.
3. Once they have finished, have them compare their lists. Are they in the same order? What is different? Why did one group put a step in a certain place and not another. Now that they have discussed them, do they want to move any of their cards?

4. Repeat this with the second set of cards, explaining that these represent a client or community member's action during each of the steps they just posted. Tell them to tape these cards below the behavior change steps where they fit best. Show that the cards have a step on the front and an example on the back.
5. Repeat with the third set of cards—those with the change agent's roles—explaining that these are the role of the change agent at each step of behavior change. Ask them for a simple definition of "change agent". Then ask them to tape these under the current two rows of cards, where each fits best. These also have a step on the front and an example on the back.

> **TRAINERS NOTE**
>
> *Alternatively, have groups post all three sets of cards and then look at each other's cards, discuss their differences, and make any adjustments they want to make.*

This table reflects what an eventual grouping might look like.

Stage	Pre-Aware	Aware	Preparation	Action		Maintenance	
Step	***Identify problem***	***Study alternatives; seek info***	***Get new skill and access to resources***	***Try the new behavior***	***Reflect on & reinforce the behavior***	***Continue the behavior***	***Celebrate success***
Changer	I don't see a problem. *"It's normal to have a child every 12-18 months"*	Maybe there's a problem. *"The nurse explained that my children can be healthier if there is more space between them."*	I'm ready to try, but there are obstacles. *"I want to take the injectable, but I am worried that I might have side effects."*	I am trying it but unsure of the outcome. *"I have had my first two injections."*	I can succeed if supported and encouraged. *"My husband is happy that we do not have to worry about another pregnancy right now. He says we are doing the right thing for our family."*	I will keep trying since it is good. *"I am getting used to taking a pill every day. It is so good to not have to worry about getting pregnant again before I am ready."*	Yes, I can! *"Wow—I can do this! I didn't realize how helpful it would be to have more time between my last child and my next one!"*
Change agent	Help identify problem. *"We have so many clients who come in time after time with one sick child after another. I am glad we have started doing FP awareness."*	Provide info and possible solutions. *"I use FP counseling cards to explore options with clients."*	Help find ways to overcome obstacles. *"Rumors about side effects are common in our area. I ask mothers what their concerns are and try to address them with facts and real-life examples."*	Help discuss benefits and consequences *"I give the client advice on how to discuss FP benefits with her or his partner."*	Reinforce and support change. *"I tell clients what a great job they are doing with their FP method and keeping themselves and their child healthy."*	Monitor change. *"Every time the mother brings the child in for care or a check-up, I ask how she is doing with her FP method, help her with any problems, and make a note in her record."*	Recognize & celebrate success. *"On the first anniversary of their using FP, we give clients a small but pretty card that says 'Congratulations on one year of success!'"*

6. Process this and the Stages of Change activity by asking questions such as those below. It can be helpful to summarize responses in a table with two columns, one labeled "Learning" and the other labeled "Implications for BC Strategy." Answers to the first question below would be "Learnings." Answers to the next two would be "Implications".
   - What did you learn from these activities? How does it apply to clients and communities as you try to increase adoption of family planning?
   - Does everyone in a community go through the steps at the same time or same pace? What does this mean for your eventual strategy?
   - Once a person reaches a certain step, do they ever regress to an earlier step? What does this mean for your eventual strategy?

TRAINERS NOTE

Examples of Learnings:

1. *People have to see a problem, opportunity, or room for improvement before deciding to change their behavior.*
2. *Change can be a back-and-forth process—it doesn't always happen in a straight, one-directional line.*
3. *Positive experiences and positive feedback reinforce behavior change.*
4. *Community members have choices—to change or not, what method to use if they decide to use any, and how long to use the method.*
5. *People will need different things at different times to support behavior change.*

Examples of Implications for BC Strategy:

1. *The strategy might have to help people identify problems.*
2. *We have to provide multiples points of contact.*
3. *We have to build in support mechanisms.*
4. *We have to ensure group members can make an informed choice.*
5. *We have to build flexibility into our BC strategies.*

Activity 4 Being a Change Agent

15 minutes

LEARNING OBJECTIVE

By the end of this activity, participants should be able to describe their role as change agents with regard to family planning.

Training Methods

Discussion

Supplies Needed

- Flipchart, markers, tape
- HO – Understanding Behavior Change (optional)

Preparation Needed

- Prepare flipchart with the Role of a Family Planning Change Agent.
- Find out what is the demand or unmet need (the number of women who want to delay their next pregnancy but are not using a family planning method[5]) for family planning in your country or area.

1. Say that we have just talked about the stages of change, the process people go through as they undertake change, and the role of the change agent in this process. Ask participants if they are change agents.
2. If they say that they are, ask them to give some examples of what a family planning change agent does to help people adopt FP. If they say they are not, ask them what they think an FP change agent might do to help people adopt FP.
3. Reveal the Role of a Family Planning Change Agent and note similarities to what they listed.

TRAINERS NOTE

Role of a Family Planning Change Agent

A change agent is someone who helps people solve their problems.

A change agent can help people:

- *Identify their problems.*
- *Learn about new behaviors.*
- *Address barriers that prevent behavior change.*
- *Adopt new behaviors.*
- *Continue the new behaviors*

In the context of FP, change agents can:*

- *Raise awareness about FP.*
- *Teach people about FP methods.*
- *Help create an environment where FP is acceptable and encouraged.*
- *Provide access to FP either by referral or by providing FP services.*
- *Identify obstacles to adopting FP.*
- *Develop and implement strategies to remove obstacles to FP.*
- *Explore alternatives with clients who have problems with the method they chose.*

**This is not intended as a complete list of what FP change agents do.*

4. Tell participants that we know that many of the people we serve want to have smaller families or to have more years between children. Use national or local data to support this. We also know that not everyone who wants or would benefit from modern family planning uses it or uses it correctly.

We want to help more people use family planning and use it correctly. Ask: How do we do that? What do we have to know? Ensure all of these are mentioned:

- Who needs or wants FP
- What they know and believe about fertility/FP/birth spacing/having children
- What are their current practices related to FP/birth spacing/having children
- What is preventing them from using FP or using it correctly
- What would help them start and continue correct use of FP

5. In other words, we need a behavior change strategy. Transition to the next step by saying that we will now look at a framework for developing a behavior change strategy.
6. Optional: Distribute HO – Understanding Behavior Change. Ask participants to complete it overnight with their own behavior change example (e.g., saving money for emergencies or a large purchase, exclusive breastfeeding for the newborn's first 6-12 months, getting infant fully immunized, spacing births using modern FP). Review during the morning of Day 2, either individually or as a group, to help ensure participants understand the concepts reviewed during this step.

TA – Stages of Change Cards

Pre-Awareness

Awareness

Preparation

Action

Maintenance

TA – Process of Planned Change Cards

Instructions: Print the cards on card stock or paper. For each set of Changer and Change Agent cards, paste the relevant example on the back of the step to help participants understand the step better.

Process of Planned Change	**Identify the problem.**
Study alternatives and look for more information.	**Obtain new skills and access to resources and support.**

Try the new behavior.	**Reflect on the new behavior and reinforce it.**
Continue the behavior.	**Celebrate success at maintaining the behavior.**

Changer	**I don't see a problem, so I am not thinking about making a change.**
Something happened to make me think maybe there is is a problem. Now I need more information and some alternatives on how to deal with it.	**I'm ready to try something new, but there are obstacles.**

I am trying the new behavior, but I am not 100% certain what the outcome will be.	**With support and encouragement from my family, friends, and community, I can succeed.**
I need to keep practicing the new behavior until it becomes a habit. I believe the change is positive.	**Yes! I am doing it!**

Change Agent	**I will do something to help people identify the problem.**
I will do something to help people identify ways of solving the problem and provide them with additional information about it.	**I will do something to help people identify how to overcome the obstacles, and I will organize access to resources or help them to do so.**

I will facilitate a discussion on the benefits of adopting the new behavior and the consequences of not adopting it. This is one way to encourage permanent or long-term change.	**I will continue to reinforce and support people people to do the new behavior so that it becomes permanent or long-term.**
I will monitor the change to provide needed support and information.	**I will recognize and celebrate the success of positive behavior change!**

Changer (example)	**“It i is normal to have a child every year.”**
“The nurse explained that my children can be healthier if there is more space between them.”	**“I want to take the injectable, but I am worried that I might have side effects.”**

“I have had my first two injections.”	“My husband is happy that we do not have to worry about another pregnancy right now. He says we are doing the right thing for our family.”
“I am getting used to taking a pill every day. It is so good to not have to worry about getting pregnant again before I am ready.”	“Wow—I can do this! I didn’t realize how helpful it would be to have more time between my last child and my next one!”

Change Agent (examples)	**"We have so many clients who come in time after time with one sick child after another. I am glad we have started doing FP awareness."**
"I use FP counseling cards to explore options with clients."	**"Rumors about side effects are common in our area. I ask mothers what their concerns are and try to address them with facts and real-life examples."**

"I tell clients what a great job they are doing with their FP method and keeping themselves and their child healthy."

"I give the client advice on how to discuss FP benefits with her or his partner."

"On the first anniversary of their using FP, we give clients a small but pretty card that says 'Congratulations on one year of success!'"

"Every time the mother brings the child in for care or a check-up, I ask how she is doing with her FP method, help her with any problems, and make a note in her record."

HO – Understanding Behavior Change (optional)

Stage	Pre-Aware	Aware	Preparation	Action		Maintenance	
Step	***Identify problem***	***Study alternatives; seek info***	***Get new skill and access to resources***	***Try the new behavior***	***Reflect on & reinforce the behavior***	***Continue the behavior***	***Celebrate success***
Changer	I don't see a problem. *Example:*	Maybe there's a problem. *Example:*	I'm ready to try, but there are obstacles. *Example:*	I am trying it but unsure of the outcome. *Example:*	I can succeed if supported and encouraged. *Example:*	I will keep trying since it is good. *Example:*	Yes, I can! *Example:*
Change agent	Help identify problem. *Example:*	Provide info and possible. *Example:*	Help find ways to overcome obstacles. *Example:*	Help discuss benefits and consequences. *Example:*	Reinforce and support change. *Example:*	Monitor change. *Example:*	Recognize & celebrate success. *Example:*

STEP 2

Develop a Framework for the Behavior Change Strategy

Total Suggested Time
40 minutes

Here we decide what types of information will go into our behavior change strategy.

Activity: Behavior Change Strategy Overview

LEARNING OBJECTIVES

By the end of this step, participants should be able to:

1. Identify the key elements of a behavior change strategy.
2. List at least four of the six principles of developing an evidence-based behavior change strategy.

Training Methods

Brainstorming, mini-lecture

Supplies Needed

- HO – Behavior Change Strategy Framework (blank)
- HO – Six Principles of Designing a Behavior Change Strategy
- HO – Sample Behavior Change Strategy Based on Doer/Non-Doer Survey Results (Optional)

Preparation Needed

- Prepare flipchart with a definition of "behavior change strategy"
- Prepare flipchart with the Behavior Change Strategy matrix
- Prepare flipchart with the Six Principles of Designing a Behavior Change Strategy

1. Show the following definition of Behavior Change Strategy on a flipchart:

   A comprehensive approach to achieving behavior change, containing a set of activities that work together to make a difference. A good BC strategy is:
   - Based on data and formative research (research done in order to "form" or create)
   - Integrated within a comprehensive program design—it fits well into the overall program
   - Focused on the desired behaviors and things that influence them
2. Ask participants if they have ever been involved in the design of a behavior change strategy (or any kind of strategy). Allow one participant to briefly describe his or her experience.
3. Ask participants what are the things they need to consider when designing a behavior change strategy. List the group's ideas on a flipchart.
4. Show the flipchart with the Behavior Change Strategy framework and distribute the handout version. Explain that it is a tool to help us think about the different things that need to be considered when designing a behavior change strategy. Point out the similarities between what the group proposed and what is in the framework. Briefly explain any element not already

discussed, noting that the next steps explore each element in more detail. Come to agreement with the group on any adjustments that need to be made, and have them make those changes on their handouts. Point out that in this workshop we will describe influencing groups but not do research to develop activities targeting them. Such activities can be developed using existing research or after conducting research at a later date.

TRAINERS NOTE

Key Elements of a Behavior Change Strategy

Program Objective: What is the program trying to achieve with regard o family planning?

Behavior: What is a feasible and effective family planning behavior to promote in order to achieve the program objective?

Priority Group: Who is the main group who should practice the behavior?

Influencing Group: Who are the people who influence that group?

Drivers of Behavior: What are the main things that determine whether or not members of the priority group will practice the behavior?

Benefits and Obstacles: Within the drivers of behavior, what are the main benefits the group will get from practicing the behavior, and what the main obstacles in their way?

Activities: What are activities the program can implement to help group members adopt the new behavior?

5. Tell participants there are some principles they should keep in mind when developing a behavior change strategy. Distribute the handout and have a volunteer read the flipchart "Six Principles of Designing a Behavior Change Strategy."

TRAINERS NOTE

Six Principles of Designing a Behavior Change Strategy

1. *Know exactly who your group is and look at everything from their point of view.*
2. *Action is what counts— beliefs and knowledge are not enough.*
3. *People take action when it benefits them.*
4. *Obstacles keep people from acting.*
5. *All the activities you choose should focus on the main things that drive the behavior you want to see, maximize benefits, and minimize obstacles.*
6. *Base decisions on evidence, not on guesses or assumptions, and keep checking. Are we getting the behavior change we expected? If not, do we need to do more research to make sure what we thought were the most important drivers, benefits, and obstacles really are the most important?*

6. Optional: Review the Sample Behavior Change Strategy with the group, giving them time to ask questions and verifying that they understand why the various elements are included and how the elements relate to each other. If you have adapted the framework, ask participants how the sample strategy would be adjusted to fit the new framework.
7. Tell participants they will now look more closely at the various elements of the strategy.

HO – Behavior Change Strategy Framework

Using a good framework helps you organize your ideas. It can help to ensure that the activities you choose address specific, significant research findings. Here is one framework that can be used or adapted.

Program Objective:				
Priority Group	**Desired Behavior**	**Key Drivers of Behavior**	**Key Benefits & Obstacles**	**Activities**
Influencing Groups:				

HO – Six Principles of Designing a Behavior Change Strategy

1. Know exactly who your priority group is and look at everything from their point of view. The priority group is people responsible for doing the behavior.
2. Action is what counts—changing beliefs and knowledge is not enough.
3. People take action when it benefits them.
4. Obstacles keep people from acting.
5. All your activities should focus on the main things that drive the behavior you want to see, maximize the most important benefits, and minimize the most significant obstacles.
6. Base decisions on evidence (not assumptions or guesses) and keep checking to be sure the evidence is true. Are you seeing the amount of change you expected? If not, do you need to do more research to see if what you thought were the most important drivers, benefits, and obstacles really are the most important?

Adapted from *Designing for Behavior Change*, CORE Group, 2008

Step 2 – Develop a Framework for the Behavior Change Strategy (optional)
Step 8 – Develop a Behavior Change Strategy

HO – Sample Behavior Change Strategy Based on Doer/Non-Doer Survey Results

Program Objective: Increase use of OCs, IUDs, and condoms among women of childbearing age by an average of 25% within two years.

Priority Group 1	Desired Behavior	Driver of Behavior	Benefits/Obstacles	Implications/Goal	Activities
Women of childbearing age with at least one living child	Regular and correct use of contraceptive pills, IUD, or condoms for at least one year	Perceived Consequences	The mother will be healthy	Increase the number of women, couples, and influencers who believe that using FP improves mothers' and children's health and development.	Develop and implement a campaign promoting the health benefits of FP for the mother and the growth benefit to the child.
		Perceived Self-Efficacy	Users have the	Show community/non-doers how easy it is	During education and counseling sessions at community and facility level, describe and demonstrate how the methods are used. Allow clients to handle method samples and ask questions.
			Non-users lack sufficient funds to pay for the FP method	Decrease cost of FP use.	Work with government, NGO and donor leaders to lower the price of contraceptives to low-income consumers. Vouchers and income-based subsidies are among the options for consideration.

Priority Group 1	Desired Behavior	Driver of Behavior	Benefits/Obstacles	Implications/Goal	Activities
		Social Norms	Most of the people users know approve of their using OCs, the IUD, or condoms to space births or prevent a new pregnancy	Increase influencing groups' visible and vocal support of FP use.	
			Users believe health facility personnel approve of FP use, whereas non-users do not believe this to be true	Increase	See Influencing Group 1, below.

Influencing Group	Desired Behavior	Role	Research needed	Potential Activities
Health Facility Staff in 5 specified districts	During MCH visits, counsel at least 75% of mothers about the benefits of modern FP.	Health promotion, counseling, service provision	Conduct a formal or informal survey	Train health

STEP 3

Define the Priority Group and Behavior

Total Suggested Time
3 hours, 5 minutes

To develop a solid strategy and know if the desired change has taken place, it is important to be clear about exactly who we want to adopt the new behavior and what conditions encourage or prevent behavior change. It is equally necessary to clearly define the desired behavior. We learn here how to identify and describe the priority group and how to write a clear behavior statement.

LEARNING OBJECTIVES

By the end of this step, participants should be able to:

1. Demonstrate that one's behaviors do not always match what one knows or believes.
2. Be able to state at least one reason why raising awareness or increasing knowledge often is not enough to achieve behavior change.
3. Be able to state at least one reason why it is important to use formative research to design a behavior change strategy.
4. Describe a priority and influencing group in five ways.
5. Describe how priority and influencing group characteristics influence the choice of behavior change strategies.
6. Write at least two well-defined FP behavior statements.
7. Describe why it is important to identify the points of view of the priority and influencing groups.
8. Describe what are "things that drive behavior".
9. List the three most powerful things that usually drive health behavior.
10. Write key benefit and obstacle statements.

Supplies Needed

- Flipchart, markers, tape
- TA – Exercise Statements
- HO – Five Ways to Describe Your Priority or Influencing Group (sample)
- HO – Five Ways to Describe Your Priority or Influencing Group (blank)
- HO – Clearly Defining Behaviors
- HO – Things that Drive Behavior

Preparation Needed

- Flipcharts with the three sets of Exercise statements written on them
- Use clinic/community data to determine what are your likely priority and influencing groups.
- Prepare flip chart with definitions of Priority Group and Influencing Group
- Prepare a flipchart of "Five Ways to Describe your Priority or Influencing Group"
- Prepare flipchart with a definition of "behavior"

- Prepare or designate participants to prepare a template (paper or flipchart) for the behavior change strategies they will develop from this step onward.
- Prepare flipchart with well-written and poorly-written behavior statements
- Prepare flipchart with definitions of the things that drive behavior

Activity 1 "Exercise" Exercise

45 minutes

The purpose of this exercise is to help participants begin to see value in defining and segmenting priority groups.

LEARNING OBJECTIVES

By the end of this activity, participants should:

1. Have demonstrated that one's behaviors do not always match what one knows or believes.
2. Be able to state at least one reason why raising awareness or increasing knowledge often is not enough to achieve behavior change.
3. Be able to state at least one reason why it is important to use formative research to design a behavior change strategy.

Training Methods

Exercise

What Might Need Adaptation

If exercise is not an appropriate or familiar topic, choose a topic more relevant to your participants. Be sure it is not a topic that will embarrass them or make anyone uncomfortable.

Supplies Needed

- TA – Exercise Statements
- Flipchart, tape, markers

Preparation Needed

Write the knowledge, belief, and behavior statements on flipchart paper, with one set of Exercise statements written on each, as per the TA (all three statements for one set on one page). Fold and tape each page so that only the heading is revealed, while all the statements are hidden. With some distance between them so participants have room to stand in groups in front of the statement that most accurately reflects them, tape the three pages to a wall. During the exercise, you will unfold the pages just enough to reveal the knowledge statement, then the belief statement, and then the behavior statement.

1. Tell participants that in this exercise, they will play the role of community members. Explain that in this exercise, the health promotion program has a behavior change goal for the community: Increase the number of community members who engage in at least 30 minutes of moderate physical activity four or more days every week.
2. Tell participants that, to decide how to achieve that goal, you will do some formative research, and they will be the priority group (i.e., a sample of community members).

> **TRAINERS NOTE**
>
> *You can write the goal on flipchart paper to make it easier for you and for participants.*

3. Reveal the first statement, the ***knowledge*** statement, of each of the three flipchart pages taped to the wall. Read or have a volunteer read each knowledge statement out loud.
4. Ask participants to stand near the statement that best reflects their knowledge. After they have moved to their selection, ask the following questions:
   - What do you notice about the groups?
   - How many are in each group?
   - What else do you notice? Demographic observations? By profession? Gender? Age? Nationality? Language group? Region? Other?
5. Tell participants they have just divided themselves into segments, or subgroups of the community, according to their stated knowledge about exercise. We will now see what happens when we look at beliefs.
6. Reveal the ***belief*** statement in each page on the wall. Read or have a volunteer read each belief statement out loud.
7. Ask participants to stand near the statement that best reflects their belief. Then ask the following questions:
   - What do you notice about these groups?
   - What differences do you see?
   - Do you notice anything else?
8. Select a different volunteer. Reveal the ***behavior*** statement in each set on the wall. Read or have a volunteer reach each behavior statement out loud.
9. Ask participants to stand near the statement that best reflects what they did last week. After they have moved, ask:
   - Is there anything different about the groupings this time? If so, what?
10. While they remain in their groups, ask them:
    - Did knowledge always predict behavior? (I.e., did everyone who knew regular exercise 4 times per week would improve health actually exercise 4 times last week?)
    - If you had to pick one part of the priority group to work with first, which would you choose?
    - Why?
    - What have we learned from this exercise?

TRAINERS NOTE

Be sure the following points are brought out:

- *What people know or believe doesn't always dictate what they do. While that can be obvious to us when we think about our own behaviors, sometimes we forget it when we are planning health promotion activities.*
- *Just giving people information is usually not enough to change their behavior. Even convincing them that the behavior is good may not move them to start practicing it.*
- *Competition is obvious in some arenas. For example, Pepsi knows that it must compete against Coke. In health promotion, we must also identify the competition—what other messages, signals, activities, and behaviors are competing for our audience members' attention, taking up their time, or are easier or more fun or more normal to do?*
- *We must look for where and how we can get the biggest bang for the buck—that is, where we can have the most impact. In the exercise example, we might have more success in getting the people who already exercise 1–2 times per week to exercise 4 times a week for 30 minutes at a time (our goal). That's because they are already part of the way to the goal. We would probably have to do a lot more to get the "never exercise" people to exercise 4 times per week.*
- *This activity highlights the value of doing **formative research**. We learned a lot about our community just by asking a few questions.*

11. Transition to the next activity by saying that now you will begin to select and describe priority and influencing groups.

Activity 2 Selecting Priority and Influencing Groups

45 minutes

LEARNING OBJECTIVES

By the end of this activity, participants should be able to:

1. Describe why it is important to focus on the points of view of the priority and influencing groups.
2. Describe a priority and influencing group in five ways.
3. Describe how priority and influencing group characteristics influence the choice of behavior change strategies.

Training Methods

Discussion

What Might Need Adaptation

- If participants are a small group that will work together to develop a behavior change strategy for one or two pre-determined priority groups, ensure that those are the groups used in the activities starting from now.

- Facilitators will need to decide how much time and emphasis to spend on influencing groups during this workshop and adjust the content appropriately. One might decide, for example, to have one case study group focus on a likely influencing group throughout this and the next several activities.

Supplies Needed

- HO – Five Ways to Describe Your Priority or Influencing Group (sample)
- HO – Five Ways to Describe Your Priority or Influencing Group (blank)

Preparation Needed

- Prepare flip chart with definitions of Priority Group and Influencing Group
- Prepare a flipchart of "Five Ways to Describe your Priority Group"
- Use clinic or community data to determine in advance what your likely priority and influencing groups might be (if this has not already been done).
- Prepare or designate participants to prepare a template (paper or flipchart) for the behavior change strategies they will develop from this step onward.

1. Pointing to the Behavior Change Strategy framework on the wall, tell participants that the next question is "Who are the priority and influencing groups?" Ask participants to define both terms. Refine their definitions as needed. Briefly review the definitions prepared on flip chart.

> TRAINERS NOTE
>
> *The **priority group** is the group we want to adopt the behavior. The **influencing group** consists of the people who will encourage or discourage adoption of the behavior by the priority group.*

2. Ask why it is important to distinguish between the priority group and influencing group when designing a behavior change strategy.

> TRAINERS NOTE
>
> - *These two groups tend to have different characteristics, so they might need to be approached differently.*
> - *You want different things from the two groups: you want the priority group to adopt the new behavior, while you want the influencing group to encourage them to do so or at least not get in the way of the priority group adopting the new behavior.*

3. Tell participants that the more specifically they can describe their priority and influencing groups, the more effectively they should be able to design their intervention. Point out that there are at least five categories of audience description, as shown on the handout, "Five Ways to Describe Your Priority Group." Distribute the handout and reveal the flipchart version. Ask a volunteer to read the definition for each category, and have another volunteer read the example. Ask them what questions they have. Explain that they will use a blank version of this tool to help organize what they know and find out about their priority group.
4. Now focus briefly on influencing groups. Point out that, while there might be many groups that influence the behavior of the priority group, they should focus efforts first on the one group that most directly influences the family planning behavior of the priority group and which exercises

"positive potential". Influencing groups with positive potential are those who are most likely to support, rather than prevent, adoption of family planning. Changing the mind and behavior of someone who is staunchly against family planning is usually much more difficult. It is often better to do that after the program has demonstrated some success in improving family planning use. They probably have a good idea of which groups [most] influence FP behavior, but they won't know for sure until they conduct research with the priority group.

5. Tell participants they will now work in case study groups to describe a priority group or influencing group with which they work, in as much detail as possible, using all five of the categories in the handout. They should consider **who they most want** to adopt FP behaviors. What are their characteristics? Then they will write a few lines that describe the implications that these characteristics have on the design of a behavior change strategy. They will continue to work with those same groups throughout the workshop, so they should choose groups that are truly relevant for their family planning work/programs.

TRAINERS NOTE

Use clinic or community data to determine in advance what your likely priority and influencing groups might be. You may choose to limit this exercise to one or two priority groups or include an influencing group as well. Limiting will allow you to focus the field practice and strategy development exercises. Also, the Doer/Non-Doer Survey will help clarify which influencing groups are most important for effecting FP behavior change.

6. Help them choose groups relevant to the family planning component of the program and show them an example:

Characteristic	**Priority Group**
1. Demographic Features	Urban men 18–25 years old, unemployed or with low-to-moderate income, living in the capital, speaking the national language and creole, 6th grade education
2. Common behaviors/practices	Frequent bars and have one or more sexual partners
3. Common desires	Good jobs; frequent sex; freedom of movement
4. Common obstacles	Do not see themselves at risk for potential negative consequences such as unwanted pregnancy, STIs, HIV/AIDS. Cannot afford to buy condoms regularly.
5. Stages of Change	Most aware that condoms are available to prevent pregnancy, STIs, HIV/AIDS. Few using condoms with regular or non-regular partners.

7. Distribute the handout "Five Ways to Describe Your Priority or Influencing Group (blank)" and give them ten minutes to work in their case study groups to define their priority or influencing group.
8. After ten minutes, bring the full group together and ask one person in each group to read aloud what they found.
9. Process by allowing the groups to comment on and improve one another's descriptions. Point out that, in practice, they will use research to further refine these.
10. Tell them to note their priority group in the framework their group to capture their strategy as the workshop proceeds.

11. Transition to the next activity by saying that now that they have identified their priority groups, they will learn to clearly define the behavior to be adopted.

Activity 3 Defining the Behavior You Will Promote

45 minutes

LEARNING OBJECTIVE

By the end of this activity, participants should be able to write at least two well-defined FP behavior statements.

Training Methods

Discussion, small group work

Supplies Needed

HO – Clearly Defining Behaviors

Preparation Needed

- Review the program's FP objectives. If participants come from different programs, ask them to bring a copy of their FP objectives.
- Prepare flipchart showing the elements of a well-defined behavior.
- Prepare flipchart with well-written and poorly-written behavior statements.

1. Tell participants we will begin by looking at the question, "How do we clearly state the behavior we want to promote?" Reveal the flipchart with the following description of a behavior statement and have a participant read it aloud:

   In order for us to develop a clearly focused strategy, we must first clearly define the behavior we want people to adopt. This means our behavior statements should include:
   - An **action** that is **observable**, **specific** (in time, place, quantity, duration, and/or frequency, as appropriate), **measurable**, **feasible**, and **directly linked to an improved outcome**.

> TRAINERS NOTE
>
> *Programs can decide how rigidly they want to stick to this way of defining behaviors, based on what they want to achieve through this brief training and how the FP program objectives are defined. The behaviors chosen should fit well with the existing FP objectives (or, if appropriate and feasible, the FP objectives could be more clearly defined).*

2. Discuss what each of the highlighted terms means.

TRAINERS NOTE

- ***Observable**: it can be seen in some way.*
- ***Specific**: details around it make it clear what is meant—what counts—so that very little is left to individual interpretation.*
- ***Measurable**: it can be counted.*
- ***Feasible**: it can be done with a reasonable amount of effort.*
- *"**Directly linked to an improved outcome**" refers to the need to focus on behaviors that will demonstrably and directly contribute to the program's FP objectives.*

3. Ask the group why it is important that we define a behavior very clearly.

TRAINERS NOTE

Defining the behavior clearly and specifically is critical so we can all agree on what change we are striving for, know how to plan to get people to make the change, and determine the extent to which the desired change has taken place.

4. Reveal the list of sample behaviors on a flipchart and ask if they are written in a way that would help lead us to a focused and effective behavior change strategy. Discuss why or why not.

Sample Behaviors

- Use family planning
- Practice safer sex
- Hand washing
- Show leadership
- Abstinence
- Condom use

TRAINERS NOTE

None of the behaviors as listed are specific or measurable enough to be useful in planning a behavior change strategy.

5. Give participants one example of a well-defined FP behavior and have them point out how it meets the criteria.

TRAINERS NOTE

Examples of well-defined FP behaviors

- *New mothers who choose Depo Provera return to the clinic six weeks after giving birth and then every three months for their next injection for at least one year.*
- *Women of reproductive age who are counseled about child spacing bring their husband to the clinic within four weeks of the counseling visit to learn about contraception and whether it is right for them as a couple.*
- *Women of reproductive age visiting the MCH clinic report they are currently using at least one [modern] family planning/pregnancy prevention method.*

6. Ask participants to choose one of the poorly defined behaviors from the earlier flipchart. Now ask how to make it a better-defined behavior. Start by asking how to make it observable (or one of the other criteria). Build from there to ensure it meets all five criteria.
7. Tell participants they will now work in their case study groups to write one clearly defined FP behavior statement. Each group should write a behavior for the priority group it chose earlier. Refer participants to their program's (or the MOH's) FP program objectives, asking them to define a behavior that is in line with those objectives. Explain that we will come back together as a large group to compare the behavior statements of each group and refine them as necessary. Tell them they have up to ten minutes for this task.
8. Check on their progress after five minutes. Give them additional time if needed. Then bring the full group back together.
9. As each group presents its behavior statement, lead a discussion of what they did well and what could be improved. Be sure to let the group do most of the commenting. Allow for around three minutes per statement, but do not waste time if any statements are fine as written. Have participants add their well-written behavior to their case study group's behavior change framework.
10. Highlight the following points, writing them on a flip chart.
    - While we want to improve knowledge and attitudes, people's actions are what count.
    - The behavior must be observable, measurable, context-specific, feasible, and contribute to a positive outcome.
    - We will use data to define what behavior we promote.
11. Distribute the handout "Clearly Defining Behaviors" so participants can refer to it when defining FP behaviors. Summarize this activity by saying that, in addition to know what behavior needs to be promoted, we must determine who are the priority and influencing groups that need to be reached.

Activity 4 Things that Drive Behavior

30 minutes

LEARNING OBJECTIVES

By the end of this activity, participants should be able to:

1. Describe what are "Things that drive behavior".
2. List the three most powerful things that drive behavior.

Training Methods

Discussion, brainstorm, and matching

What Might Need Adaptation

- If time and resources permit, facilitators may choose to present the full list of things that drive behavior. Add at least 20 minutes to this activity in that case. All are included in the long-form version of the Doer/Non-Doer survey questionnaire. If the long form is used, conducting the field practice and survey will also take longer.
- This module substitutes "Things that drive behavior" for the term "determinant" used in Barrier Analysis and elsewhere. Trainers can choose instead to use the term "determinant" Adapt handouts appropriately if "determinant" or alternatives will be used. What is important is that participants understand and can use the concepts.

Supplies Needed

HO – Things that Drive Behavior

Preparation Needed

Prepare flipchart with definitions of the things that drive behavior

1. Ask participants how they would normally develop strategies to help people adopt new behaviors. Note that many programs jump from the priority group and behavior straight to the activities, either without giving much thought to **why** people do or don't do certain things or **assuming they know** why people do what they do. In defining our priority groups, we may have already mentioned what we think we know about why people who want to space their children do not use family planning. These things might be based on anecdotal evidence (e.g., what we hear from our clients), but we do not actually know if they are the most important things that motivate or constrain most members of our priority groups.
2. Emphasize that one purpose of this workshop is to learn how to find out what is **really** driving our priority groups to use or not use FP, as opposed to relying on anecdotal information.
3. Remind participants of the "Exercise" Exercise. Ask those who do not exercise at all why they don't exercise. Point out that these are the kinds of things we want to find out from our priority groups (but specific to FP, of course).
4. Explain further that there are many theories that suggest reasons why people do and don't do things. For our purposes today, there are three main things that seem to be important in influencing many health behaviors.
5. These three are not always the answer, but they are almost always a good place to start if you have limited resources. These three things are "perceived consequences", "self-efficacy", and "perceived social norms".

TRAINERS NOTE

***Perceived Consequences**: What a person thinks will happen—positive or negative—as a result of practicing the behavior. (Will this be good for me? For my family?)*

***Self-Efficacy**: A person's belief that he or she can do a particular behavior—that she has the time, skills, and self-confidence to do it. The set of skills or abilities needed to perform a particular behavior. ("Can I do this? How difficult will it be for me?)*

***Perceived Social Norms**: The idea that people important to the primary target audience (primary group) think the group member(s) should do the behavior. (What will others in my community think if I do this?)*

6. Ask participants what they think each term means. Add to and clarify their explanations as necessary. You could start by asking what "perceived" means.
7. Explain that, while there are many other things that can drive behavior, we will focus on these three to develop our behavior change strategy for now.
8. Ask participants to think of something they do regularly and to write it in their notebook. It can be as simple as brushing their teeth every day or meeting friends at a bar after work. Ask three or four participants to read aloud what they wrote. From the examples given by participants, choose to further explore one that more participants are likely to be able to relate to.
9. Ask participants why they do this particular behavior, starting with the person who volunteered it. You need to get several different responses. Summarize responses on a flip chart.

10. Ask participants if anything on the list is a perceived consequence, i.e., something happens when they do it. Mark those with a "C".
11. Now ask if anything on the list reflects self-efficacy—the person's belief that he or she can do the behavior. Mark those with an "E".
12. Now ask if anything on the list relates to what society, peer groups, or others think about the behavior. Mark those with an "N".
13. If it is not likely to embarrass him or her, ask the participant who volunteered the behavior how important the "C", "E", and "N" reasons are to his adopting and maintaining the behavior—are any of them the most important reasons? The question can also be asked of the whole group.

> **TRAINERS NOTE**
>
> *Studies and experience show that directing efforts at what motivates behavior is an effective way of helping people change behavior. Neglecting the motivation often leads to very ineffective behavior change efforts. Next, we will discuss more specifically the next level of motivation: benefits and obstacles as related to the things that drive behavior.*
>
> *If time permits, trainers can continue this exercise with the full list of things that drive behavior to give participants experience with the concepts and show that not all are important for any given behavior.*

14. Highlight that, as noted earlier, these are often, but not always, the most important drivers of health behaviors. Ask participants why they would want to know about them before developing a behavior change strategy.
15. Distribute the handout "Things that Drive Behavior". Point out that the handout describes the three drivers discussed as well as several drivers that were not discussed but that can be important. Ask them to review the handout overnight and return in the morning with any questions they have about them.
16. Transition to the next activity by saying that now you will look within those things that drive behavior to identify more specifically what motivates or inhibits people's behavior.

Activity 5 Key Benefits and Obstacles

20 minutes

LEARNING OBJECTIVES

By the end of this activity, participants should be able to write benefit and obstacle statements.

Training Methods

Discussion

What Might Need Adaptation

Trainers can choose instead to follow the exercises and terminology in the DBC curricula, adapting the handouts appropriately. What is important is that participants understand and can use the concepts to identify appropriate behavior change activities.

Supplies Needed

Flipchart, markers, tape

Preparation Needed

Prepare flipchart with sample key benefits and obstacles associated with three drivers of MCH or FP behavior.

1. Tell participants that for each of the things that drive behavior, there are benefits that motivate people to adopt a behavior (in this case, family planning behaviors) and obstacles that prevent them from doing so. Emphasize that finding out what these key benefits and obstacles are is a crucial part of developing a family planning behavior change strategy.
2. Show the flip chart with a sample set of key benefits and obstacles. An oral rehydration therapy example is included here in case participants have experience with MCH but not FP.

Priority Group: Women of childbearing age with at least one living child		
Behavior: Taking oral contraceptives correctly and regularly for at least 18 months after childbirth		
Things that drive behavior:	***Key Benefits***	***Key Obstacles***
Perceived consequences	Mothers will be healthier. Children will grow better.	Some methods can cause weight gain.
Self-efficacy	Knows how to use the method correctly	Insufficient funds to pay for the FP method
Perceived social norms	Most people I know would approve of my spacing births	Health workers at the clinic think using FP is wrong.

Or:

Behavior: Correct administration of ORS whenever children under 5 have diarrhea		
Priority Group: Mothers of childbearing age with children under 5		
Things that drive behavior:	***Key Benefits***	***Key Obstacles***
Perceived consequences	Some mothers believe ORS can help their children feel better	Mothers-in-law would accuse mothers of rejecting traditional medicine
Self-efficacy	Mothers will find it easier to mix ORS if they are given a spoon and measuring cup	Most mothers do not know how to mix ORS properly
Perceived social norms	Most fathers approve of giving their children ORS.	Mothers-in-law do not value ORS for treating children's diarrhea

3. Using the priority group and behavior of one of the case study groups, ask participants to provide examples of possible key benefits and obstacles for each of the three main things that drive behavior. Write these in a table on flipchart, following the above examples.
4. Tell participants this exercise was just to get them familiar with the concepts of key benefits and obstacles and that they have now learned or reviewed six of the seven elements of their eventual behavior change strategy. In the next step, they will learn to conduct a Doer/Non-Doer Survey. If done well, this survey will reveal what the priority group sees as the key benefits and obstacles to using modern family planning methods. Participants will then use that information to design or choose activities that address the most important benefits and obstacles.

TRAINERS NOTE

If using the long-form survey, you will also discover what are the key things that drive the behavior of the priority group. These will be the ones where doers and non-doers differ most.

TA – Exercise Statements

Exercise Statement, Set 1

1. I know that getting exercise is very important. I have read many studies that prove it. I also have heard many advertisements promoting good health through exercise.
2. I believe exercise is very important. I think everyone should exercise regularly, at least 4 times per week.
3. Last week, I exercised 4 times, for 30 minutes each time.

Exercise Statement, Set 2

1. I have only heard that exercising can reduce your chances of heart disease.
2. I believe exercise is somewhat important; most people should exercise 1–2 times per week.
3. I exercised twice last week.

Exercise Statement, Set 3

1. I know that many people are in shape because they exercise, but I don't know what they do or how it helps them.
2. I think that we get enough exercise with the routine activities of the day.
3. I did not do any exercise last week.

H0 – Five Ways to Describe Your Priority or Influencing Group (sample)

The **priority group** is the people you want to do the behavior. The influencing group is the people that most directly influence the action of the priority group. There might be many people we would like to influence, such as CHWs and nurses, but we need to prioritize the one or two that will have the most direct and positive influence on the priority group (for example, husbands and mothers-in-law). Selection of the influencing group should also be based on positive potential—choosing those who already support the behavior or who are likely to become supportive should be the first choice.

1. Demographic features
2. Something most group members **do**
3. Something most group members **want**
4. Something that keeps the group from doing the desired behavior
5. Readiness to adopt the new behavior (Stage of Change)

Sample Description of Priority Group: Rural Mayan women 18–38 years old

1. Demographic features—age, income, residence, skill set, language, education level, etc.:	*18–38 years old; live in Huehuetenango; majority are non-literate; one-third work outside the community; 20 are single*
2. Things that members of the priority group do—common behaviors, practices:	*Give foods to babies from 6 months of age; breastfeed; give bottle; majority attend IMCI Counseling sessions*
3. Things that members of the priority group want—common desires:	*Healthy children; better homes; education for their children; good source of income*
4. Things that prevent members of the priority group from doing the desired behavior—common obstacles:	*Work outside the home; incorrect information about ideal practices; limited time; too many children too closely spaced*
5. Stages of Change—common levels of readiness: pre-awareness, awareness, decision-making, action, maintenance:	*Awareness/contemplation about giving their babies only breast milk for the first 6 months*

Adapted from *Designing for Behavior Change*, CORE Group, 2008

HO – Five Ways to Describe Your Priority or Influencing Group (blank)

Priority or Influencing Group (circle one):

1. Demographic features—age, income, residence, skill set, language, education level, etc.:	
2. Things that members of the priority group do—common behaviors, practices:	
3. Things that members of the priority group want—common desires:	
4. Things that prevent members of the priority group from doing the desired behavior—common obstacles:	
5. Stages of Change—common levels of readiness: pre-awareness, awareness, decision-making, action, maintenance:	

Adapted from *Designing for Behavior Change*, CORE Group, 2008

HO – Clearly Defining Behaviors

In order for us to develop a clearly focused strategy, we must first clearly define the behavior we want people to adopt. This means our behavior statements should include:

An **action** that is **observable**, **specific** (in time, place, quantity, duration, and/or frequency, as appropriate), **measurable**, **feasible**, and **directly linked to an improved outcome**

- **Observable**: can be seen
- **Specific**: limits the scope of the action by saying when, where, how many, how long, or how often it should take place
- **Measurable**: can be counted in some way
- **Feasible**: can reasonably be done by the person or people you want to do it
- **Directly linked to an improved outcome**: doing it will demonstrably and directly contribute to the program's FP objectives

Defining the behavior clearly and specifically is critical so we can all agree on what change we are striving for, know how to plan to get people to make the change, and determine the extent to which the desired change has taken place.

Examples of well-defined FP behaviors:

- New mothers who choose to use Depo Provera return to the clinic six weeks after giving birth and then every three months for their next Depo injection for at least one year.
- Women of reproductive age who are counseled about child spacing bring their husband to the clinic within four weeks of the counseling visit to learn about contraception and whether it is right for them as a couple.
- Women of reproductive age visiting the MCH clinic report they are currently using at least one [modern] family planning/pregnancy prevention methods.

Key Points:

- While we want to increase knowledge and improve attitudes, people's actions are what count.
- The behavior must be observable, measurable, context-specific, feasible, and contribute to a positive outcome.
- We will use data to define what behavior we promote.

HO –Things that Drive Behavior

The three main things that typically influence behavior change:

Perceived Self-efficacy, Skills: an individual's belief that he or she can do a particular behavior; the set of skills or abilities necessary to perform a particular behavior (e.g. women believe they can put condoms on their partner correctly).

Perceived Social Norms: perception that people important to an individual think that s/he should do the behavior; norms have two parts: who matters most to the person on a particular issue, and what s/he perceives those people think s/he should do (e.g. young mothers in Community X think that their in-laws are against using FP).

Perceived Positive or Negative Consequences: what a person thinks will happen, either positive or negative, as a result of performing a behavior (e.g. women in Community Y think that their husbands will beat them if they use contraception).

Other things that can influence behavior change:

Perceived Action Efficacy: belief that the action is actually effective in addressing the problem (e.g. a mother's belief that using contraceptives will be effective in preventing pregnancies).

Access: The degree of availability (to a particular audience) of the needed products (e.g., OCs, IUD, condoms) or services (e.g., counseling, pregnancy testing) required to adopt a given behavior. Access includes the audience's comfort level in going to get the products or using the service. For example, having condoms available at many pharmacies can increase access for women who want to use them, but having them behind a counter so that the woman must ask for them can decrease access.

Perceived Enablers: Things that make it easier to perform a given behavior. Example: Many women using an injectable contraceptive like that they only need to get injected once every two or three months (depending on the type).

Perceived Barriers: Things that make it more difficult to perform a given behavior. Cost can be seen by couples as a barrier to using OCs if they are poor and would have to buy a new packet of pills every 28 days.

Cues for Action / Reminders: The presence of reminders that help a person to remember to do a particular behavior or remember the steps involved in doing the behavior. One example is a woman putting her OC packet some place where she knows that she will look each day around the same time. Another is a project in India that is testing the use of a daily text message (SMS) reminder to women using CycleBeads to estimate the days they are at risk of becoming pregnant if they have sex. Cues for action also include powerful events that triggered a behavior change in a person (e.g., "my sister-in-law died in childbirth after her eighth pregnancy in seven years").

Perceived Susceptibility (together with Perceived Severity, this is sometimes referred to as Perceived Risk): How vulnerable a person feels to the problem the new behavior seeks to avoid. In family planning, does the woman/man/couple feel pregnancy is likely if they don't use contraception?

Perceived Severity: Belief that the problem (which the behavior can prevent) is serious. In family planning, does a woman/man/couple think it would be a bad or very bad thing for pregnancy to occur in the near future? (Perceived severity is related to perceived consequences.)

Perception of Divine Will: a person's belief that it is God's will or the gods' will for her or him to have the problem or to overcome it. In some families, religions, or cultures, people believe that whether or not (and when) a woman gets pregnant is for God to decide, not them.

Policy: laws and regulations that affect behaviors and access to products and services. For example, modern contraceptive methods might be illegal to sell in countries with pro-natalist laws and policies, or women might not be able to get family planning services unless accompanied by their husband. Policy often affects "enablers," things that make it easier to do a behavior.

Culture: the set of history, customs, lifestyles, values and practices within a self-defined group. May be associated with ethnicity or with lifestyle. Some ethnic groups, for example, count their wealth by the number of children they have—the more children they, the wealthier they are. Culture often influences perceived social norms.

This handout is adapted from materials originally developed by AED, the Food for the Hungry Barrier Analysis manual, the 2008 Designing for Behavior Change Curriculum, and the November 2011 Designing for Behavior Change for Agriculture, Natural Resource Management, Health, and Nutrition curriculum.

STEP 4

Learn More about the Priority Group and Influencing Group

Total Suggested Time
90–120 minutes

We know a lot about the groups to whom we provide health care, but we often don't know everything we need to know about what motivates them to adopt a particular behavior and what are the most important obstacles to behavior change. In this step, we learn about one way to discover these things about our priority groups. We also adapt a questionnaire that will help us get the information we need to develop a targeted, evidence-based behavior change strategy.

LEARNING OBJECTIVES

By the end of this step, participants should have or be able to:

1. Describe the purpose of Doer/Non-Doer Analysis.
2. Cite the main reason it is necessary to interview at least 45 doers and at least 45 non-doers for Doer/Non-Doer analysis.
3. Adapt the Doer/Non-Doer survey questionnaire to their priority group and desired behavior.
4. Describe the type of information each question is designed to get.

Supplies Needed

- Flipchart, markers, tape
- TA – Types of Formative Research
- HO – Accessing Existing FP Research (optional)
- Activity – Getting Access to Existing Research (optional)
- HO – Doer/Non-Doer Survey Questionnaire
- HO – Long-Form Doer/Non-Doer Survey Questionnaire (optional)
- TA – Doer/Non-Doer Survey Questionnaire Instructions

Preparation Needed

- Review TA – Types of Formative Research.
- Decide whether to use the short or long-form survey questionnaire. The long-form questionnaire will get more information but takes longer to administer. The shorter questionnaire will only get information about three drivers of behavior. These are often but not always the most important ones. Using this version might cause you to miss what are really the most important drivers for your priority group.
- Become very familiar with the questionnaire and the instructions for completing it.
- If there is more than one priority group or behavior, decide on just one to use for now.
- If photocopying is easily available, just make enough copies for each participant to get one. Then make copies of the revised questionnaire in time for the role play and field test.

- Establish a system for ensuring respondent confidentiality. Consider where completed questionnaires will be stored during and after the survey, for example. Also consider removing respondent names once surveys have been reviewed and verified.

Activity 1 Doer/Non-Doer Analysis Overview

45–60 minutes

LEARNING OBJECTIVES

By the end of this activity, participants should be able to:

1. Describe the purpose of Doer/Non-Doer Analysis.
2. Cite the main reason it is necessary to interview at least 45 doers and at least 45 non-doers.

Training Methods

Discussion, mini-lecture

Supplies Needed

TA – Types of Formative Research

HO – Accessing Existing FP Research (optional)

Activity – Getting Access to Existing Research (optional)

Preparation Needed

Review TA – Types of Formative Research to ensure enough familiarity to engage participants in the discussion. This TA includes information on how to access existing research and an optional training module that can be used if appropriate.

1. Explain to participants that it is important to gather information to describe the priority groups in detail and to look at everything from their perspective instead of your own. Ask why this is important, and what would happen if we didn't.

> TRAINERS NOTE
>
> *Some possible responses include:*
>
> - *We might find out too late that our assumptions were wrong, wasting time and money on ineffective strategies.*
> - *If we don't consider things from their perspective, we won't be able to motivate them toward adoption of family planning.*
> - *Even if we come from the same place as our priority and influencing groups, we might have experienced things that make us see things quite differently.*

2. Ask what are some types of research that could be done to learn more about the priority group. Encourage them to say what they know about each type of research and whether they have participated in any formative research as a respondent or interviewer.

TRAINERS NOTE

These might include surveys, key informant interviews, focus group discussions, doer/non-doer surveys, and barrier analysis, among others.

3. Explain that the Doer/Non-Doer Survey helps get specific input from the priority group about things that drive their behavior. It is easy to do, requires small non-random samples (45 doers and 45 non-doers), and helps us see beyond our assumptions about why the priority group does or does not practice a desired behavior. It is a good way to get in-depth information about the priority and influencing groups in order to develop a targeted behavior change strategy.
4. Remind participants of the "Exercise" Exercise. There were people who exercised regularly and people who didn't. Why might it be useful to know about differences between those two groups? Ask participants what might we learn by looking at these groups separately.
5. Note that it is important to have some knowledge about the priority group and behavior in order to develop an effective Doer/Non-Doer survey. Ask how they have already learned things about their priority and influencing groups.

TRAINERS NOTE

Some possibilities include:

- *Through interactions with them when they seek services*
- *Have seen or been briefed on KAP surveys or FGDs done to get in-depth information about them*
- *Looking at service statistics/clinic records*

6. The Doer/Non-Doer survey should help us decide which of the many factors affecting family planning behavior are the most important to target in our efforts. It should help us develop activities and messages that help reduce obstacles to family planning adoption and emphasize what our audiences see as the key benefits of adopting family planning.
7. Explain that in Doer/Non-Doer analysis we systematically compare people who "do" a particular behavior (doers) with those who don't do the behavior (non-doers) among our priority group. We can then focus our efforts on the biggest differences between them. If we can effectively address those differences, we are more likely to help people who want to space or limit births to adopt effective family planning methods.
8. Emphasize that some of the differences we find won't be true differences. The more doers and non-doers we interview, the more likely it is that the differences we find will be real and meaningful. Statistics and experience show that we must interview at least 45 doers and 45 non-doers in the priority group in order to have confidence in the findings. If we interview fewer than that, any differences we find could be due to pure chance. (Even with 45 doers and 45 non-doers, differences of less than 15% might not be true differences.) A behavior change strategy or activities based on those findings would have a good chance of failing to achieve the desired level of behavior change.
9. Ask if participants have any questions so far, or anything to add based on their own experience with trying to help people adopt new behaviors. Why do they think Doer/Non-Doer analysis could be useful?
10. Transition to the next step by saying that, now that the group understands what Doer/Non-Doer analysis is, they will adapt a questionnaire for a Doer/Non-Doer survey on family planning use.

Activity 2 Adapting the Doer/Non-Doer Survey Questionnaire

45–60 minutes

Now we adapt a survey questionnaire that will help us get the information we need to develop a targeted, evidence-based behavior change strategy.

LEARNING OBJECTIVES

By the end of this activity, participants should:

1. Have adapted the Doer/Non-Doer survey questionnaire to their priority group and desired behavior.
2. Be able to describe the type of information each question is designed to get.

Training Methods

Discussion

What Might Need Adaptation

- Facilitators or program managers might choose to adapt the survey in advance, making further changes as needed during the review with participants. Make any changes you feel are necessary before photocopying the questionnaire for the participants.
- If the questionnaire will be administered in a language other than the version being distributed, allow extra time for participants to say and discuss how they will translate each question during the actual interviews. This will help ensure consistency across interviewers and also help identify any misunderstanding of the meaning or intent of questions.

Supplies Needed

- Flipchart, markers, tape
- HO – Doer/Non-Doer Survey Questionnaire
- HO – Long Form Doer/Non-Doer Survey Questionnaire (optional)
- TA – Doer/Non-Doer Survey Questionnaire Instructions

Preparation Needed

- Decide whether to use the short or long-form survey questionnaire. The long-form questionnaire will get more information but takes longer to administer. The shorter questionnaire will only get information about three drivers of behavior. These are often but not always the most important ones. Using this version might cause you to miss what are really the most important drivers for your priority group.
- Become very familiar with the questionnaire and the instructions for completing it.
- If there is more than one priority group or behavior, decide on just one to use for now.
- If photocopying is easily available, just make enough copies for each participant to get one. Then make copies of the revised questionnaire in time for the role play and field test.
- Establish a system for ensuring respondent confidentiality. Consider where completed questionnaires will be stored during and after the survey, for example. Also consider removing respondent names once surveys have been reviewed and verified.

1. Explain that participants will now adapt a Doer/Non-Doer questionnaire to one priority group and behavior. Say which group and behavior you have chosen, or choose with participants. Distribute the short or long-form Doer/Non-Doer questionnaire.
2. Review the top part of the questionnaire, instructing participants on how to complete it and verifying what they understand. Adapt the introduction as needed to improve clarity and relevance. Ask why confidentiality is important and what you and they will do to ensure the confidentiality is maintained.
3. Explain that the first two questions will allow us to distinguish doers from non-doers. Remind participants that we determine this based on the **behavior** on which we have decided to focus.
4. Have a volunteer read the behavior questions. Work with participants to refine them as needed. You should be satisfied that the questions agreed on will (1) be understood by respondents and (2) separate users of modern FP from non-users. ("Non-users" includes those who use traditional methods.) Ensure participants write the final questions on their questionnaire.
5. Explain to participants that the rest of the questions are designed to help them discover what motivates and stands in the way of respondents' use of modern family planning. Tell them the questions are organized around the drivers of behavior.
6. Allowing participants to take turns reading the questions aloud, work with them to review and refine each question. Ask for suggestions on how to improve wording in order to get accurate, helpful responses. Adjust the order of the questions as needed to improve the flow of the questionnaire. As you come to each driver of behavior, ask what it means and why it is important to find out where the doers and non-doers stand on it.
7. If possible, have the changes input and print/copy enough of the revised questionnaire to use for the role plays (1 per participant) and field test (2–3 per participant).
8. Transition to the next step by saying participants will practice using the questionnaire through role plays. Tell them they will have the chance to make further improvements to the survey based on their role play experience.

TRAINERS NOTE

As participants role-play using the questionnaire, they will likely identify the need for additional improvements. Participants can make the corrections on the copies of the questionnaire they were given.

TA – Types of Formative Research

This list is not meant to be exhaustive. It defines and explains a few research methodologies that can be used to inform the development of messages, activities, or strategies.

Focus Group Discussion (FGD). A focus group discussion is an in-depth discussion in which a small number of people, usually eight to ten, under the guidance of a facilitator, talk about topics that are of popular importance to a forthcoming project or activity. Participants in each FGD are chosen from a single target group whose opinions, ideas, and beliefs about the topic(s) being researched are of interest to the person(s) who commissioned the research. The focus group technique is a qualitative social science research method that was popularized by commercial market research organizations. It has been employed successfully in health and family planning research in many developing countries. FGDs emphasize understanding the participant's perspective. They are helpful in answering questions of "how," and in particular "why," people behave as they do. They capitalize on group dynamics by encouraging members of the group to build on ideas generated by co-participants. FGDs are also characterized by extensive probing and open-ended questions that go beyond superficial responses and focus on participants' feelings and firmly held beliefs. They are useful for finding out how to design and implement projects and programs that will meet the expressed needs of the target population(s).

In-Depth Interview. In-depth interviews are a direct, face-to-face probing technique used to gather information from individuals instead of groups. There arc different kinds of in-depth interviews. ln open-ended interviews the interviewer uses an interview schedule with no fixed response categories. This allows the interviewer to ask questions based on his or her knowledge and the flow of the interview. In the questionnaire-administered interview, the interview follows a set of prepared questions that may have prearranged way to code answers and follows the questionnaire format to gather the information. In-depth interviews may be used alone, in combination with other qualitative or quantitative techniques, or as part of another qualitative technique, e.g., participant observation.

Extensive probing and open-ended questions characterize both FGDs and individual in-depth interviews. However, they also differ in certain aspects. In-depth interviews are conducted on a one-to-one basis. In-depth interviews should present a more complete picture of the individual than when he/she is in a group. A series of individual in-depth interviews is time-consuming and may be more expensive than FGDS.

As is true for FGDs, the information collected through in-depth interviews can provide feedback to the interviewer/implement or plan, monitor, and evaluate programs, and can help in the interpretation of available quantitative data. As in all interviews, the interviewer and the respondent structure in-depth interviews.

Participant Observation. The participant observer lives in the community he or she studies and immerses him or herself in the lives of the people he/she studies, while systematically studying their culture. In this way, participant observation provides a holistic view of the culture of the study population. Participant observation incorporates many different research techniques. A few examples include in-depth interviews, observation of behavior, network analysis, (to discover who knows who and how often they interact, as well as who are the gate-keepers (i.e., locally or nationally influential people), casual conversations, or informal interviews. In participant observation, the researcher goes to the study community (whether that is a region of a country, a village, an urban neighborhood or, the catchment area of a clinic) and lives in or near the study site. The participant observer approaches the study site as a social system, revealing factors that influence the subject under research but would not be readily apparent through any other means of research. The researcher observes and records these factors, and notes their interaction with other variables and significance in influencing the research topic.

Behavior Observation. Behavior observation is data collection by viewing, recording, and analyzing behavior according to predetermined behavioral categories. Behavior observations may be conducted in a community, region of the country, village, urban neighborhood, or clinic. Because observation research allows the researcher to study behavior in its natural setting, it may provide a more in-depth understanding of behavior than quantitative research techniques or qualitative techniques that assess behavior through self-reports, such as FGDs or in-depth interviews, Behavior observations focus on discreet behaviors or activities. The researcher observes behavior by using checklists and guidelines that categorize the behavior under observation. Behavior observations are usually conducted in specified time periods, e.g., five minutes, and are subjective.

Exit Interviews. This is a face-to-face or one-on-one, interview between an interviewer and a client to assess if the client's needs have been met or if program objectives are being met. For example, in the health sciences one can have an exit interview with the client after the client has visited a service center and received some form of service. This is an after-effect technique which means it occurs after an activity has taken place. It is the reconstruction of the scene. The client may be asked to recall his or her experiences.

Information collected from the clients provides feedback to the program implementer, who uses it to improve or change services or interventions.

From *Qualitative Research for Program Development*, PATH/World Bank, 1990.

HO – Accessing Existing FP Research (optional)

Quite often, someone has already done relevant research on your target audience(s) and/or behavior. What they found out can be useful in your own research or help you reduce the amount of research you have to do to develop your FP behavior change strategy. To get this information, ask people who might have done it or know about it or know someone who might know about it.

Potential Sources of Existing FP Research

- Your own organization—research they have done in the past; reports they got from other organizations; research they might have forgotten was done
- Online search using Google, Yahoo, or Bing. Possible search terms:
  - » family planning attitudes and use in [country]
  - » perceptions of modern contraceptive methods in [country]
  - » family planning knowledge, attitudes, practices in [country]
  - » male involvement in family planning in [country]
  - » family planning demand study [country]
  - » expanding family planning services in [country]
  - » Obstacles to family planning in [country]
- Web sites of groups that address FP/RH: www.coregroup.org , www.k4health.org, www.unfpa.org, www.unicef.org, www.worldbank.org, www.usaid.gov, US & EU based NGOs (www.guttmacher.org, www.fhi.org, www.jsi.coml, www.popcouncil.org, www.jhuccp.org, www.jhpiego.org, www.path.org, www.irh.org, www.intrahealth.org, www.cedpa.org, www.care.org, www.c-changeprogram.org). ***Even if you don't find a report online, you might find descriptions of programs that are relevant. You can then ask the organization for a report, executive summary or key findings of the research done to inform the program design.*** Explain that you are trying to avoid "reinventing the wheel" and would like your community to benefit from what that organization has already done.
- NGOs working in this country or neighboring countries
- Research groups/agencies in your country, including universities
- USAID mission (Health and Population division)
- MOH (department of FP/RH, M&E, women, population/demography, etc.)
- US and EU-funded NGOs (via email to a specific person or their general inquiry mailbox)

Once you find any reports, review them to see if they cover topics of interest, such as reasons for using or not using family planning, preferred methods and reasons for those preferences, etc. Scan the table of contents to see where you might find useful information. Always read the executive summary and key findings.

Things to consider when deciding how much can rely on the research:

- the experience of those conducting the research
- how many respondents there were
- what regions, languages, and ethnic groups are represented in the study
- whether the questions asked or topics covered make sense for what you need to do
- whether counterintuitive findings are well-explained
- how the findings have been used and, if known, to what effect

Keep in mind, you might have to be persistent, ask a lot of questions, and ensure confidentiality to get what you need. If you find an article online and need a subscription to download it, ask others, especially the MOH and donor/partner organizations, if they can get the article for you.

Activity – Getting Access to Existing Research (optional)

Suggested Time

20–30 minutes

Learning Objectives

By the end of this activity, participants should be able to cite at least two places to find existing research and say how they will get access to it.

Training Methods

Mini-lecture, discussion, role play

What Might Need Adaptation

If you omit Activity 1, Types of Formative Research, begin this activity by asking why it is important to get and do research on priority groups before designing a strategy to help them adopt new behaviors.

Supplies Needed

FP-related studies to show as examples

Preparation Needed

Inform yourself about family planning research already done in the country or service area. Ask colleagues for sources and contacts, and try to gather and review whatever reports or data you can from the country, region, or locale where the participants' research will take place. As relevant and as time permits, inject that experience into the discussion of how easy or difficult it is to get information and how to assess the information.

1. Mini-lecture: Tell participants that, quite often, someone has already done relevant research on the priority and influencing groups. You should try to get this information to inform your own research. You might find that you have to ask fewer questions or different questions based on what the existing research shows. For example, perhaps the MOH has already done or commissioned a family planning demand study. That study shows that, despite low CYP (the estimated protection provided by contraceptive methods during a one-year period, based upon the volume of all contraceptives sold or distributed free of charge to clients during that period[1]), a large percentage of women want to space births but fear modern family planning methods. If you know this, you can decide to spend just a little time confirming this finding and focus your interview questions to find out what makes them afraid (lack of information? Rumors? Mistrust?) and what it would take to overcome their fears (talking with women who have successfully used modern methods, learning how the method works, being helped by a counselor who is sympathetic and trustworthy).

2. Ask participants what are some ways they can find out what research already exists. Also get them to discuss what they will have to do to gain access to the findings, especially if whoever did or funded the research doesn't want to share it.

1 USAID, http://www.usaid.gov/our_work/global_health/pop/techareas/cyp.html

TRAINERS NOTE

Some possibilities include:

- *Look into and ask about what your own organization has or has access to, including the country's latest Demographic and Health Survey (DHS) or similar study report*
- *Online search (Google/Yahoo/Bing, CORE Group, K4 Health, UNFPA, UNICEF, WB, USAID, US & EU based NGOs)*
- *Ask NGOs working in your country or neighboring countries*
- *Ask research groups/agencies in your country*
- *Ask USAID mission*
- *Ask MOH*
- *Ask US and EU-funded NGOs*

3. If time permits, have two participants role play asking someone from the MOH or USAID for access to studies that already exist. Process by asking what they found easy to do, what was difficult, and how they could improve their chances of getting what they need.

4. Now ask what they will do with the studies/reports once they have them. Where will they look for the specific information they need? How will they determine if the findings are valid or useful?

TRAINERS NOTE

To assess existing research, it helps to consider:

- *The experience of those conducting the research*
- *The number of respondents*
- *Whether the questions asked or topics covered make sense for what you need to do*
- *Whether counterintuitive findings are well-explained*
- *How the findings have been used and, if known, to what effect*
- *Whether the questions asked or topics covered make sense for what you need to do*
- *Whether counterintuitive findings are well-explained*
- *How the findings have been used and, if known, to what effect*

5. Option: Briefly present and discuss any family planning research you found. Send participants home with the information or summaries to identify useful information about their priority and influencing groups. The research should help identify what types of information participants still need to get in order to develop their behavior change strategies. Do the findings raise questions that can be answered through a Doer/Non-Doer survey? Should any of the findings be confirmed through the Doer/Non-Doer survey? What doesn't need to be asked because existing research provides reliable answers?

6. End this activity by asking participants to name one person or organization from whom they will seek current studies on FP KAP conducted in your country or region. Ensure that a variety of responses is given.

TRAINERS NOTE

Examples include:

- *Ask the director and staff of my own organization*
- *Ask NGOs working in your country or neighboring countries*
- *Ask research groups/agencies in your country*
- *Ask USAID mission*
- *Ask MOH*
- *Ask US and EU-funded NGOs*
- *Perform an internet search using the key words: family planning practices in [country name]*
- *Ask a friend or colleague to perform the search for you if you do not have Internet.*

7. Praise participants for their participation and great ideas. Distribute the handout "Getting and Using Existing Research" for participants to read on their own. Transition to the next topic by saying that they will now learn a method for conducting their own research.

HO – Doer/Non-Doer Survey Questionnaire

GROUP: ❑ Doer ❑ Non-Doer

DOER/NON-DOER QUESTIONNAIRE ON MODERN FAMILY PLANNING FOR WOMEN OF CHILDBEARING AGE

Interviewer's Name: _____ Questionnaire Number: _____

Who was interviewed: _____

Date: _____/_____/_____ Community: _____

Interviewee's Mother Tongue: _____ Language of Interview: _____

Age of respondent: _____ years Gender of Respondent: ❑ Male ❑ Female

Introduction, purpose, CONFIDENTIALITY

Hello, my name is _____, and I work for _____. We are conducting a survey with women so that we can improve family planning services. Everything you say will be held in strictest confidence and will not be shared. You can choose to participate in the survey, or you can refuse. No services will be withheld nor will you be discriminated against if you choose not to participate. They survey should take around 20 minutes. Do you wish to participate in the survey?
_____ Yes _____ No

If the person does not want to participate, thank them for their time. If the person is willing to participate, acknowledge their acceptance (for example: "Great" or Thank you"), ask and record their name, community where they live, mother tongue, age, and gender. Record these in the space provided above. Then proceed with the questions below.

(Screening Questions)

1. Are you doing anything to avoid or delay pregnancy?
   - ❑ a. Yes
   - ❑ b. No
   - ❑ q c. Don't know / Won't say

Note: For the next question, if respondent is pregnant but did something to space/delay before becoming pregnant and plans to space/delay again after giving birth, ask what method she **used** instead of what she is using.

(IF trying to space, delay, or avoid pregnancy, ASK:)

2. What are you doing? [What method are you using to avoid pregnancy?]
   - ❑ a. Oral contraceptive ("Pill")
   - ❑ b. Mini-pill
   - ❑ c. Injectable
   - ❑ d. Male condom
   - ❑ e. Female condom
   - ❑ f. IUD
   - ❑ g. Implants
   - ❑ h. Standard Days Method

❑ i. LAM (exclusive breastfeeding on demand)
❑ j. Female sterilization (tubal ligation or other)
❑ k. Male sterilization (vasectomy)
❑ l. Emergency contraception
❑ m. Abstinence
❑ n. Breastfeeding
❑ o. Calendar/Rhythm method
❑ p. Withdrawal
❑ q. Other traditional method (list) _____
_____

❑ Modern method	❑ Traditional Method

- **If #1 = Yes AND the person is using a modern contraceptive, mark the respondent as a DOER at the top of page one.**
- **If #1 is No or Don't Know / Won't Say OR if the person uses a traditional method, mark the respondent as a NON-DOER at the top of page one.**
- **If more than one method was used, ask why they switched or why they are using more than one, as appropriate. Note below.**

(Positive and Negative Consequences)

3. What are the **advantages** of (or would be the advantages of) your using family planning over the next 12 months? ***(Write all responses below.)***

4. What are the **disadvantages** of (or would be the disadvantages of) your using family planning over the next 12 months? ***(Write all responses below.)***

(Perceived Self Efficacy)

5. With your present knowledge and skills, do you think that you could use family planning over the next 12 months?
   ❑ a. Yes
   ❑ b. Possibly
   ❑ c. No
   ❑ d. Don't Know

6. What makes it **easy** (or would make it easier) for you to use family planning over the next 12 months? ***(Write all responses below.)***

7. What makes it **difficult** (or would make it difficult) for you to use family planning over the next 12 months?
(Write all responses below.)

(Perceived Social Norms)

8. Would most of the people that you know approve of your using family planning over the next 12 months?
   - ❑ a. Yes
   - ❑ b. Possibly
   - ❑ c. No
   - ❑ d. Don't Know

9. Who are the people that **would approve** of your using a contraceptive over the next 12 months?
(Write all responses below.)

10. Who are the people that **would disapprove** of your using family planning over the next 12 months?
(Write all responses below.)

THANK THE RESPONDENT FOR HER OR HIS TIME! THEN ASK:

DO YOU HAVE ANY QUESTIONS FOR ME?

Adapted from *The Care Group Approach: Health Promotion and Behavior Change Through A Sustainable Community Based Strategy*, Rachelle St. Onge, Peace Corps Benin Health Sector, 2010

HO – Long-Form Doer/Non-Doer Survey Questionnaire (optional)

GROUP: ❑ Doer ❑ Non-Doer

DOER/NON-DOER QUESTIONNAIRE ON MODERN FAMILY PLANNING:
WOMEN OF CHILDBEARING AGE WITH AT LEAST ONE LIVING CHILD

Interviewer's Name: _____ Questionnaire Number: _____

Who was interviewed: _____

Date: _____/_____/_____ Community: _____

Interviewee's Mother Tongue: _____ Language of Interview: _____

Age of respondent: _____ years Gender of Respondent: ❑ Male ❑ Female

Introduction, purpose, CONFIDENTIALITY

Hello, my name is _____, and I work for _____. We are conducting a survey with women so that we can improve family planning services. Everything you say will be held in strictest confidence and will not be shared. You can choose to participate in the survey, or you can refuse. No services will be withheld nor will you be discriminated against if you choose not to participate. They survey should take around 20 minutes. Do you wish to participate in the survey?
_____ Yes _____ No

If the person does not want to participate, thank them for their time. If the person is willing to participate, acknowledge their acceptance (for example: "Great" or Thank you"), ask and record their name, community where they live, mother tongue, age, and gender. Record these in the space provided above. Then proceed with the questions below.

(Doer/Non-Doer Screening Questions)

1. Are you doing anything to avoid or delay pregnancy?
   - ❑ a. Yes
   - ❑ b. No
   - ❑ c. Don't know / Won't say

Note: For the next question, if respondent is pregnant but did something to space/delay before becoming pregnant and plans to space/delay again after giving birth, ask what method she **used** instead of what she is using.

(If trying to space births or to delay or avoid pregnancy, ASK:)

2. What method are you using to avoid pregnancy? (Check the specific method. If it is a modern contraceptive, also check "Modern FP Method." If not, also check "Traditional Method.")
   - ❑ a. Combined oral contraceptive (pill, COC, OC)
   - ❑ b. Mini-pill
   - ❑ c. Injectable
   - ❑ d. Male condom
   - ❑ e. Female condom
   - ❑ f. IUD
   - ❑ g. Implants
   - ❑ h. Standard Days Method

❑ i. LAM (exclusive breastfeeding on demand)
❑ j. Female sterilization (tubal ligation or other)
❑ k. Male sterilization (vasectomy)
❑ l. Emergency contraception
❑ m. Abstinence
❑ n. Breastfeeding
❑ o. Calendar/Rhythm method
❑ p. Withdrawal
❑ q. Other traditional method (list) _____
_____

❑ Modern method ❑ Traditional Method

- **If #1 = Yes AND the person is using a modern contraceptive, mark the respondent as a DOER at the top of page one.**
- **If #1 is No or Don't Know / Won't Say OR if the person uses a traditional method, mark the respondent as a NON-DOER at the top of page one.**
- **If more than one method was used, ask why they switched or why they are using more than one, as appropriate. Note below.**

(Positive and Negative Consequences)

3. What are the **advantages** of (or would be the advantages of) your using family planning over the next 12 months? ***(Write all responses below.)***

4. What are the **disadvantages** of (or would be the disadvantages of) your using family planning over the next 12 months? ***(Write all responses below.)***

(Perceived Self Efficacy)

5. With your present knowledge and skills, do you think that you could use family planning over the next 12 months?
❑ a. Yes
❑ b. Possibly
❑ c. No
❑ d. Don't Know

6. What makes it **easy** (or would make it easier) for you to use family planning over the next 12 months? ***(Write all responses below.)***

7. What makes it **difficult** (or would make it difficult) for you to use family planning over the next 12 months? ***(Write all responses below.)***

(Perceived Social Norms)

8. Would most of the people that you know approve of your using family planning over the next 12 months?
❑ a. Yes
❑ b. Possibly
❑ c. No
❑ d. Don't Know

9. Who are the people that **would approve** of your using a contraceptive over the next 12 months? ***(Write all responses below.)***

10. Who are the people that **would disapprove** of your using family planning over the next 12 months? ***(Write all responses below.)***

(Perceived Action Efficacy)

11. Do you think that if you use family planning you could space or prevent a next pregnancy?
    - ❑ a. Yes
    - ❑ b. Possibly/Sometimes
    - ❑ c. No
    - ❑ d. Don't Know

(Access)

12. Is it difficult to find contraceptives?
    - ❑ a. Yes
    - ❑ b. Possibly/Sometimes
    - ❑ c. No
    - ❑ d. Don't Know

13. How difficult is it to find contraceptives?
    - ❑ a. Very difficult
    - ❑ b. Somewhat difficult
    - ❑ c. A little bit difficult
    - ❑ d. Not at all difficult
    - ❑ e. Don't know

(Cues for Action / Reminders)

14. If you wanted to use contraceptives, how difficult would it be to remember to do it all the time?
    - ❑ a. Very difficult
    - ❑ b. Somewhat difficult
    - ❑ c. A little bit difficult
    - ❑ d. Not at all difficult
    - ❑ e. Don't know

(Perceived Susceptibility)

15. Do you think you could have another child in the next 2 years if you don't family planning?
    - ❑ a. Yes
    - ❑ b. Possibly/Sometimes
    - ❑ c. No
    - ❑ d. Don't Know

(Perceived Severity)

16. Some women think having closely spaced pregnancies is a problem while others don't. Do you think that getting pregnant in the two years following your last birth could be a problem for you? (if yes:) How serious a problem?
    - ❑ a. Very serious
    - ❑ b. Somewhat serious
    - ❑ c. A little bit serious
    - ❑ d. No/Not at all serious
    - ❑ e. Don't know

17. Does having little time between pregnancies make women more likely to die during pregnancy or childbirth?
    - ❑ a. Yes
    - ❑ b. Possibly/Sometimes
    - ❑ c. No
    - ❑ d. Don't Know

(Perception of Divine Will)

18. Do you think God approves of couples using family planning?
    - ❑ a. Yes
    - ❑ b. Possibly/Sometimes
    - ❑ c. No
    - ❑ d. Don't Know

19. Do you think God disapproves of YOU using family planning?
    - ❑ a. Yes
    - ❑ b. Possibly/Sometimes
    - ❑ c. No
    - ❑ d. Don't Know

(Policy)

20. Are there laws or rules that discourage you from using family planning/child spacing?
    - ❑ a. Yes
    - ❑ b. Possibly/Sometimes
    - ❑ c. No
    - ❑ d. Don't Know

(Culture)

21. What does your tribe/ethnic group/community think about having many children?
    (Write all responses below.)

22. What does your tribe/ethic group/community think about having few children?
    (Write all responses below.)

23. What does your tribe/ethnic group/community think about spacing pregnancies two or more years apart?
    (Write all responses below.)

THANK THE RESPONDENT FOR HER OR HIS TIME! THEN ASK:

DO YOU HAVE ANY QUESTIONS FOR ME?

Adapted from:

- *The Care Group Approach: Health Promotion and Behavior Change Through A Sustainable Community Based Strategy*, Rachelle St. Onge, Peace Corps Benin Health Sector, 2010
- Food for the Hungry, Family Planning Barrier Analysis Survey (unpublished), 2011
- Designing for Behavior Change 2011 (revised list of key determinants of behavior)

TA – Doer/Non-Doer Survey Questionnaire Instructions

GROUP: ❑ Doer ❑ Non-Doer

[To be ticked after respondent answers question #1 if respondent is doing nothing to delay/prevent pregnancy or #2 if participant is doing something. Also tick "doer" if woman is pregnant but was using FP before becoming pregnant and intends to use FP again soon after giving birth.]

[Adapt topic and priority group to meet program needs]

DOER/NON-DOER QUESTIONNAIRE ON MODERN FAMILY PLANNING:
WOMEN OF CHILDBEARING AGE WITH AT LEAST ONE LIVING CHILD

Introduction, purpose, CONFIDENTIALITY [Adapt to suit the survey and culture.]

Hello, my name is _____, and I work for _____. We are conducting a survey with women so that we can improve family planning services. Everything you say will be held in strictest confidence and will not be shared. You can choose to participate in the survey, or you can refuse. No services will be withheld nor will you be discriminated against if you choose not to participate. They survey should take around 20 minutes. Do you wish to participate in the survey?
_____ Yes _____ No

If the person does not want to participate, thank them for their time. If the person is willing to participate, acknowledge their acceptance (for example: "Great" or Thank you"), ask and record their name, community where they live, mother tongue, age, and gender. Record these in the space provided above. Then proceed with the questions below.

Interviewer's Name: [First and last name of the interviewer (family name and given name)]

Questionnaire Number: [Interviewer letter plus the number of the respondent—A1, A2, A3, for interviewer A. B1, B2, B3 for interviewer B; C1, C2, C3 for interviewer C, and so on]

Who was interviewed: [If the person agrees to be interviewed during the introduction, ask and record his or her first and last name here.]

Date: _____/_____/_____ [The date the interview takes place, DD/MM/YY]

Community: _____ [Town, village, catchment area, or other designation where interview takes place, as agreed by facilitators and respondents so the information is consistent]

Interviewee's Mother Tongue: [Ask and record. Language should take place in this language if that is easiest for the respondent and the interviewer speaks the language well enough.]

Language of Interview: [The language in which the interview takes place]

Age of respondent: _____ years **Gender of Respondent: ❑ Male ❑ Female** [Tick one even if all respondents are supposed to be the same gender.]

(Screening Questions)

1. Are you doing anything to avoid or delay pregnancy?
   - ❑ a. Yes
   - ❑ b. No
   - ❑ c. Don't know / Won't say

(If trying to space births or to delay or avoid pregnancy, ASK:)

2. What method are you using to avoid pregnancy? (Check the specific method. If it is a modern contraceptive, also check "Modern FP Method." If not, also check "Traditional Method.")
   - ❑ a. Combined oral contraceptive (pill, COC, OC)
   - ❑ b. Mini-pill
   - ❑ c. Injectable
   - ❑ d. Male condom
   - ❑ e. Female condom
   - ❑ f. IUD
   - ❑ g. Implants
   - ❑ h. Standard Days Method
   - ❑ i. LAM (exclusive breastfeeding on demand)
   - ❑ j. Female sterilization (tubal ligation or other)
   - ❑ k. Male sterilization (vasectomy)
   - ❑ l. Emergency contraception
   - ❑ m. Abstinence
   - ❑ n. Breastfeeding
   - ❑ o. Calendar/Rhythm method
   - ❑ p. Withdrawal
   - ❑ q. Other traditional method (list) _____

❑ Modern method	❑ Traditional Method

Alternate screening questions for pregnant respondents:

1. Before deciding to get pregnant, were you doing anything to space births or to delay or avoid pregnancy? [If not, go to the next section, *Positive and Negative Consequences*.]
2. [If yes] After having this child, do you plan to do something to delay getting pregnant again? [If not, go to the next section, *Positive and Negative Consequences*.]
3. [If yes] What do you plan to do to delay or avoid pregnancy after this birth? [Tick the appropriate boxes above.]

- **If #1 = Yes AND the person is using a modern contraceptive, mark the respondent as a DOER at the top of page one.**
- **If #1 is No or Don't Know / Won't Say OR if the person uses a traditional method, mark the respondent as a NON-DOER at the top of page one.**
- **If more than one method was used, ask why they switched or why they are using more than one, as appropriate. Note below.**

(Positive and Negative Consequences)

3. What are the **advantages** of (or would be the advantages of) your using family planning over the next 12 months? ***(Write all responses below.)***
   [For doers, ask "What **are**..." For non-doers, ask "What **would be**..."]

4. What are the **disadvantages** of (or would be the disadvantages of) your using family planning over the next 12 months? ***(Write all responses below.)***
   [For doers, ask "What **are**..." For non-doers, ask "What **would be**..."]

(Perceived Self Efficacy)

5. With your present knowledge and skills, do you think that you could use family planning over the next 12 months?
   - ❑ a. Yes
   - ❑ b. Possibly
   - ❑ c. No
   - ❑ d. Don't Know

6. What makes it **easy** (or would make it easier) for you to use family planning over the next 12 months? ***(Write all responses below.)***
   [If answer to #5 is yes, ask "What **makes it easy**..." If answer is b, c, or d, ask "What **would make it easier**..."]

7. What makes it **difficult** (or would make it difficult) for you to use family planning over the next 12 months? ***(Write all responses below.)***
   [If answer to #5 is b, c, or d, ask "What **makes it difficult**..." If answer to #5 is yes, ask "What **would** make it difficult..."]

(Perceived Social Norms)

8. Would most of the people that you know approve of your using family planning over the next 12 months?
   - ❑ a. Yes
   - ❑ b. Possibly
   - ❑ c. No
   - ❑ d. Don't Know

9. Who are the people that **would approve** of your using a contraceptive over the next 12 months? ***(Write all responses below.)***

10. Who are the people that **would disapprove** of your using family planning over the next 12 months? ***(Write all responses below.)***

(Perceived Action Efficacy)

11. Do you think that if you use family planning you could space or prevent a next pregnancy?
   - ❑ a. Yes
   - ❑ b. Possibly/Sometimes
   - ❑ c. No
   - ❑ d. Don't Know

(Access)

12. Is it difficult to find contraceptives?
   - ❑ a. Yes
   - ❑ b. Possibly/Sometimes
   - ❑ c. No
   - ❑ d. Don't Know

13. **How** difficult is it to find contraceptives?
   - ❑ a. Very difficult
   - ❑ b. Somewhat difficult
   - ❑ c. A little bit difficult
   - ❑ d. Not at all difficult
   - ❑ e. Don't know

[Agree on whether to read the choices above. Reading them removes the responsibility of interpreting the response.]

(Cues for Action / Reminders)

14. If you wanted to use contraceptives, how difficult would it be to remember to do it all the time?
   - ❑ a. Very difficult
   - ❑ b. Somewhat difficult
   - ❑ c. A little bit difficult
   - ❑ d. Not at all difficult
   - ❑ e. Don't know

[Agree on whether to read the choices above. Reading them removes the responsibility of interpreting the response.]

(Perceived Susceptibility)

15. Do you think you could have another child in the next 2 years if you don't family planning?
   - ❑ a. Yes
   - ❑ b. Possibly/Sometimes
   - ❑ c. No
   - ❑ d. Don't Know

(Perceived Severity)

16. Some women think having closely spaced pregnancies is a problem while others don't. Do you think that getting pregnant in the two years following your last birth could be a problem for you? (if yes:) How serious a problem?
   - ❑ a. Very serious
   - ❑ b. Somewhat serious
   - ❑ c. A little bit serious
   - ❑ d. No/Not at all serious
   - ❑ e. Don't know

[Agree on whether to read the choices above. Reading them removes the responsibility of interpreting the response.]

17. Does having little time between pregnancies make women more likely to die during pregnancy or childbirth?
    - ❑ a. Yes
    - ❑ b. Possibly/Sometimes
    - ❑ c. No
    - ❑ d. Don't Know

(Perception of Divine Will)

18. Do you think God approves of couples using family planning?
    - ❑ a. Yes
    - ❑ b. Possibly/Sometimes
    - ❑ c. No
    - ❑ d. Don't Know

19. Do you think God disapproves of YOU using family planning?
    - ❑ a. Yes
    - ❑ b. Possibly/Sometimes
    - ❑ c. No
    - ❑ d. Don't Know

(Policy)

20. Are there laws or rules that discourage you from using family planning/child spacing?
    - ❑ a. Yes
    - ❑ b. Possibly/Sometimes
    - ❑ c. No
    - ❑ d. Don't Know

(Culture)

21. What does your tribe/ethnic group/community think about having many children? ***(Write all responses below.)***

22. What does your tribe/ethic group/community think about having few children? ***(Write all responses below.)***

23. What does your tribe/ethnic group/community think about spacing pregnancies two or more years apart? ***(Write all responses below.)***

THANK THE RESPONDENT FOR HER OR HIS TIME! THEN ASK:

DO YOU HAVE ANY QUESTIONS FOR ME?

STEP 5

Field Test the Doer/Non-Doer Survey

Total Suggested Time
4 hours, 35 minutes

In this step, we practice conducting a survey to learn what motivates our priority or influencing group and what prevents them from making the desired change. We also field-test the survey questionnaire and practice analyzing the findings.

LEARNING OBJECTIVES

By the end of this step, participants should be able to:

- Cite at least two reasons it is important to use good interviewing techniques when conducting a survey.
- List at least four good interviewing techniques.
- Demonstrate good interviewing techniques.
- Accurately complete Doer/Non-Doer interview questionnaires.
- Define "probe" in the context of interviews.
- Appropriately solicit respondents for Doer/Non-Doer interviews.
- Conduct Doer/Non-Doer interviews.
- Tabulate the responses of doers and non-doers.
- Examine data from the Doer/Non-Doer survey.
- Compare doers and non-doers.
- Based on the data, identify which benefits and obstacles are the most important.

Supplies Needed

- Flipchart, markers, tape
- HO – Tips for Effective Interviewing
- Copies of the Doer/Non-Doer survey questionnaire (3–4 per participant)
- Clipboards or notebooks in case tables are not available during the interviews
- Pens, sharpened pencils, erasers
- TA – Doer/Non-Doer Survey Field Test Observation Checklist (optional)
- Completed surveys
- HO – Coding Guide (blank)
- Completed coding guides
- Research findings grid (handout or flipchart)
- HO – Sample Doer/Non-Doer Survey Results
- TA – Sample Doer/Non-Doer Survey Results

Preparation Needed

- Determine locations where participants can find people in the priority group to interview. Arrange for appropriate and willing respondents to be there to be interviewed.
- Arrange for transportation and include round-trip travel time in total time needed.
- If permission from community leaders is needed, secure it in advance if possible.
- Prepare a list showing who goes to which site and which trainer will accompany them.
- Prepare sufficient copies of the questionnaire (at least three for each participant).
- If appropriate, provide for a token of thanks for respondents (soft drink, rice, soap, etc.)
- To ensure there are enough doers and non-doers, consider using clinic records to identify FP clients and non-users to include in the field test and survey. However, it is very important not to limit the respondent pool to clinic users, or you will miss hearing from people for whom even going to the clinic is a key obstacle.
- Adapt the observation checklist as appropriate.
- Before making copies, adapt the coding guide to reflect any changes made to the questionnaire in Step 4, Activity 2, Adapting the Doer/Non-Doer Survey Questionnaire.
- To save time, trainers can read through the surveys to develop a coding guide based on the most common answers to each questions.
- Summarize on flipchart the list of things participants must remember when analyzing the data.

Activity 1 Discussion and Optional Demonstration

15 minutes

LEARNING OBJECTIVES

By the end of this activity, participants should be able to:

1. Cite at least two reasons it is important to use good interviewing techniques when conducting a survey.
2. List at least four good interviewing techniques.
3. Demonstrate good interviewing techniques.

Training Methods

Discussion, optional role play

Materials and Supplies Needed

HO – Tips for Effective Interviewing

1. Tell participants that the next step is to test, plan, and conduct the Doer/Non-Doer survey. In this workshop, however, we will only field test the survey.
2. Ask if any participants have ever conducted interviews or been interviewed by someone. What do they think are good interview techniques they can use? Alternatively, conduct a brief role play where you are the interviewer and a co-trainer or participant is the respondent. Do some things well and other things poorly so that participants can comment on what went well and what should be done differently.

TRAINERS NOTE

Some possible responses include:

- *Greet respondent warmly but professionally.*
- *Use the language respondent is most comfortable using.*
- *Explain the purpose of the interview (using the explanation agreed upon by the research team).*
- *Confirm that this is an okay time to do the interview.*
- *Look at the person when he or she is responding.*
- *Probe to better understand what the respondent is saying or to get more in-depth information about a statement.*
- *Thank the person for his or her time and openness.*

3. Ask participants why it is important to use good interviewing techniques when conducting or field-testing the survey.

TRAINERS NOTE

Some possible responses include:

- *To ensure we get the information we need*
- *To ensure that respondents are comfortable*
- *To avoid tainting the information with our own opinions/beliefs/feelings*
- *To avoid steering respondents in one way or another*

4. Review the handout "Tips for Effective Interviewing" with participants. Engage them in a brief discussion of how the techniques help [and which are most important to remember].

Activity 2 Role Play

50–60 minutes

LEARNING OBJECTIVES

By the end of this activity, participants should be able to:

1. Accurately complete Doer/Non-Doer interview questionnaires.
2. Define "probe" in the context of interviews.

Training Methods

Exercise

What Might Need Adaptation

If the Doer/Non-Doer survey will be conducted in a language other than the language used in the training, you will have to add time for participants to practice in that language and agree on how to phrase the questions in that language.

Supplies Needed

- Enough copies of the Doer/Non-Doer survey questionnaire for each participant to have one (participants can make their own copies if no printer or photocopier is available)
- Erasers and sharpened pencils

1. Explain that participants will now work in pairs to role play effective interviewing skills while practicing use of the Doer/Non-Doer questionnaire. Tell them they will each have 10 minutes to be the interviewer and that the "interviewee" should act like a member of the priority group for which the questionnaire was designed. Ask them to pay attention to what the interviewer does well and could do better so that these can be discussed to help them and everyone in the group improve their skills.
2. Divide participants into pairs and send them to different areas of the room to do their role plays. Tell them when to start, and let them know when the first 10 minutes have elapsed so they can switch roles. Walk around to observe the pairs so that during the full group discussion you can bring up anything important (good or needing improvement) that was missed by partners. After 20 minutes, bring the full group back together. Give each person 1 minute to say what he or she did well and wishes he or she had done better. Then give each person 1 minute to provide constructive feedback on his or her partner.
3. Add your feedback on anything important but not mentioned by participants.
4. Work with the full group to refine the questionnaire as needed to make it easier to use.

> **TRAINERS NOTE**
>
> *Consider issues such as:*
>
> - *If they stumbled over questions, was it because of awkward phrasing or the newness of the questionnaire?*
> - *If questions were hard to answer, might the priority group answer them more easily?*

5. Summarize or have a participant summarize the key learnings from this exercise.

> **TRAINERS NOTE**
>
> *Key learnings might include:*
>
> - *It's difficult to write while maintaining eye contact, but it really makes the respondent more comfortable.*
> - *Being very familiar with the questionnaire makes the interview feel more natural.*
> - *It is easier to know when to probe if you fully understand the research objective.*
> - *We interview friends and family all the time without realizing it, and some of the same techniques can be used in research.*
> - *Practicing and field-testing the questionnaire allow for important improvements before implementing the survey.*
> - *Our assumptions, even about groups or people we think we know, are often wrong, so it is critical to ask the intended audience.*

Activity 3 Field Practice and Questionnaire Pre-Test

2 hours

The field practice serves two purposes: (1) to give participants a chance to practice effective interview techniques using the questionnaire and (2) to pretest the questionnaire.

LEARNING OBJECTIVES

By the end of this activity, participants should be able to:

1. Appropriately solicit respondents for Doer/Non-Doer interviews.
2. Conduct Doer/Non-Doer interviews.

Training Methods

Field work, discussion

What Might Need Adaptation

Instructions will need to be specific to the location(s) chosen for pretesting—these include timing, transportation, number of respondents available, and other factors as appropriate. After the pretest and revision of the questionnaire, use a similar process to plan and conduct the actual survey. Keep in mind that the team will need to survey at least 45 doers and 45 non-doers for the survey to be valid.

Supplies Needed

- Copies of the questionnaire (2–3 per participant)
- Clipboards or notebooks in case tables are not available during the interviews
- Pens, sharpened pencils, erasers
- TA – Doer/Non-Doer Survey Field Test Observation Checklist (optional)

Preparation Needed

- Determine locations where participants can find people in the priority group to interview. Arrange for appropriate and willing respondents to be there to be interviewed.
- If transportation is necessary, arrange for it and include the time to go and return in your calculation of the time needed for this activity.
- If permission from community leaders is needed, secure it in advance if possible.
- If participants will travel to different sites, prepare a list showing who goes where and which trainer will accompany them. You may also decide to pair participants based on ability, language, priority group, or other factors. If so, include those pairings in the list.
- Prepare sufficient copies of the questionnaire. Plan for each participant to interview at least three people.
- If appropriate, provide for a token of thanks for respondents (soft drink, rice, soap, etc.)
- In order to ensure that participants interview enough doers and non-doers, it will be helpful to use clinic records to identify FP clients and seek to include them in the field test and survey. Clinic records could also be used to identify clients who do not access FP services there. One advantage to that is that it ensures that some doers and non-doers are people who use the clinic. However, it is very important not to limit the respondent pool to clinic users, or you will miss hearing from people for whom even going to the clinic is a key obstacle.
- Trainers may choose to use an observation checklist. One that can be adapted is included as a training aid.

Pretesting the questionnaire:

1. Decide whether to let participants know in advance that, upon return, you will ask them questions about how easy or difficult it was to ask the questions, how well respondents understood and reacted to the questions, whether enough or the right possible answers are listed for each question, whether the order of the questions made sense and flowed naturally, whether they have suggestions for improving the questionnaire, what should stay the same, and whether they feel they were able to get the information they needed to identify doers and non-doers and understand their motivations related to family planning. (If participants have little or no experience interviewing, it might be best not to distract them with this information. Rather, let them concentrate on the interview while you observe at least one full interview and parts of others. You should still ask the pre-test questions once the group has returned.)
2. Distribute 3–4 questionnaires to each participant. Ensure that they have pencils for completing the questionnaires, and something hard to write on in case no table or desk is available.
3. Explain that the group will go to one or more sites where members of the priority group will be waiting to be interviewed. Each person should interview at least three people. If they finish before time is up, they should interview more than three. Reassure them that trainers will be available if they need help. Everyone must meet at the rendezvous point at an agreed upon time to return to the training site. Upon return, participants will have time to provide feedback on the field work before learning to analyze the survey results.
4. Alternative strategy: Assign teams of two, interviewer and notetaker. Have team members switch roles as many times as they can in the allotted time.
5. Ask if there are any questions before they leave.

During the pretest:

6. If appropriate, let the community leader know the team is there. Secure permission to conduct the pretest if that was not done in advance.
7. Ensure that participants know where to find appropriate respondents.
8. Try to observe each person in your group in order to provide constructive feedback during the pretest debriefing.
9. Ensure all participants finish and return in the allotted time.

Upon return from the field:

10. Ask participants for feedback on their experience. This is a good way to identify problems with interviewing techniques, the way questions are phrased, and the possible answers listed.
    - How easy or difficult it was to ask the questions?
    - How well did respondents understand the questions? Did you have to explain any?
    - What are some of the answers you got? What unexpected answers did you get?
    - Were enough or the right possible answers are listed?
    - Did the questions make sense and flow naturally?
    - What suggestions do you have for improving the questionnaire?
    - What should stay the same?
    - Do you feel you were able to get the information you needed to identify doers and non-doers and understand their motivations related to family planning?
11. Ensure that the first page of the questionnaire was completed correctly. Address any problems.
12. Work with the group to refine the questionnaire based on feedback from the experience.

TRAINERS NOTE

If the questionnaire was very problematic, the revisions should be pretested and revised again before proceeding to the full survey.

Activity 4 Tabulating the Results

60 minutes

LEARNING OBJECTIVES

By the end of this activity, participants should be able to tabulate the responses of doers and non-doers.

Training Methods

Practice

What Might Need Adaptation

- Allow for more time if the long version questionnaire is used
- You will repeat this step after the conduct of the full survey and should adapt it to take into account the experience with the pretest and analysis of the pretest findings.

Supplies Needed

- Flipchart, markers, tape
- Completed surveys
- HO – Coding Guide (blank)
- HO – Sample Doer/Non-Doer Survey Results

Preparation Needed

- Before making copies, adapt the coding guide to reflect any changes made to the questionnaire in Step 4, Activity 2, Adapting the Doer/Non-Doer Survey Questionnaire.
- To save time, trainers can read through the surveys to develop a coding guide based on the most common answers to each questions.

1. Allow participants up to 15 minutes to read through the surveys to get a sense of the types of answers people gave. For example:
   What are the advantages of using FP? *Good spacing between births, mother will be healthy, baby will be healthy.*
2. Working with participants, group together similar answers as appropriate. For example, if as disadvantages respondents mention weight gain, headache, and heavier menses, these could be grouped together as "side effects". Likewise, *condoms get stuck, pills gave my aunt cancer*, and *injection causes more water/secretions* could be grouped together as "rumors" or "misinformation".

3. With participants, take the most common answers to open-ended questions and add them to the coding guide, creating a checklist of probable answers. See the example on the next page.

> **TRAINERS NOTE**
>
> *Coding means providing structure for unstructured information. The answers to open-ended questions are unstructured—respondents can say whatever they want. It is then up to those analyzing the data to fit those answers into a usable structure.*

Coding Guide for Perceived Consequences of FP

	# of DOERS = _____		# of NON-DOERS = _____		Difference
Perceived Consequences		%		%	
ADVANTAGES					
Benefit 1: Good spacing between births					
Benefit 2: The mother will be healthy					
Benefit 3: The children will be healthy					
Benefit 4					
DISADVANTAGES					
Obstacle 1: Could become sterile					
Obstacle 2: Could get sick					
Obstacle 3: Could reduce pleasure during sex					
Obstacle 4					

4. Divide the questionnaires into two stacks: *doers* and *non-doers*. (Interviewers should have ticked the appropriate box on page 1 during the interviews.)
5. Divide participants into two groups. Give each group one stack of questionnaires.
6. If there are enough questionnaires and participants, divide each stack up among the group members tabulating the responses. Have each tabulator work with one or two pages of the questionnaire to speed things up. In this case, give each group member a different page of the coding guide (covering the questions that person is assigned). This is an assembly line approach.
7. Participants should look at each response and try to find the same or a very similar response on the coding sheet. Participants should place a mark next to that response in either the "Doer" or "Non-doer" column of the coding guide, depending on the stack from which it came. At the same time, they should tick off the response on the actual questionnaire, indicating that the response has already been counted.
8. If they find a genuinely different response, they should add it to the coding guide and add a mark in the appropriate column (*doer* or *non-doer*). The table below is an example of what their coding guides should look like at the end (except that each group will have completed only the doer or non-doer columns, not both).

	# of DOERS = __8__		# of NON-DOERS = __10__		Difference
Perceived Consequences		%		%	
ADVANTAGES					
Benefit 1: Good spacing between births	|| (2)	25%	||| (3)	30%	
Benefit 2: The mother will be healthy	|||| | (6)	75%	| (1)	10%	
Benefit 3: The children will be healthy	|||| (4)	50%	|||| (4)	40%	
Benefit 4					
DISADVANTAGES					
Obstacle 1: Could become sterile	| (1)	12.5%	|||| (5)	50%	
Obstacle 2: Could get sick	|| (2)	25%	|||| || (7)	70%	
Obstacle 3: Could reduce pleasure during sex	||| (3)	37.5%	||| (3)	30%	
Obstacle 4					

9. As participants finish with their one or two pages, they should pass the questionnaire to the next person and follow the same process until all the responses have been tabulated.
10. Check (or assign a very capable participant in each group to check) to ensure that all responses on all the questionnaires have been ticked to indicate they were coded.
11. Once all questionnaires have been tabulated, reassemble all the pages of the coding sheet and quickly calculate percentages for each possible response. To do that, first write in each cell the total number of marks in that cell. Then calculate percentages by using the total number of "D" questionnaires as the denominator for the "doers" column. Use the total number of "N-D" questionnaires as the denominator for the "non-doers" column. In the example above, there are 8 doers and 10 non-doers. Two doers cited Benefit 1, and 2 out of 8 = .25, which is 25%. Three non-doers cited Benefit 1, and 3 out of 10 = 30%.
12. Transition to the next activity by saying you will next look at differences between (responses of) doers and non-doers to see what they tell you.

Activity 5 Making Sense of the Results

30 minutes

LEARNING OBJECTIVES

By the end of this activity, participants should be able to:

1. Examine data from the Doer/Non-Doer survey.
2. Compare doers and non-doers.
3. Based on the data, identify which benefits and obstacles are the most important.

Training Methods

Practice

What Might Need Adaptation

Completing this activity before conducting the full survey can help participants better understand and refine the survey but might not be essential at this point. It is repeated once the full survey results are available.

Supplies Needed

- Completed coding guides
- TA – Sample Doer/Non-Doer Survey Results
- Research findings grid (handout or flipchart)

Preparation Needed

Summarize on flipchart the list of things participants must remember when analyzing the data (item #3 below).

1. Quickly combine or have participants combine the responses from doers and non-doers onto one coding guide. Eventually it will look like this:

	# of DOERS = __8__		# of NON-DOERS = __10__		Difference
Perceived Consequences		%		%	
ADVANTAGES					
Benefit 1: Good spacing between births	2	25%	3	30%	5%
B**enefit 2**: The mother will be healthy	6	75%	1	10%	65%
Benefit 3: The children will be healthy	4	50%	4	40%	10%
Benefit 4					
DISADVANTAGES					
Obstacle 1: Could become sterile	1	12.5%	5	50%	37.5%
Obstacle 2: Could get sick	2	25%	7	70%	45%
Obstacle 3: Could reduce pleasure during sex	3	37.5%	3	30%	7.5%
Obstacle 4					

2. Ask participants to look for the biggest differences between responses doers and non-doers. Note these on a flipchart and have participants highlight them on the coding guide.

TRAINERS NOTE

This rapid survey technique is not a rigorous statistical analysis of your findings. Therefore, when we speak of differences between the responses of doers and non-doers, it is important to look for "big" differences, that is, differences of ***at least*** *15 percentage points (e.g., 50% - 35% = 15% or 69% - 51% = 18%. Any differences should be statistically significant. But because we are not suggesting you run statistical tests to determine significance, you will need to look for differences that are big enough to* ***probably*** *be meaningful. With samples of less than 50 doers and 50 non-doers, the differences should be at least 15 percentage points to be trustworthy. If you have a lot of respondents in both groups, differences of less than 15 percentage points might be significant.*

3. Tell them to keep in mind the following (summarized on a flipchart):
   - When doers' responses are radically different from non-doers' responses, that item *is* very likely a driver of the behavior for this audience. It is important to look for "big" differences—differences of at least 15 percentage points. These are the ones to consider in developing the behavior change strategy.
   - Doers' responses might include ideas for how to make the behavior easier or more appealing. They could also provide clues for messages to non-doers.
   - Sometimes, more doers list a particular disadvantage to the behavior than do non-doers, for example, mild side effects. This might just be because doers are more familiar with the behavior. They are aware of the disadvantage and have overcome it to become doers. Program planners should consider whether a difference between doers and non-doers in this case indicates something that the BC strategy should address. They might need to talk more with doers and non-doers to determine whether to do anything with regard to that disadvantage.
   - Differences in who approves or disapproves of the behavior might be important for deciding on an intervention. Big differences could mean you need to work first with the group influencing non-doers to change their attitudes toward family planning.

> **TRAINERS NOTE**
>
> *Especially if the long-form Doer/Non-Doer survey is used, participants might also be able to determine which of the many drivers of behavior are the most important, i.e., which ones show the biggest differences between doers and non-doers. Since it might not be possible for the BC strategy to address all the big differences, it could be useful to focus on the drivers that seem most important.*

4. Now look for responses that were surprisingly similar between doers and non-doers. Briefly discuss what these similarities might mean for the BC strategy.
   - When doers and non-doers report similar percentages for any item, that item *is not* a likely driver of the behavior for this group. Therefore it does not need to be a focus of the behavior change strategy.
   - Knowledge about the health benefits of the FP behavior is likely to be similar among doers and non-doers, and therefore probably are not a practical focus for an intervention.
   - There might be some cases where highlighting similarities can be beneficial. For example, if doers and non-doers mention the same minor/temporary side effect at a similar rate, testimonials from doers about how they dealt with it might be helpful in getting non-doers to try the behavior. Program planners will want to consider such cases carefully.
5. Ask if they feel the Doer/Non-Doer survey is giving them the kind of information they need to develop an effective behavior change strategy. How so?
6. Tell participants that the next step for them will be to use what they learned from the field practice and analysis to plan and conduct a full Doer/Non-Doer survey so they can then develop an effective behavior change strategy.

HO – Tips for Effective Interviewing

1. Be sure you understand the rational behind each question in case you need to rephrase it—what is it really asking, and why?
2. Greet the potential interviewee in a culturally appropriate way, for example, warmly but professionally.
3. Introduce yourself and briefly describe the purpose of the interview (using the explanation agreed upon by the research team).
4. Find out if the person is a member of the priority group. If not, thank them and move on.
5. Ask the person if they are willing to participate and if they have time now.
6. Find a quiet place to conduct the interview where you won't be overheard or disturbed.
7. Sit facing or next to the interviewee—close enough for an intimate conversation but no so close as to make him or her uncomfortable.
8. Use the language respondent is most comfortable using.
9. Speak loudly and clearly enough for the person to hear you easily.
10. As much as possible, look at the person when he or she is responding to show that you are listening. Avoid the temptation to look only at what you are reading or writing.
11. Ask the questions in the agreed-upon way to maintain consistency with the other interviewers. Repeat the question slowly if the person does not seem to understand. Rephrase only if necessary.
12. Avoid asking leading questions—questions that imply the response you want to hear.
13. If agreed among interviewers and facilitators, read the choices for the "very… somewhat… a little… not at all… don't know" questions. This allows the respondent to choose instead of having interviewers interpret the response.
14. Avoid being judgmental. There are no right or wrong answers.
15. Smile to make the respondent feel comfortable (if culturally appropriate).
16. Nod or otherwise affirm responses to encourage open, honest responses.
17. Probe to better understand what the respondent is saying or to get more in-depth information about a statement.
18. Say "Anything else?" if the question can have more than one response.
19. Thank the person for his or her time and openness. Ask if he or she has any questions.

TA – Doer/Non-Doer Survey Field Test Observation Checklist (optional)

Interviewer's Name _____ Observer's Name _____

For each item below, please rate the interviewer's performance as **Satisfactory (S)** or **Needs Improvement (NI)** by placing a check (✓) in the appropriate column. In the Comments column, record specific comments that you think might help the person improve his or her performance or highlight what was done particularly well.

Item	S	NI	Comments
Greeted interviewee in a culturally appropriate way			
Introduced him- or herself			
Briefly and correctly described interview purpose			
Found out if the person is a member of the priority group			
Asked the person if they are willing to participate and if they have time now			
Proceeded with interview or tha thanked person and moved on, as appropriate			
Found a quiet place to conduct the interview			
Used the language respondent is most comfortable using			
Speak loudly and clearly enough for the person to hear easily (but not too loudly)			
Made eye contact if appropriate for the culture			
Asked the questions in the agreed-upon way to maintain consistency with the other interviewers			
Repeated the question slowly if the person did not seem to understand			
Probed to better understand what the respondent said or to get more in-depth information about a statement			
Encouraged and thanked the person for his or her responses			
Said "Anything else?" if the question can have more than one response			
Obtained all the required information			
Thank the person for his or her time and openness			

Step 5, Activities 4 & 5 – Tabulating and Making Sense of the Results
Step 7, Activities 1 & 2 – Tabulating and Making Sense of the Results

HO – Coding Guide (blank)

Directions: Record the key findings in each category. Following this model below or adapting as needed, workshop participants can use flipcharts or their notebooks to code and calculate most of the survey responses before transferring them here. Be sure to adapt the coding guide to match the survey.

	# of DOERS	%	# of NON-DOERS	%	Difference
Perceived Consequences					
ADVANTAGES:					
Benefit 1					
Benefit 2					
Benefit 3					
Benefit 4					
DISADVANTAGES:					
Obstacle 1					
Obstacle 2					
Obstacle 3					
Obstacle 4					

	# of DOERS	%	# of NON-DOERS	%	Difference
Perceived Self-Efficacy					
With your present knowledge and skills, do you think that you could use					
Yes					
Possibly					
No					
Don't know					
What would make it **easier** for you to use a contraceptive over the next 12 months?					
Benefit 1					
Benefit 2					
Benefit 3					
Benefit 4					

What would make it **more difficult** for you to use contraceptives over the next 12 months?					
Obstacle 1					
Obstacle 2					
Obstacle 3					
Obstacle 4					

	# of DOERS	%	# of NON-DOERS	%	Difference
Perceived Social Norms					
Would most of the people that you know **approve** of your family planning over the next 12 months?					
Yes					
Possibly					
No					
Don't know					
Who are the people that **would approve** of your using a contraceptive over the next 12 months?					
Benefit 1					
Benefit 2					
Benefit 3					
Benefit 4					
Who are the people that **would disapprove** of your using family planning over the next 12 months?					
Obstacle 1					
Obstacle 2					
Obstacle 3					
Obstacle 4					

	# of DOERS	%	# of NON-DOERS	%	Difference
Perceived Action Efficacy					
Do you think that if you use family planning you could space or prevent a next pregnancy?					
Yes					
Possibly					
No					
Don't know					

	# of DOERS	%	# of NON-DOERS	%	Difference
Access					
Is it (or could it be) difficult to find contraceptives?					
Yes					
Possibly					
No					
Don't know					
How difficult is it (or could it be) to find contraceptives?					
Very difficult					
Somewhat difficult					
A little bit difficult					
Not at all difficult					
Don't know					

	# of DOERS	%	# of NON-DOERS	%	Difference
Cues for Action/Reminders					
If you wanted to use contraceptives, how difficult would it be to remember to do it all the time?					
Very difficult					
Somewhat difficult					
A little bit difficult					
Not at all difficult					
Don't know					

	# of DOERS	%	# of NON-DOERS	%	Difference
Perceived Susceptibility					
Do you think you could have another child in the next 2 years if you don't use family planning?					
Yes					
Possibly					
No					
Don't know					

	# of DOERS	%	# of NON-DOERS	%	Difference
Perceived Severity					
Some women think having closely spaced pregnancies is a problem while others don't. Could you think that getting pregnant in the two years following your last birth could be a problem for you? (if yes:) How serious a problem?					
Very					
Somewhat					
A little bit					
No/Not at all					
Don't know					
Does having little time between pregnancies make women more likely to die during pregnancy or childbirth?					
Yes					
Possibly					
No					
Don't know					

	# of DOERS	%	# of NON-DOERS	%	Difference
Perception of Divine Will					
Do you think God approves of couples using family planning?					
Yes					
Possibly					
No					
Don't know					
Do you think God approves of YOU using family planning?					
Yes					
Possibly					
No					
Don't know					

	# of DOERS	%	# of NON-DOERS	%	Difference
Policy					
Are there laws or rules that discourage you from using family planning/child spacing?					
Yes					
Possibly					
No					
Don't know					

	# of DOERS	%	# of NON-DOERS	%	Difference
Culture					
What does your tribe/ethnic group/community think about having many children?					
ADVANTAGES:					
Benefit 1					
Benefit 2					
Benefit 3					
Benefit 4					

DISADVANTAGES:					
Obstacle 1					
Obstacle 2					
Obstacle 3					
Obstacle 4					
What does your tribe/ethic group/ community think about having few children?					
ADVANTAGES:					
Benefit 1					
Benefit 2					
Benefit 3					
Benefit 4					
DISADVANTAGES:					
Obstacle 1					
Obstacle 2					
Obstacle 3					
Obstacle 4					
What does your tribe/ethnic group/community think about spacing pregnancies two or more years apart?					
ADVANTAGES:					
Benefit 1					
Benefit 2					
Benefit 3					
Benefit 4					
DISADVANTAGES:					
Obstacle 1					
Obstacle 2					
Obstacle 3					
Obstacle 4					

HO – Sample Doer/Non-Doer Survey Results

Priority Group: Mothers of Children Under Five Years Old
Desired Behavior: Current Use of at least One Modern Family Planning Method

Total Non-Doers	90	Total Doers	90

	Doers: + Exp.	Non-Doers: + Exp.	Doers: - Exp.	Non-Doers: - Exp.	Doers %	Non-Doers %	Difference
Key things that drive behavior							
Perceived Consequences							
ADVANTAGES:							
Good spacing between births	41	43	49	47	46%	48%	-2%
The mother will be healthy	32	16	58	74	36%	18%	18%
The children will be healthy	20	15	70	75	22%	17%	6%
The children will grow well	27	12	63	78	30%	13%	17%
Avoid sickness and death	9	2	81	88	10%	2%	8%
Rest the body	10	9	80	81	11%	10%	1%
Fewer expenses	11	6					
DISADVANTAGES:							
Could become sterile	13	13	77	77	14%	14%	0%
Could get sick	15	17	75	73	17%	19%	-2%
Could reduce pleasure during sex	0	1	90	89	0%	1%	-1%
The condom would tear and stay in the vagina	3	7	87	83	3%	8%	-4%
Don't know	1	10					
Perceived Self-efficacy							
Do you think you currently have the knowledge, skills, and funds to be able to use contraceptive pills, an IUD, or condoms?							
Yes	48	34	42	56	53%	38%	16%
Possibly	17	21	73	69	19%	23%	-4%
No	24	34	66	56	27%	38%	-11%
I don't know	1	1	89	89	1%	1%	0%

	Doers: + Exp.	Non-Doers: + Exp.	Doers: - Exp.	Non-Doers: - Exp.	Doers %	Non-Doers %	Difference
What makes it easier?							
Availability of FP products	34	34	56	56	38%	38%	0%
Husband's acceptance	26	17	64	73	29%	19%	10%
Money to pay for FP products	39	36	51	54	43%	40%	3%
Having the desire/will	20	14	70	76	22%	16%	7%
Being a sex worker	2	0	88	90	2%	0%	2%
What makes it more difficult?							
Insufficient funds to pay for the FP method	49	33	41	57	54%	37%	18%
Husband's refusal	24	26	66	64	27%	29%	-2%
Lack of FP methods in the area	27	27	63	63	30%	30%	0%
Distrust of the method	11	22	79	68	12%	24%	-12%
Lack of habit / Not used to it	4	3	86	87	4%	3%	1%
Perceived Social Norms							
Do most of the people you know approve of your using oral contraceptives, the IUD, or condoms to space births or prevent a new pregnancy?							
Yes	68	45	22	45	76%	50%	26%
Possibly	11	9	79	81	12%	10%	2%
No	11	34	79	56	12%	38%	-26%
Don't know	0	1	90	89	0%	1%	-1%
Who would approve:							
Husbands	49	42	41	48	54%	47%	8%
Neighbors	16	14	74	76	18%	16%	2%
Mothers-in-law	2	2	88	88	2%	2%	0%
Mothers	2	2	88	88	2%	2%	0%
Other in-laws	5	7	85	83	6%	8%	-2%
My own family members	16	11	74	79	18%	12%	6%
Health facility personnel	14	0	76	90	16%	0%	16%
No one	3	7	87	83	3%	8%	-4%
Friends	14	11					

	Doers: + Exp.	Non-Doers: + Exp.	Doers: - Exp.	Non-Doers: - Exp.	Doers %	Non-Doers %	Difference
Who would disapprove:							
Husband	4	15	86	75	4%	17%	-12%
Neighbors	22	15	68	75	24%	17%	8%
Mothers-in-law	5	3	85	87	6%	3%	2%
Friends	7	5	83	85	8%	6%	2%
Mothers	0	1	90	89	0%	1%	-1%
Other in-laws	10	3	80	87	11%	3%	8%
My own family members	17	15					
Other things that impact behavior							
Perceived Susceptibility							
Do you think you could have another child in the next 2 years if you don't use a contraceptive method?							
Yes	71	60	19	30	79%	67%	12%
Sometimes / Possibly	18	18	72	72	20%	20%	0%
No	1	10	89	80	1%	11%	-10%
Don't know	0	2	90	88	0%	2%	-2%
Perceived Action Efficacy							
Do you think that if you use oral contraceptives, an IUD, or condoms you could space or prevent a next pregnancy?							
Yes	87	62	3	28	97%	69%	28%
Possibly	3	23	87	67	3%	26%	-22%
No	0	3	90	87	0%	3%	-3%
Don't know	0	2	90	88	0%	2%	-2%
Perception of divine will							
Do you think God approves of couples using OCs, the IUD, or condoms?							
Yes	67	41	23	49	74%	46%	29%
Possibly	11	10	79	80	12%	11%	1%
No	12	33	78	57	13%	37%	-23%
Don't know	0	6	90	84	0%	7%	-7%

	Doers: + Exp.	Non-Doers: + Exp.	Doers: - Exp.	Non-Doers: - Exp.	Doers %	Non-Doers %	Difference
Do you think God disapproves of YOU using OCs, the IUD, or condoms?							
Yes	21	32	69	58	23%	36%	-12%
Possibly	4	6	86	84	4%	7%	-2%
No	65	44	25	46	72%	49%	23%
Don't know	0	8	90	82	0%	9%	-9%
Perceived Severity							
Some women think having closely spaced pregnancies is a problem while others don't. Could you think that getting pregnant in the two years following your last birth could be a problem for you? (if yes:) How serious a problem?							
Very serious	82	52	8	38	91%	58%	33%
Somewhat serious	6	19	84	71	7%	21%	-14%
A little serious	1	11	89	79	1%	12%	-11%
Not at all serious	1	8	89	82	1%	9%	-8%
Does having little time between pregnancies make women more likely to die during pregnancy or childbirth?							
Yes	82	55	8	35	91%	61%	30%
Sometimes / Possibly	6	24	84	66	7%	27%	-20%
No	2	8	88	82	2%	9%	-7%
Don't know	0	3	90	87	0%	3%	-3%
Does having closely-spaced pregnancies make it more likely that the newborn will die?							
Yes	62	48	28	42	69%	53%	16%
Sometimes / Possibly	13	20	77	70	14%	22%	-8%
No	15	19	75	71	17%	21%	-4%
Don't know	0	3	90	87	0%	3%	-3%

	Doers: + Exp.	Non-Doers: + Exp.	Doers: - Exp.	Non-Doers: - Exp.	Doers %	Non-Doers %	Difference
Cues for action							
If you wanted to use OCs, the IUD, or condoms, how difficult would it be to remember to do it all the time?							
Very difficult	1	14	89	76	1%	16%	-14%
Somewhat difficult	1	8	89	82	1%	9%	-8%
A little difficult	5	18	85	72	6%	20%	-14%
Not at all difficult	83	50	7	40	92%	56%	37%
Importance of the behavior							
Do you think it is important that you and your husband be able to practice family planning by using OCs, the IUD, or condoms?							
Very important	81	52	9	38	90%	58%	32%
Somewhat important	7	16	83	74	8%	18%	-10%
A little important	2	8	88	82	2%	9%	-7%
Not important	0	13	90	77	0%	14%	-14%
No response	0	1	90	89	0%	1%	-1%
Access							
Is it (or could it be) difficult to find materials that could help you use oral contraceptives, condoms, or the IUD?							
Very difficult	21	57	69	33	23%	63%	-40%
Somewhat difficult	18	13	72	77	20%	14%	6%
A little difficult	41	18	49	72	46%	20%	26%
Not at all difficult	10	2	80	88	11%	2%	9%

TA – Sample Doer/Non-Doer Survey Results

Priority Group: Mothers of Children Under Five Years Old
Desired Behavior: Current Use of at least One Modern Family Planning Method

Total Non-Doers	90	Total Doers	90

	Doers: + Exp.	Non-Doers: + Exp.	Doers: - Exp.	Non-Doers: - Exp.	Doers %	Non-Doers %	Difference
Key things that drive behavior							
Perceived Consequences							
ADVANTAGES:							
Good spacing between births	41	43	49	47	46%	48%	-2%
The mother will be healthy	32	16	58	74	36%	18%	18%
The children will be healthy	20	15	70	75	22%	17%	6%
The children will grow well	27	12	63	78	30%	13%	17%
Avoid sickness and death	9	2	81	88	10%	2%	8%
Rest the body	10	9	80	81	11%	10%	1%
Fewer expenses	11	6					
DISADVANTAGES:							
Could become sterile	13	13	77	77	14%	14%	0%
Could get sick	15	17	75	73	17%	19%	-2%
Could reduce pleasure during sex	0	1	90	89	0%	1%	-1%
The condom would tear and stay in the vagina	3	7	87	83	3%	8%	-4%
Don't know	1	10					
Perceived Self-efficacy							
Do you think you currently have the knowledge, skills, and funds to be able to use contraceptive pills, an IUD, or condoms?							
Yes	48	34	42	56	53%	38%	16%
Possibly	17	21	73	69	19%	23%	-4%
No	24	34	66	56	27%	38%	-11%
I don't know	1	1	89	89	1%	1%	0%

	Doers: + Exp.	Non-Doers: + Exp.	Doers: - Exp.	Non-Doers: - Exp.	Doers %	Non-Doers %	Difference
What makes it easier?							
Availability of FP products	34	34	56	56	38%	38%	0%
Husband's acceptance	26	17	64	73	29%	19%	10%
Money to pay for FP products	39	36	51	54	43%	40%	3%
Having the desire/will	20	14	70	76	22%	16%	7%
Being a sex worker	2	0	88	90	2%	0%	2%
What makes it more difficult?							
Insufficient funds to pay for the FP method	49	33	41	57	54%	37%	18%
Husband's refusal	24	26	66	64	27%	29%	-2%
Lack of FP methods in the area	27	27	63	63	30%	30%	0%
Distrust of the method	11	22	79	68	12%	24%	-12%
Lack of habit / Not used to it	4	3	86	87	4%	3%	1%
Perceived Social Norms							
Do most of the people you know approve of your using oral contraceptives, the IUD, or condoms to space births or prevent a new pregnancy?							
Yes	68	45	22	45	76%	50%	26%
Possibly	11	9	79	81	12%	10%	2%
No	11	34	79	56	12%	38%	-26%
Don't know	0	1	90	89	0%	1%	-1%
Who would approve:							
Husbands	49	42	41	48	54%	47%	8%
Neighbors	16	14	74	76	18%	16%	2%
Mothers-in-law	2	2	88	88	2%	2%	0%
Mothers	2	2	88	88	2%	2%	0%
Other in-laws	5	7	85	83	6%	8%	-2%
My own family members	16	11	74	79	18%	12%	6%
Health facility personnel	14	0	76	90	16%	0%	16%
No one	3	7	87	83	3%	8%	-4%
Friends	14	11					

	Doers: + Exp.	Non-Doers: + Exp.	Doers: - Exp.	Non-Doers: - Exp.	Doers %	Non-Doers %	Difference
Who would disapprove:							
Husband	4	15	86	75	4%	17%	-12%
Neighbors	22	15	68	75	24%	17%	8%
Mothers-in-law	5	3	85	87	6%	3%	2%
Friends	7	5	83	85	8%	6%	2%
Mothers	0	1	90	89	0%	1%	-1%
Other in-laws	10	3	80	87	11%	3%	8%
My own family members	17	15					
Other things that impact behavior							
Perceived Susceptibility							
Do you think you could have another child in the next 2 years if you don't use a contraceptive method?							
Yes	71	60	19	30	79%	67%	12%
Sometimes / Possibly	18	18	72	72	20%	20%	0%
No	1	10	89	80	1%	11%	-10%
Don't know	0	2	90	88	0%	2%	-2%
Perceived Action Efficacy							
Do you think that if you use oral contraceptives, an IUD, or condoms you could space or prevent a next pregnancy?							
Yes	87	62	3	28	97%	69%	28%
Possibly	3	23	87	67	3%	26%	-22%
No	0	3	90	87	0%	3%	-3%
Don't know	0	2	90	88	0%	2%	-2%
Perception of divine will							
Do you think God approves of couples using OCs, the IUD, or condoms?							
Yes	67	41	23	49	74%	46%	29%
Possibly	11	10	79	80	12%	11%	1%
No	12	33	78	57	13%	37%	-23%
Don't know	0	6	90	84	0%	7%	-7%

	Doers: + Exp.	Non-Doers: + Exp.	Doers: - Exp.	Non-Doers: - Exp.	Doers %	Non-Doers %	Difference
Do you think God disapproves of YOU using OCs, the IUD, or condoms?							
Yes	21	32	69	58	23%	36%	-12%
Possibly	4	6	86	84	4%	7%	-2%
No	65	44	25	46	72%	49%	23%
Don't know	0	8	90	82	0%	9%	-9%
Perceived Severity							
Some women think having closely spaced pregnancies is a problem while others don't. Could you think that getting pregnant in the two years following your last birth could be a problem for you? (if yes:) How serious a problem?							
Very serious	82	52	8	38	91%	58%	33%
Somewhat serious	6	19	84	71	7%	21%	-14%
A little serious	1	11	89	79	1%	12%	-11%
Not at all serious	1	8	89	82	1%	9%	-8%
Does having little time between pregnancies make women more likely to die during pregnancy or childbirth?							
Yes	82	55	8	35	91%	61%	30%
Sometimes / Possibly	6	24	84	66	7%	27%	-20%
No	2	8	88	82	2%	9%	-7%
Don't know	0	3	90	87	0%	3%	-3%
Does having closely-spaced pregnancies make it more likely that the newborn will die?							
Yes	62	48	28	42	69%	53%	16%
Sometimes / Possibly	13	20	77	70	14%	22%	-8%
No	15	19	75	71	17%	21%	-4%
Don't know	0	3	90	87	0%	3%	-3%

	Doers: + Exp.	Non-Doers: + Exp.	Doers: - Exp.	Non-Doers: - Exp.	Doers %	Non-Doers %	Difference
Cues for action							
If you wanted to use OCs, the IUD, or condoms, how difficult would it be to remember to do it all the time?							
Very difficult	1	14	89	76	1%	16%	-14%
Somewhat difficult	1	8	89	82	1%	9%	-8%
A little difficult	5	18	85	72	6%	20%	-14%
Not at all difficult	83	50	7	40	92%	56%	37%
Importance of the behavior							
Do you think it is important that you and your husband be able to practice family planning by using OCs, the IUD, or condoms?							
Very important	81	52	9	38	90%	58%	32%
Somewhat important	7	16	83	74	8%	18%	-10%
A little important	2	8	88	82	2%	9%	-7%
Not important	0	13	90	77	0%	14%	-14%
No response	0	1	90	89	0%	1%	-1%
Access							
Is it (or could it be) difficult to find materials that could help you use oral contraceptives, condoms, or the IUD?							
Very difficult	21	57	69	33	23%	63%	-40%
Somewhat difficult	18	13	72	77	20%	14%	6%
A little difficult	41	18	49	72	46%	20%	26%
Not at all difficult	10	2	80	88	11%	2%	9%

Source: Food for the Hungry, unpublished survey, 2011

STEP 6

Plan and Conduct a Doer/Non Doer Survey

Total Suggested Time

30 minutes, plus the time it will take to conduct the survey over days or weeks

The team will agree on how and in what timeframe to conduct the actual survey—and then do it.

Activity: Parameters for Conducting the Survey

LEARNING OBJECTIVES

By the end of this step, participants will be able to:

1. Describe how the Doer/Non-Doer survey will be conducted.
2. Describe their own role and responsibilities in the survey.
3. Interview the required number of doers and non-doers.

Training Methods

Discussion

Supplies Needed

TA – Doer/Non-Doer Survey Summary (example)

Preparation Needed

Think through likely scenarios for conducting the survey. Make any arrangements necessary to facilitate the field work, including an official letter or overview to community leaders or others as appropriate.

1. Tell or determine with the group how the actual survey will be conducted.

> TRAINERS NOTE
>
> *It's usually better to engage participants in the process. The planning then benefits from their experience and encourages their ownership of the process and of the survey.*

Several questions need to be answered:

- If during the workshop you have defined more than one priority group or behavior, which group and behavior will be the subject of the Doer/Non-Doer survey?
- How many doers and non-doers are needed for the survey (remembering the minimum of 45 each).
- Will the survey be conducted now and in the area where the workshop has taken place? Or will each participant return to his or her community and survey a certain number of doers and non-doers? How many of each?

- Do interviewers need documentation to secure permission to conduct the survey?
- Do interviewers need a name badge identifying them as being part of the project?
- How and when will participants get copies of the questionnaire to use?
- What other resources are needed (transportation, storage files, other)?
- Will the survey be conducted in areas where other surveys have been conducted recently? Will this have any impact on how interviewers are received and perceived?
- How will interviewers store completed surveys to help maintain confidentiality and avoid damage?
- Will all the participants work over the next few days or over the next few weeks?
- Will facilitators or select participants take on the role of survey coordinator and check completed questionnaires early in the process to identify problems and make course corrections?
- When will the group come back together to analyze the data and develop the strategy?

2. Summarize parameters and expectations on a flipchart and ensure participants copy it in their notebooks or are given the summary as a handout. See TA – Doer/Non-Doer Survey Summary (Example)
3. Distribute the required number of questionnaires plus a few extra. Also distribute folders in which to keep blank and completed questionnaires.
4. Ask participants if they have any questions about what they are supposed to do.

> **TRAINERS NOTE**
>
> *One way to both review and find out if everyone is on the same page is to toss a ball of paper to random participants and ask questions such as:*
>
> - *What will you do first/next?*
> - *How many doers do you need to interview?*
> - *By when do you need to finish?*
> - *Etc.*

5. Thank participants for their time and enthusiasm. Let them know how to contact you if they have any problems conducting the survey. Tell them you look forward to seeing them during your monitoring or once the survey has been completed.
6. Be sure to make arrangements for resuming the workshop on the agreed-upon day and place.

TA – Doer/Non-Doer Survey Summary (example)

Doer/Non-Doer Survey with Women 15–49 Years Old in Sarai District

Behavior: Current use of a modern family planning method

Research Sites: Community A, B, C, D, and E

Data Collection Coordinator: Maria

Research Period: 15 days, beginning immediately

Total Number of Respondents Needed: 100 Doers and 100 Non-Doers

Interviewers: 10

Number of Respondents per Interviewer: 10 Doers and 10 Non-Doers

Places to Identify Non-Doers: Health facilities, markets, door-to-door

How to Identify Doers (if unlikely/unable to find enough through a general approach): Clinics and clinic records where FP is provided

Transportation: None provided. Conduct interviews with walking distance of facility and home.

Return to Workshop for Data Analysis and BC Strategy Development: [Specify date, time, location, # of days]

STEP 7

Analyze Data Collected in the Field

Total Suggested Time
4 or more hours

Now that we have collected information, we must analyze it and decide what is important for our behavior change strategy.

LEARNING OBJECTIVES

By the end of this step, participants should be able to:

1. Tabulate the responses of doers and non-doers.
2. Examine data from the Doer/Non-Doer survey.
3. Compare doers and non-doers.
4. Based on the data, identify which drivers of behavior are the most important.

Supplies Needed

- Flipchart, markers, tape
- Completed surveys
- HO – Coding Guide (as revised during analysis of the field test results, originally introduced in Step 4)
- Completed coding guides
- Research findings grid (handout or flipchart)

Preparation Needed

- Before making copies, adapt the coding guide to reflect any changes made to the questionnaire following the field test and to incorporate common benefits and obstacles added during the analysis of pretest results.
- If necessary to save time, trainers or select participants can read through the surveys to update the coding guide based on the most common answers to each question.
- Summarize on flipchart the list of things participants must remember when analyzing the data (item #1 below).

Activity 1 Tabulating the Results

2+ hours

LEARNING OBJECTIVES

By the end of this activity, participants should have tabulated the responses of doers and non-doers.

Training Methods

Practice

What Might Need Adaptation

Allow for more time if the long version questionnaire is used

Supplies Needed

- Flipchart, markers, tape
- Completed surveys
- HO – Coding Guide (as revised during analysis of the field test results)

Preparation Needed

- Before making copies, adapt the coding guide to reflect any changes made to the questionnaire following the field test and to incorporate common benefits and obstacles added during the analysis of pretest results.
- To save time, trainers can read through the surveys to update the coding guide based on the most common answers to each question.

1. Allow participants to read through of all the surveys to get a sense of the types of answers people gave.
2. Working with participants, group together similar answers as appropriate (if the review of completed questionnaires indicates that new categories are needed).
3. As necessary, work with participants to add to the coding guide any new commonly given answers to open-ended questions, creating an updated checklist of probable answers. See the example in Step 5, Activity 4, Tabulating the Results.

> TRAINERS NOTE
>
> *As noted in Step 5, coding means providing structure for unstructured information. The answers to open-ended questions are unstructured—respondents can say whatever they want. It is then up to those analyzing the data to fit those answers into a usable structure.*

4. Divide the questionnaires into two stacks: *doers* and *non-doers*. (Interviewers should have ticked the appropriate box on page 1 during the interviews.)
5. Divide participants into two groups. Give each group one stack of questionnaires.
6. If there are enough questionnaires and participants, divide each stack up among the group members tabulating the responses. Have each tabulator work with one or two pages of the questionnaire to speed things up. In this case, give each group member a different page of the coding guide (covering the questions that person is assigned).

7. Participants should look at each response and try to find the same or a very similar response on the coding sheet. Participants should place a mark next to that response in either the "Doer" or "Non-Doer" column of the coding guide, depending on the stack from which it came. At the same time, they should tick off the response on the actual questionnaire, indicating that the response has already been counted.
8. If they find a genuinely different response, they should add it to the coding guide and add a mark in the appropriate column (doer or non-doer). The table below is an example of what their coding guides should look like at the end (except that each group will have completed only the doer or non-doer columns, not both).

	# of DOERS = __8__		**# of NON-DOERS = __10__**		**Difference**
Perceived Consequences		%		%	
ADVANTAGES					
Benefit 1: Good spacing between births	|| (2)	25%	||| (3)	30%	
Benefit 2: The mother will be healthy	||||| | (6)	75%	| (1)	10%	
Benefit 3: The children will be healthy	|||| (4)	50%	|||| (4)	40%	
Benefit 4					
DISADVANTAGES					
Obstacle 1: Could become sterile	| (1)	12.5%	||||| (5)	50%	
Obstacle 2: Could get sick	|| (2)	25%	||||| || (7)	70%	
Obstacle 3: Could reduce pleasure during sex	||| (3)	37.5%	||| (3)	30%	
Obstacle 4					

9. As participants finish with their one or two pages, they should pass the questionnaire to the next person and follow the same process until all the responses have been tabulated.
10. Check (or assign a very capable participant in each group to check) to ensure that all responses on all the questionnaires have been ticked to indicate they were coded.
11. Once all questionnaires have been tabulated, quickly calculate percentages for each possible response. To do that, first write in each cell the total number of marks in that cell. Then calculate percentages by using the total number of "D" questionnaires as the denominator for the "doers" column. Use the total number of "N-D" questionnaires as the denominator for the "non-doers" column. In the example above, there are 8 doers and 10 non-doers. Two doers cited Benefit 1, and 2/8 = .25, which is 25%. Three non-doers cited Benefit 1, so 3/10 = 30%.
12. Transition to the next activity by saying you will next look at differences between (responses of) doers and non-doers to see what they tell you.

Activity 2 Making Sense of the Results

2+ hours

LEARNING OBJECTIVES

By the end of this activity, participants should be able to:

1. Examine data from the Doer/Non-Doer survey.
2. Compare doers and non-doers.
3. Based on the data, identify which drivers of behavior are the most important.

Training Methods

Practice

Supplies Needed

- Completed coding guides
- Research findings grid (handout or flipchart)

Preparation Needed

Summarize on flipchart the list of things participants must remember when analyzing the data (item #3 below).

1. Quickly combine or have participants combine the responses from doers and non-doers onto one coding guide. Eventually it will look like this:

	# of DOERS = 8		**# of NON-DOERS = 10**		**Difference**
Perceived Consequences		%		%	
ADVANTAGES					
Benefit 1: Good spacing between births	2	25%	3	30%	5%
Benefit 2: The mother will be healthy	6	75%	1	10%	65%
Benefit 3: The children will be healthy	4	50%	4	40%	10%
Benefit 4					
DISADVANTAGES					
Obstacle 1: Could become sterile	1	12.5%	5	50%	37.5%
Obstacle 2: Could get sick	2	25%	7	70%	45%
Obstacle 3: Could reduce pleasure during sex	3	37.5%	3	30%	7.5%
Obstacle 4					

2. Ask participants to look for the biggest differences between responses doers and non-doers. Note these on a flipchart and have participants highlight them on the coding guide.

> **TRAINERS NOTE**
>
> *Remember that this rapid survey technique is not a rigorous statistical analysis of your findings. Therefore, it is important to look for differences of* ***at least*** *15 percentage points (e.g., 50% - 35% = 15%) between the responses of doers and non-doers. With samples of less than 50 doers and 50 non-doers, the differences should be at least 15 percentage points to be trustworthy. If you have a large number of respondents in both groups, differences of less than 15 percentage points might be significant.*

3. Post a flipchart with the italicized statements below. Ask participants to expand on each summary statement:
   - *Big differences likely point to real drivers of behavior.* When doers' responses are radically different from non-doers' responses, that item *is* very likely a driver of the behavior for this priority group. It is important to look for differences of at least 15 percentage points.
   - *Look at doers' responses for ideas for messages and making the behavior appealing.* Doers' responses might include ideas for how to make the behavior easier or more appealing. They could also provide clues for messages to non-doers.
   - *Consider how to deal with disadvantages listed by doers.* Sometimes, more doers list a particular disadvantage to the behavior than do non-doers, for example, mild side effects. This might be because doers are more familiar with the behavior. They have overcome the disadvantage to become doers. Program planners should consider whether a difference in this case indicates something that the BC strategy should address. They might need to talk more with doers and non-doers to decide whether to do anything regarding that disadvantage.
   - *Pay attention to big differences in who approves or disapproves.* Differences in who approves or disapproves of the behavior might provide important information on how to develop an intervention. Big differences might mean you need to work first with the group influencing non-doers to change their attitudes toward family planning.
   - *Small differences mean that item is not likely to drive the behavior.* When doers and non-doers report similar percentages for anything, that item is not a likely driver of the behavior for this group. Therefore it does not need to be a focus of the behavior change strategy.
   - Knowledge about the health benefits of the behavior is likely to be similar among doers and non-doers, and therefore not a practical focus for an intervention.
   - *Highlighting similarities between doer and non-doers can be beneficial.* There might be some cases where highlighting similarities can be beneficial. For example, if doers and non-doers mention the same temporary side effect at a similar rate, testimonials from doers about how they dealt with it might be helpful in getting non-doers to try the behavior. Program planners will want to consider such cases carefully.

> **TRAINERS NOTE**
>
> *See the Resource "Influencing Groups" for more information on identifying, learning about, and influencing influencing groups.*

4. Transition to the next step by saying that you will now use the key findings to develop or select behavior change activities.

STEP 8

Develop Your Behavior Change Strategy

Total Suggested Time
2 hours, 30 minutes

This is where we bring it all together. We will think about what the key Doer/Non-Doer survey findings mean for behavior change strategy development and identify activities—based solidly on our research—to achieve the desired behavior change.

LEARNING OBJECTIVES

By the end of this activity, participants should be able to

1. Say what the key differences mean for their behavior change strategies.
2. Identify 3–4 activities that focus on the most important benefits and obstacles to the behavior.
3. Give 3 reasons it is important to go beyond awareness-raising.
4. Develop an effective behavior change strategy.

What Might Need Adaptation

If the BC strategy is for one organization or location, ensure that the strategies developed by the case study groups fit together, are feasible, and can be implemented in a logical order.

Supplies Needed

- HO – Implications of Big Differences
- HO – Developing a Behavior Change Strategy
- HO – Behavior Change Strategy Framework (in process, originally introduced in Step 2)
- HO – Beyond Awareness Raising
- TA – Organizational Experiences with FP Integration
- TA – Sample Healthy Timing and Spacing of Pregnancy (HTSP) Messages

Preparation Needed

Post the flipchart with Six Principles of Designing a Behavior Change Strategy and other relevant flipcharts from previous activities, to refer to as needed.

Activity 1 Identifying Implications of Big Differences

45 minutes

LEARNING OBJECTIVES

By the end of this activity, participants should be able to say what the key differences mean for their behavior change strategies.

Training Methods

Discussion and small group work

Supplies Needed

HO – Implications of Big Differences

1. Start with the following story:

   Group X did a broad-based FP awareness campaign. As a result, 10 women came into the clinic for FP counseling during the three months the campaign ran. The program expected more. They decided to repeat the campaign since they already had the radio spots, posters, and other materials. What might be wrong with this approach?

> TRAINERS NOTE
>
> *Some possible answers include*
>
> - *Either people got the message or they didn't—avoid repeating what doesn't work*
> - *Awareness alone rarely leads immediately to behavior change*
> - *Programs should develop a comprehensive BC strategy based on stage of change, key benefits, and key obstacles*

2. Summarize the key benefits and obstacles on a flipchart, leaving a column for implications. The summary could look something like this:

Big Differences	Implications for Behavior Change Strategy
Perceived Consequences	
Benefit: Doers believe with FP the mother will be healthy (75% vs. 10% =→ 65%)	Increase knowledge that spacing births with modern FP improves mothers' health.
Obstacle: Non-doers believe FP could make them sterile (50% vs. 12.5% =→ 37.5%)	Reduce misconception that FP causes widespread infertility. Increase knowledge that fertility returns after temporary methods are stopped.
Obstacle: Non-doers believe FP could make them sick (70% vs. 25% =→ 37.5%)	No specific focus, but can address with other side effects and rumors.

3. Distribute HO – Implications of Big Differences. Have participants work in their case study groups to discuss and record implications of the big differences for program planning. They should make notes about them and whether any activities should focus on those differences. Each

group can focus on a different set of differences. Give them 10–20 minutes for this, depending on how many differences each group needs to discuss.

4. Have the groups post their summaries. Give each group five minutes to present, followed by five-to-seven minutes of questions and feedback from the other participants. Groups should note feedback in their notebooks for consideration during the next activity.

Activity 2 Identifying Appropriate Activities

90–115 minutes

LEARNING OBJECTIVES

By the end of this activity, participants should be able to:

1. Identify 3–4 activities that focus on the most important benefits and obstacles to the behavior.
2. Give 3 reasons it is important to go beyond awareness-raising.
3. Develop an effective behavior change strategy.

Training Methods

Mini-lecture, small group work

What Might Need Adaptation

If the BC strategy is for one organization or location, ensure that the strategies developed by the case study groups fit together, are feasible, and can be implemented in a logical order.

Supplies Needed

- HO – Developing a Behavior Change Strategy
- HO – Behavior Change Change Strategy Framework (in process)
- HO – Beyond Awareness Raising
- TA – Organizational Experiences with FP Integration
- TA – Sample Healthy Timing and Spacing of Pregnancy (HTSP) Messages

Preparation Needed

Post the flipchart with Six Principles of Designing a Behavior Change Strategy and other relevant flipcharts from previous activities, to refer to as needed.

1. Tell participants we have reached the last element of the strategy, "What Activities will be implemented to promote the desired behaviors?" The case study groups are now ready to identify activities that will address the key benefits and obstacles and, in turn, help people adopt a specified behavior. They will use the Behavior Change Framework they began completing in Step 3, Define the Priority Group and Behavior.
2. Tell participants they should keep three things in mind as they develop their strategies:
   - Be creative, while at the same time benefiting from what others have done.
   - Consider policy and environment-level changes when appropriate.
   - **Keep your audience's perspective.**

Be Creative

Behavior change strategy development lets you be creative in how you address the priority group's wants and needs. Brainstorm new and exciting ideas. Try to describe the priority group's experiences—both current experiences and those you would like them to have. For example, if your priority group is pregnant women 18 to 34 years old and you would like them to bring their partner in for family planning counseling for couples, pull all the information you found during the Doer/Non-Doer survey and from other research about all the steps they have to go through to do this. For example:

- How does she already approach health and family discussions with her partner?
- How does she get the partner in the right mood for such a discussion?
- What are some reasons and words she can use to start the discussion?
- When is the partner most likely to be available for couples counseling? (Early morning, late afternoon, evening?)
- How easy or difficult is it to get the partner to come to the health center for anything?
- Have they discussed child spacing before?
- What has the partner ever said about family planning?

Keep in mind that sometimes the most obvious answers are the best ones. Your strategy does not have to be complicated or revolutionary—it needs to get the job done. Tell participants that they will have the chance to look at examples of what other programs have done to help clients adopt family planning. They can determine whether aspects of any of them relate well to what they found in their research. They must be sure to take into account differences between your community and the community where the strategy or activity had success. **Some** key differences to consider will be: current attitudes and practices related to the desired behavior, community income and lifestyle, resources available, methods available, funding, and infrastructure. There might be many other things to consider as well.

Consider Policy and Environmental Changes

Policy or environmental changes can support individual behavior change. Many health programs get caught up in developing strategies to get individual-level behavior change without complementing those changes with policy or environmental level changes. How can you help make the behavior easier for your priority group? What barriers from your research findings can be overcome with policy or environmental changes? Think about strategies you can use to influence the behavior of policymakers and those responsible for the infrastructure, if appropriate. This can help you create a more comprehensive plan.

If you decide now that you want to incorporate policy and environmental changes in your program, you may need to go back to gather information about policymakers and other decision-makers (for example, a hospital administrator who decides where and when FP services will be offered). Think of them as influencing groups or as priority groups with their own behaviors to change.

Keep an Audience Perspective

We've talked about getting and keeping the priority group's perspective from the beginning. It is easy to get frustrated and start thinking of the priority group or influencing group as having poor attitudes or lacking basic knowledge. If you find yourself in this position, it can be helpful to remind yourself of the need for keeping their point of view. The behavior change strategy you develop should link directly to the results of your research and any other research you found credible. (When you look at your strategy, it should be easy to see the connections between the activities and what you have learned about the priority group. Key factors you found when you were analyzing your data should play a very strong role in the strategies you develop. The audience perspective includes where members are in the change process. For example, if most members of the priority group are aware of FP and can name several modern FP methods, they don't need

awareness-raising about FP. Depending on the Doer/Non-Doer Survey findings, they might need more information on how methods work or for the cost of FP to be lowered.

3. Ask for or give participants a few examples of BC activities before sending them off in their groups.
4. Each group will now identify 3–4 activities that are appropriate for reaching their priority group and addressing the key benefits and obstacles they have selected. They should make sure that not all activities relate to awareness and knowledge! Refer to the handout "Beyond Awareness Raising: Examples of Non-Communication Related Behavior Change Activities" for inspiration or to select some activities.
5. After they have chosen three or four activities, they should describe the content for each, especially showing how the activity addresses one or more of the benefits and obstacles. Then they should write the activity and the content in your Designing for Behavior Change Matrix.
6. Ask the groups to review their activities to be sure that they have picked a mix that:
   - Reaches enough people in the priority groups
   - Acknowledges where priority group members are in the process of change
   - Makes a clear call to action
   - Addresses the most important benefits and obstacles
   - Minimizes obstacles
   - Works together
   - Fits budget
7. After the case study group work is completed, have participants post their strategies and walk around and observe every group's Matrix, providing constructive feedback.
8. If time permits, distribute and review TA – Organizational Experiences with FP Integration and HO – Beyond Awareness, engaging participants in a discussion of how they might be relevant for the behavior change strategies they are developing. You might also want to review, or refer to, or distribute TA – Sample Healthy Timing and Spacing of Pregnancy Messages.

TRAINERS NOTE

Giving participants examples before they start could stimulate or stifle their creativity. As case study groups identify activities, visit to see how they are doing. If any seem stuck, give them the Beyond Awareness handout or Organizational Experiences training aid to help stimulate their thinking.

HO – Implications of Big Differences

Example:

Big Differences	**Implications for Behavior Change Strategy**
Perceived Consequences	
Benefit: Doers believe with FP the mother will be healthy (75% vs. 10% =→ 65%)	Increase knowledge that spacing births with modern FP improves mothers' health.
Obstacle: Non-doers believe FP could make them sterile (50% vs. 12.5% =→ 37.5%)	Reduce misconception that FP causes widespread infertility. Increase knowledge that fertility returns after temporary methods are stopped.
Obstacle: Non-doers believe FP could make them sick (70% vs. 25% =→ 37.5%)	No specific focus, but can address with other side effects and rumors.

Key (Big) Differences	**Implications for Behavior Change Strategy**
Perceived Consequences	
Self-Efficacy	
Social Norms	
Other Important Driver of Behavior	

HO – Developing a Behavior Change Strategy

General Principles

Some things to keep in mind when making strategy decisions are

- Be creative.
- Consider policy and environment-level changes when appropriate.
- **Keep your audience's perspective**.

The behavior change strategy you develop should link directly to the results of your research and any other research you found credible. (When you look at your strategy, it should be easy to see the connections between the activities and what you have learned about the priority group. Key factors you found when you were analyzing your data should play a strong role in the strategies you develop.

Be Creative

Behavior change strategy development lets you be creative in how you address the priority group's wants and needs. Brainstorm new and exciting ideas. Try to describe the priority group's experiences—both current experiences and those you would like them to have. For example, if your priority group is pregnant women 18 to 34 years old and you would like them to bring their partner in for family planning counseling for couples, pull all the information you found during the Doer/Non-Doer survey and from other research about all the steps they have to go through to do this. For example:

- How does she already approach health and family discussions with her partner?
- How does she get the partner in the right mood for such a discussion?
- What are some reasons and words she can use to start the discussion?
- When is the partner most likely to be available for couples counseling? (Early morning, late afternoon, evening?)
- How easy or difficult is it to get the partner to come to the health center for anything?
- Have they discussed child spacing before?
- What has the partner ever said about family planning?

Keep in mind that sometimes the most obvious answers are the best ones. Your strategy does not have to be complicated or revolutionary—it needs to get the job done. Tell participants that they will have the chance to look at examples of what other programs have done to help clients adopt family planning. They can determine whether aspects of any of them relate well to what they found in their research. They must be sure to take into account differences between your community and the community where the strategy or activity had success. **Some** key differences to consider will be: current attitudes and practices related to the desired behavior, community income and lifestyle, resources available, methods available, funding, and infrastructure. There might be many other things to consider as well.

Consider Policy and Environmental Changes

Policy or environmental changes can support individual behavior change. Many health programs get caught up in developing strategies to get individual-level behavior change without complementing those changes with policy or environmental level changes. How can you help make the behavior easier for your priority group? What barriers from your research findings can be overcome with policy or environmental changes? Think about strategies you can use to influence the behavior of policymakers and those responsible for the infrastructure, if appropriate. This can help you create a more comprehensive plan.

If you decide now that you want to incorporate policy and environmental changes in your program, you may need to go back to gather information about policymakers and other decision-makers (for example, a hospital

administrator who decides where and when FP services will be offered). Think of them as influencing groups or as priority groups with their own behaviors to change.

Keep an Audience Perspective

We've talked about getting and keeping the priority group's perspective from the beginning. It is easy to get frustrated and start thinking of the priority group or influencing group as having poor attitudes or lacking basic knowledge. If you find yourself in this position, it can be helpful to remind yourself of the need for keeping their point of view. The behavior change strategy you develop should link directly to the results of your research and any other research you found credible. (When you look at your strategy, it should be easy to see the connections between the activities and what you have learned about the priority group. Key factors you found when you were analyzing your data should play a very strong role in the strategies you develop. The audience perspective includes where members are in the change process. For example, if most members of the priority group are aware of FP and can name several modern FP methods, they don't need awareness-raising about FP. Depending on the Doer/Non-Doer Survey findings, they might need more information on how methods work or for the cost of FP to be lowered.

Look at What Others Have Done Successfully

This module contains case studies of successful integration of FP into MCH programs as well as sample behavior change strategies. Determine whether aspects of any of them relate well to what you found in your research. Do any aspects address the specific obstacles and benefits you discovered? Are their audiences similar to yours? How can you adapt them to make them more applicable to your audience and what you are trying to achieve?

Be sure to take into account differences between your community and the community where the strategy or activity had success. Some key differences to consider are: current attitudes and practices related to the desired behavior, community income and lifestyle, resources available, methods available, funding, and infrastructure. There might be many other things to consider as well.

Put your Strategy into a Framework

Using a good framework helps you organize your ideas. It can help to ensure that the activities you choose address specific, significant research findings. Here is one framework that can be used or adapted.

Program Objective:				
Priority Group	**Desired Behavior**	**Key Drivers of Behavior**	**Key Benefits & Obstacles**	**Activities**
Influencing Groups:				

Adapted from http://www.cdc.gov/nccdphp/dnpa/socialmarketing/training/index.htm

HO – Beyond Awareness Raising

Examples of Non-Communication Related Behavior Change Activities

Introducing a New Product/Promoting a Commodity Rather than Communication

- **CycleBeads** to help girls and women monitor their monthly cycle.
- **Condom Carrying Case** (for promoting safer sex)
- **"Tippy Tap"** During a midterm evaluation for a health project in Kenya, staff saw large changes in hand washing before eating, but not at the other critical moments. Mothers had agreed to increase hand washing prior to eating, but they had so little water, they reported that it was difficult to wash their hands at all the other times (self-efficacy related to resources). Health staff thus encouraged the promotion of the Tippy Tap as a way to conserve water, making it easier for them to do the behavior. (Tippy Taps are simple and economical hand washing stations, made with commonly available materials and not dependent on a piped water supply.)
- **Improved water storage containers** for drinking/cooking water (Haiti)
- **Small bottles** that project staff regularly refilled with small amounts of chlorine bleach for people to treat their drinking water.
- **Hand-washing stations** next to the latrine and 'kitchen' in Madagascar to increase hand washing with soap
- **PUR** (for water purification)
- **Soap** (for hand washing)
- **ITNs** (for malaria prevention)
- **Bowl** (rather than eating from the family plate) so a mother can monitor quantities of semi-solid foods actually going to the child for infant feeding
- **Thermos** (provided to health centers to keep the open vials fresh to the next day)

Activities to Increase Access

- **Community-based distribution** of FP methods such as oral contraceptives, condoms, and injectable contraceptives (requires needs assessment, training, re-supply, supervision, and monitoring)
- Including FP commodities in **community pharmacies**
- **Integrating FP into clinic outreach services**
- **Increasing the supply of HIV test kits** at health center level
- **Creating a counseling corner** away from the earshot of other waiting clients (for increasing uptake of FP and/or HIV counseling (in antenatal visits or otherwise)
- **Introducing youth-friendly reproductive health services**
- **Increasing/improving supply of vaccines** to health center
- **Providing micro-loans** to start small businesses that sell contraceptives in local markets
- **Advocating for Policy Changes:** convincing private sector soap companies or the government to either reduce prices, subsidize, or make soap tax free; convincing clinics to support baby friendly initiatives (to encourage women who deliver to exclusively breastfeed); encouraging clinics to eliminate restrictions saying they cannot open a vaccine vial to immunize just one infant at a time; working with employers to provide nursing breaks; working with schools to stipulate that children must be vaccinated to enter school; convincing hospital administrators to reject free formula in hospitals & to encourage rooming-in; changing legislation so that AIDS orphans are able to inherit their parents' land

Environmental Changes

- **Helping health workers explore ad evolve their attitudes** about family planning and the use of modern methods to space pregnancies**.**
- **Training in negotiating practices**: Train health care providers in negotiating skills and in how to teach negotiating skills to clients.
- **Using role plays** to practice negotiating safer sex, or talking with your doctor, or talking with your patients.
- **Training community members on how to talk about sensitive topics with their partner or teen/ preteen children**. An example from Malawi: parents and 8–11 year olds agreed to talk twice a week for three months about sexual and reproductive health issues. Parents and children were supported with some initial training about how to talk about sensitive subjects with each other and were given a booklet to stimulate discussion. Follow up visits from project staff were to learn how it was going and give encouragement—not to communicate any new messages. The result was that each group came away feeling like they could talk to the other much better on every day topics as well as the project related topics.
- **Training people on legal issues** in communities where there are problems with reproductive rights, etc. In these cases, there may be a set of messages that you want to get out to people about their rights (including health providers, who might not know they can provide FP without permission of a spouse or to unmarried people.
- **Training nurses to give tablets** as opposed to always giving injections.
- **Promoting Values**: some organizations (like Food for the Hungry) promote certain **values** to try to help behavior change happen. For example, they might promote the value that women and men are both made in the image of God and have value, or that each child's life is sacred. For example, in some cultures, the word for woman is the same as the word "tool." In a culture such as that, we need to go deeper than behavior, to the values level, if we want to see changes happen. The target is still on behavior change, but the level of intervention will be deeper in the psyche.

Adapted from: *Basics of Community-Based Family Planning Training Curriculum*, 2009

TA – Organizational Experiences with FP Integration

Case Study: Keneya Ciwara: Supporting Family Planning In Mali

Submitted to The Communications Initiative by kdevries on November 13, 2009 – 12:44pm

Author: Sarah Castle **Publication Date**: May 1, 2009

Summary: *"In Bamanankan, Mali's lingua franca, 'Keneya' means 'health' and 'Ciwara' is an antelope mask used in celebratory masked dances. The Ciwara has become Mali's symbol of national pride and identity and, above all, courage."*

From the series *Voices from the Village: Improving Lives through CARE's Sexual and Reproductive Health Programs*, this 12-page report highlights a communication-centred family planning programme implemented in Mali. The case study describes Keneya Ciwara, an initiative carried out in the economically poor and remote commune of Kendie, located in the heart of Mali's Dogon country (named after the area's principal ethnic group). The goal is to increase the availability and demand for quality health services at the community level while improving essential health practices in the household.

"Taken together, the region's extreme poverty, high child mortality, low levels of education and cultural emphasis on large families make family planning a tough sell." The greatest challenge, however, is reported to be overcoming men's opposition to contraceptives—which is based on a number of misconceptions, including the myth that contraceptive use makes women sterile. It is such challenge that motivated the project's implementation by a consortium composed of CARE, the Johns Hopkins University/Center for Communication Programs (JHU/CCP), IntraHealth International, and the Groupe Pivot/Santé Population (GP/SP)—with support from the United States Agency for International Development (USAID).

During its first phase (2003–2008), Keneya Ciwara focused on actively involving community members in contraceptive distribution, and it worked to improve immunisation, control of malaria and diarrhoeal diseases, nutrition, and reproductive health. The second phase of began in October 2008 and will last 3 years, eventually covering every health district in the country.

Keneya Ciwara revolves around a system of volunteer outreach workers ("relais") that seeks to raise awareness about family planning and other health issues among community members who lack access to local health centres. After prospective outreach workers are chosen by their village committees, they receive 7 days of training, followed by a certificate and recognition by the community ("an important step toward gaining the trust and respect of the people they aim to serve"). In Kendie health district, 18 outreach workers are assigned to serve 7 area villages.

Another crucial component of the programme is Musow Ka Jigiya Ton (MJTs, or **Women's Savings Clubs**). Because they are designed to provide women with an opportunity to improve their financial security as well as a source of funds to help ensure their reproductive health, the name given to this approach in Bamanankan is tonofla, meaning "a two-fold purpose". Each MJT selects members who are trained by the programme to be community health agents. These agents then provide basic health information and peer counselling; for example, they talk with other women about how to better communicate with their husbands about family planning. Like the outreach workers, each health agent is given an initial stock of contraceptive products that she can sell to generate income, which she then contributes to a communal fund. This money can finance the purchase of more family planning products and also fund women's visits to the community health centre, where they can procure other contraceptives, such as injectables, when needed. Members can also borrow money from the fund to start their own small enterprises. During the first phase of Keneya Ciwara, the leaders of more than 300 MJTs throughout Mali were trained; in addition, the groups received 1,000 boxes of contraceptives to sell in their respective communities. As of May 2007, there were about 560 women participating in 20 MJTs across 7 villages in the Kendie health district. In the first phase of the programme, they mobilised more than US$18,000 in credit and carried out 188 awareness-raising sessions on health and family planning, which involved nearly 4,000 local women.

Results:

At the 2004 baseline survey of Keneya Ciwara, 75.9% of women of reproductive age (WRA) in Bandiagara Cercle knew a modern method of contraception. At mid-term (2006), that number had increased to 84.6%, and at the final evaluation, that percentage rose to 84.9%. Furthermore, the final evaluation showed that the contraceptive prevalence rate (CPR) was 13.5% for women in MJTs, versus 6.1% for those not in a group. MJT membership rose considerably during the first phase of the programme, from 25.6% to 45.2%.

There was a nearly threefold increase in contraceptive use in Bandiagara Cercle during the first phase of the programme; by comparison, the CPR in the entire Mopti region, which includes Bandiagara Cercle, was only 2% in 2006 (less than half that of the rate in Bandiagara Cercle). Furthermore, "the use of injectables in Kendie began to rise steadily in 2006, indicating that MJT community health agents and local outreach workers were referring increasing numbers of women to the health center for injectables. At the same time there is a decrease in the use of pills. This is likely due to the fact that women were purchasing them from the MJT community health agents and outreach workers."

CARE's Dr. Nouhoum Koita, deputy chief of party of Keneya Ciwara, commented: "If such good results can be achieved among the Dogon population of Bandiagara, who are from a very rural, conservative setting, then this reflects the efforts of the outreach workers, the women's groups and, especially, the goodwill of the villagers."

According to this document, "[t]he clear message emerging from Keneya Ciwara is that women's groups can help significantly increase rates of family planning. The groups offer women economic independence from men, allowing them to support one another in the face of opposition from their husbands. This dynamic system needs to be increasingly capitalized on through the recruitment of more female outreach workers and through the creation of more women's associations throughout the Keneya Ciwara program. Keneya Ciwara will also strive to increase the number of women trained as outreach workers. An important next step in the program is thus to emphasize, particularly to men, that there are economic advantages to using family planning. Women's groups can help open up dialogue on this subject by giving women the support and negotiating skills to improve spousal communication."

Web link: Click here to access the full document in PDF format (in English).

Contact Information: Sexual and Reproductive Health Department – CARE USA

Source: Implementing Best Practices (IBP) Knowledge Gateway Global Community eNewsletter, November 9 2009.

Edited for length. Source: http://www.comminit.com/?q=africa/node/305711 (accessed 26 October 2011)

Best Practices, Success Stories, Innovations, Lessons Learned

Respondents participating in the CORE Group survey on CBFP/MCH Integration conducted August–September, 2010, provided the following examples, which have been edited.

Save the Children

In our emergency malnutrition crisis response in a district in Southern Ethiopia, we documented mothers who need FP services (long- or short-term) during our outpatient Community-Based Management of Acute Malnutrition (CMAM) program and during health education sessions. We found out that hundreds of mothers were in need and the district had no trained health workers, especially in long-term contraceptive techniques. We wanted to integrate FP in our emergency response but did not have the resources. We contacted Pathfinder. They provided training for health workers, and we facilitated supplies from the Regional Health Bureau. With this, more than 200 mothers in the CMAM program benefited. This integration and collaboration for the first time provided long-term contraception in the district.

Save the Children

We used Partnership Defined Quality methodology to increase use and coverage of FP in Guatemala as part of the Maya Salud project. However there was no clear intention to improve MCH services. But I think that because they trained the CHWs to provide FP services, improved MCH ended up being one of the synergies of the project. They used existing MCH mechanisms to establish training for CHWs. Learn more at http://www.k4health.org/toolkits/communitybasedfp/country_experiences/improving-fp_partnerships_guatemala

Helen Keller International

We have only a small experiment with FP integration, in a European Union-funded project in the Zinder region of Niger. Niger has about the world's highest fertility rates, so the connection between fertility and under-nutrition is starkly clear. The primary objective of the project was to reduce under-nutrition among children 0–24 months and their mothers through a combination of preventive strategies (using the Essential Nutrition Actions framework and training health workers and community volunteers in the key services and messages) and treatment (community-based management of acute malnutrition). The project also used growth monitoring and promotion to identify children with faltering growth, counsel mothers on appropriate feeding, and refer severe cases. Monthly GMP meetings at the village level included a weighing station, a growth curve plotting station, and a counseling station. The last station was staffed by a local health outreach agent who also provided immunization and distributed birth control pills to interested mothers. The essential nutrition messages included reference to spacing births at least three years apart to reduce malnutrition and improve survival, so it seems a good proportion of women were indeed interested.

We expect more information from an evaluation of the effectiveness of this approach (quantitative and qualitative) by the end of September 2010. HKI is most interested in building on this project in Niger, especially where FP has been so neglected and the need so urgent.

Health Alliance International

For us in Timor-Leste, the first step had to be developing a maternal and newborn care (MNC) program. That involved a lot of work with communities, showing them—as well as MOH staff—that health was our main aim. The Timor perception of family planning historically had been dominated by coercive attempts to limit population growth (under Indonesia), and any discussion of 'limiting children' was unwelcome. But the idea of making mothers and their children healthy was a very well received message. So we started with MNC, developing films and other innovative materials that stimulated a lot of discussion among both men and women in rural communities about reproductive health and ways to ensure healthy moms and babies. After a national survey (DHS) showed in 2004 that Timorese women had the highest fertility recorded in the world, the MOH agreed it was an opportune time to integrate FP into our MNC program. But qualitative investigations at the start showed that spacing of births was the acceptable entrée, so rather than using the Indonesian term for family planning, we developed one in Tetum, the local language, for Child Spacing (Espaco Oan). Using the health aspects of spacing as the main focus, we got substantial support from communities, MOH staff who were previously reticent to talk about family planning, and even many in the Catholic Church. The films we developed to promote child spacing had an appearance by one of the Timor bishops, and also a scene where a nun talks about natural methods. The Vice Minister of Health requested that she be allowed to appear in an introduction section of the film. And the child spacing motivation film (part one of two) has been shown on national television to an estimated audience of 150,000. Visit http://www.healthallianceinternational.org/success-stories/case-studies/timor/ for more information.

Save the Children

Save the Children and JHU/CCP used Flexible Fund Family Planning Program support to integrate FP with a literacy program. Because women and people are so focused on getting day-to-day needs met, they sometimes do not seek health services even though knowledge about health and family planning is high. FP should be integrated (beside MNH) with some other program that is useful for people's daily life, such as income generation and education.

Save the Children

The project leveraged existing social networks to train "amigos/as" who were concerned citizens to be FP mobilizers. They would go about their daily work and bring along a packet of FP methods and just share them with their friends. This demystified FP and encouraged women to feel comfortable going to the health center for reproductive and sexual health services.

HealthRight

FP should go through the government system, and local CBOs, private providers, and NGOs should be mobiized.

TA – Sample Healthy Timing and Spacing of Pregnancy (HTSP) Messages

These messages can be adapted to the priority group (and should be pretested with members of the priority group before being widely used).

HTSP Messages to Achieve Healthy Pregnancy Outcomes

After a live birth:

- Couples can use an effective family planning (FP) method of their choice continuously for at least two years before trying to become pregnant again.
- Couples who choose to use an effective FP method continuously can plan to have their next pregnancy not more than five years after the last birth.

After a miscarriage or abortion:

- Couples can use an effective FP method of their choice continuously for at least six months after a miscarriage or abortion before trying to become pregnant again.

For adolescents:

- Adolescents need to use an effective FP method of their choice continuously until they are 18 years old before trying to become pregnant.

HTSP Benefits

HTSP Benefits Newborns, Infants, and Children under Five

- HTSP is associated with reduced risk of:
  - » Pre-term births, low birth weight, small for gestational age, and, in some populations, stunting or underweight conditions
  - » Death for newborns, infants, and children under five
  - » Pre-term births and low birth weight for newborns, when mothers wait until age 18 to have their first pregnancy
  - » Pre-term births, small for gestational age, and low birth weight, when mothers wait at least six months from the time of a miscarriage or abortion before attempting a pregnancy again
- HTSP allows young children to experience the substantial health benefits of breastfeeding for a full two years.

HTSP Benefits Mothers

- Gives mothers two years to prepare physically, emotionally, and financially for their next pregnancy, if they choose to have one
- Helps young mothers avoid pregnancy-induced high blood pressure and associated complications, obstructed and prolonged labor, iron-deficiency anemia, and maternal death
- Provides mothers with two full years before becoming pregnant again to focus on their newborns, partners, and other children
- Is associated with reduced risk of pregnancy complications like preeclampsia
- Allows two years of breastfeeding, which is linked with reduced risk of breast and ovarian cancer

HTSP Benefits Men

- Helps men safeguard the health and wellbeing of their partners and children
- Allows men time to plan financially and emotionally for their next child, if they choose to have one
- Contributes to a man's sense of satisfaction from supporting his partner in making healthy decisions regarding HTSP and family planning use and raising a healthy family

HTSP Benefits Communities

- Benefits communities by helping to reduce deaths and illnesses among mothers, newborns, infants, and children
- Benefits communities by helping to reduce poverty and to improve the quality of life among community residents

Source: Healthy Timing and Spacing of Pregnancies: a Pocket Guide for Health Practitioners, Program Managers, and Community Leaders, http://www.esdproj.org/site/DocServer/ESD_PG_spreads.pdf?docID=141 (accessed 24 October 2011)

STEP 9

Implement Your Evidence-Based Strategy

Total Suggested Time
30 minutes

Here, we develop an implementation plan (including timeline, resources, persons responsible, and other elements) and budget.

Activity: Developing an Implementation Plan and Budget

LEARNING OBJECTIVES

At the end of this activity, participants should be able to:

1. Identify potential risks and obstacles to implementing their new behavior change strategies.
2. Develop an implementation plan.

Training Methods

Discussion, practical exercise

Supplies Needed

- Flipchart, markers, tape
- HO – Work Plan
- HO – Sample Budget

Preparation Needed

Prepare flipchart with work plan matrix

1. Explain to participants that once the behavior change strategy has been developed, the next step is to develop an implementation plan and budget. Developing these should help identify potential obstacles to implementation.
2. Ask participants to review the plans they developed (or one that can serve as an example). Ask what impact each of the proposed activities might have on the MCH program, clinic, or other entity as applicable. Summarize these on a flipchart.
3. Distribute the handout "Work Plan". Review the different elements of the work plan and have participants tell the group what type of information goes in each column. Just mention "Indicator" and "How and When to Measure", telling participants they will be covered in the next step.

Sample Work Plan

Program Objective: _____

Behavior: _____ Priority Group: _____ Project Life: _____

Driver of Behavior	Benefits/ Obstacles	Activities	Time-frame	Budget	Other Resources	Primary Respon-sible	Indicator	How and When to Measure

4. Give the case study groups 10–15 minutes to complete implementation plans for their strategies. Once the allotted time is up, allow one group to present its plan and have the rest provide feedback. For the feedback, any participant who wishes to comment should say one thing good about the work plan (one thing that no one else has already highlighted) before providing constructive feedback on one thing they feel can be improved.
5. Now that there is a work plan, ask participants how much money is needed to carry it out? Pull from them the budget categories that need to be considered, even if amounts cannot be determined during the workshop. With the group, estimate costs for which the facilitator or participants can be relatively sure. Distribute the handout "Sample Budget Categories" and ask participants how they would tailor it to meet their needs.
6. If possible, the facilitators should take time after the workshop to help finalize any work plans that will be carried out and to develop budgets for doing so. Someone should also be responsible for ensuring work plans are funded and carried out.

HO – Work Plan

Program Objective: _____

Behavior: _____ Priority Group: _____ Project Life: _____

Driver of Behavior	Benefits/Obstacles	Activities	Timeframe	Budget	Other Resources	Primary Responsible	Indicator	How and When to Measure

HO – Sample Budget

The following is sample budget for implementing a behavior change strategy. It is a guide and not meant to include everything that could possibly be found in a budget. Use this budget as a starting point for developing a budget that is specific to your strategy. What will be included in your budget varies depending on the complexity of the activities to be undertaken; the supplies, materials, and equipment needed, the number of staff devoted to the strategy, and if you have contracted out part of the work (such as materials development). Each strategy or project will have different budget line items and costs reflecting local resources, staffing patterns, and donor requirements.

FP BEHAVIOR CHANGE STRATEGY BUDGET

	Amount in USD or local currency	
Personnel Cost		
Project Director (.1 time at $xx/month)	_____	
Project Coordinator (.50 time at $xx/month)	_____	
Support staff (.25 time at $xx/month)	_____	
Driver (.2 time at $xx/month)	_____	
Benefits	_____	
Total Personnel Cost:		_____
Transportation		
Public Transport	_____	
Other	_____	
Total Transportation Cost:		_____
Supplies and Materials		
_____	_____	
_____	_____	
Total Supplies and Materials Cost:		_____
Communication (telephone, internet access, fax, postage)		_____
Administrative/Overhead Costs		_____
TOTAL BUDGET:		_____

STEP 10

Assess and Adjust Your Strategy

Total Suggested Time
30 minutes

To know if the behavior change strategy is succeeding, you need to decide what you will measure, how you will measure it, and how often. You will also need to figure out how to use what you learn to improve the strategy itself or how it is implemented. This session is intended as a very basic monitoring and evaluation (M&E) "how to" for organizations that do not have an M&E unit charged with monitoring behavior change activities. It should help staff develop a basic evaluation plan to help them see what is working and what should be adjusted. If the organization has an M&E unit that will monitor behavior change, use this step to spell out the role of staff who develop or implement the behavior change strategy. (Do they help establish indicators? Collect data? Interpret and apply the findings of the M&E unit? Work with the M&E unit in another way?)

Activity: Monitor, Evaluate, and Tweak

LEARNING OBJECTIVES

By the end of this activity, participants should be able to:

1. Cite at least two reasons assessing a behavior change strategy is important.
2. Identify at least one method of monitoring and evaluation that is feasible for your program to use.

Training Methods

Discussion, small group work (optional), game

What Might Need Adaptation

If workshop staff will not be involved directly in M&E, use this time to:

- Determine what information they need to from M&E to know how well the strategy is working and what might need to be changed.
- Explore ways to work with the M&E unit to ensure the M&E plan gives them the information they need.
- Explore what they should be looking for as implementation proceeds. A formal evaluation is not always necessary to notice if things are going really well or really poorly, and there are bound to be steps managers and implementing staff can take to improve the strategy to get better results.

Supplies Needed

- Flipchart, markers, tape
- HO – How to Monitor and Evaluate a Behavior Change Strategy
- Sample behavior change strategy and assessment findings (from the group's work)

1. Using what the group has done, prepare a flipchart with two columns—one labeled "Monitoring", the other called "Evaluation". Ask participants what are some differences between monitoring and evaluation. Summarize their responses in the appropriate column. If necessary or desired, start with definitions of each and then ask a series of who-what-when-why-how questions. Emphasize the differences that are important for the work participants will be doing. Some differences include:

Monitoring	**Evaluation**
Regular checking, observation	Measuring against objectives to judge performance
Done on an ongoing basis—weekly, monthly, etc.	Done after enough time has passed to expect to see meaningful differences
Good way to see trends as they are happening	Good way to pinpoint what needs to be changed
Gathers information	Interprets information

2. Ask participants why it is important to monitor and evaluate their behavior change strategy.

TRAINERS NOTE

Possible reasons:

- *To know if it's being implemented as planned and, if not, why not.*
- *To know if the activities are acceptable to the community.*
- *To determine if any adaptation is necessary.*
- *To determine if the strategy is effective at helping the priority group adopt healthy new behaviors and how to improve it.*
- *If successful, to be able to demonstrate that to donors, policy makers, and others.*

3. Explain that it is important to decide what will be measured, i.e., the indicators. Review the indicator section of "HO – How to Monitor and Evaluate a Behavior Change Strategy" with participants.
4. Post the sample work plan flipchart. Ask participants what they would need to measure to know if the first activity was working.
5. In the full group or small groups, have participants identify appropriate indicators for at least two of the activities in the sample work plan or their case study group's work plan.

TRAINERS NOTE

Alternatively, If the program has pre-determined FP indicators, post or distribute a list of them (at least the ones applicable to the behavior change strategies participants developed) and have participants match indicators to activities in their strategies.

6. Ask participants to brainstorm different ways to monitor and evaluate a behavior change strategy. Write all of their ideas on a flipchart. Briefly review that section of "HO – How to Monitor and Evaluate a Behavior Change Strategy."

7. Now ask participants to match practical methods they can use to monitor and evaluate their behavior change strategies with the indicators they have chosen. This can be done in the full group or case study groups, depending on the time available.
8. Once the methods are matched to indicators, lead participants in a discussion of when or how often each method should be applied. Some things can be done monthly (such as reviewing service statistics) while others (such as exit interviews) might be done after six months of implementation and then in another 12 months, for example.
9. Give participants an example of a simple behavior change strategy and what an assessment of it showed. Have the group brainstorm ways to adjust the strategy to take full advantage of what worked well and change anything that did not work well.
10. Summarize this activity by pointing out that, with at least some M&E methods, it's fine to ask for suggestions on improving the activities selected. Add that doing a formal assessment of the strategy when feasible will help them will better understand how effective the activities are and can provide good information for developing additional behavior change strategies. Emphasize the importance of **using** evaluation results to improve the program, whether this means adjusting the strategy or developing a new one.

HO – How to Monitor and Evaluate a Behavior Change Strategy

What are monitoring and evaluation?

Monitoring is the systematic collection and analysis of information as a project progresses. Organizations do it to help improve efficiency and effectiveness. It helps to keep the work on track, and can let management know when things are going wrong. If done right, it is an invaluable tool for good management, and it provides a useful base for evaluation. Comparing service statistics against targets every month is one way of monitoring a project.

Evaluation is the comparison of actual project outcomes and impacts against the agreed strategic plans and objectives. It looks at what you set out to do, at what you have accomplished, and how you accomplished it. It can take place during a project, to improve the strategy. It can also take place after a project has ended. Someone once described this as the difference between a check-up and an autopsy!

Monitoring and evaluation should go hand-in-hand. Both should help you learn from what you are doing and how you are doing it, by focusing on efficiency (is the output worth the input?), effectiveness (were the objectives achieved?), and impact (what difference did it make?).

Indicators: what they are, why we need them, and how we use them

Most simply put, an indicator is something that tells you something — it is a marker, or a sign.
Other definitions include:

- Indicators are concise measures that aim to describe as much about something as possible in as few points as possible. Indicators help us understand, compare and improve. [The Good Indicators Guide]
- An indicator is a measure of the progress made towards an objective, or a marker or target to show progress has been made (Webb 2002). Indicators are usually a marker or standard by which achievement of objectives is measured; for example, number of people trained, number of youth reporting consistent condom use, number of people referred, etc. Indicators help program managers measure what has been achieved, whether the needs of the intended beneficiaries have been met, and whether the best strategies have been pursued. *Process indicators* are used to assess whether program activities are being carried out as planned (e.g., number of counselors trained). *Behavioral outcome indicators* are used to assess whether changes in behaviors are occurring. *Impact indicators* are used to assess whether desired program impacts were achieved. [*A Guide to Participatory Monitoring of Behavior Change Communication for HIV/AIDS: Getting the Community and Program Staff Involved in Assessing and Improving Programs*, Gill et al.]

To evaluate your behavior change strategy, you need to decide on indicators and have a measurement of them before implementing your strategy. This first measurement is called the "baseline." It tells you where you are starting. That way, when you measure it again during or after implementing your strategy, you can say how much change has taken place.

Always choose indicators that are directly related to the activities in your strategy and what they are supposed to achieve. Ask yourself what are the one or two or three most important things to measure. For example, if one intervention is to make sure all new mothers are counseled about LAM and the minipill to delay their next pregnancy at least until they finish breastfeeding, indicators could be the number or percentage of new mothers counseled, the number of new mothers who say they are using LAM correctly within the first six months after giving birth, or the number of new mothers receiving the minipill when they come back for the baby's DPT1, DPT2, and DPT3. You could measure this by adding appropriate questions to the intake form for pregnant women, newborns, and under-fives. You could also measure it by looking at service statistics—comparing the number of minipill packets distributed the month before the intervention to the number distributed each month after the intervention starts, for a defined period of time (6–12 months, for example). If you want to get a better sense of whether and what parts of the intervention worked, you could survey clients about why they decided to use the minipill or LAM, where they get it, how they take it, etc.

You can also measure things that come before actual behavior change. These are indicators of where your target audience is along the behavior change continuum. What is their awareness of family planning and family planning methods? What and how much do they know about FP methods? What are their attitudes toward family planning and modern or traditional methods? Do they feel they can successfully use FP? What do they think their peers or community think about FP and women/couples who use it? Are they able to demonstrate correct use of FP methods?

Some standard indicators for family planning behavior change include:

- Couple-years protection (CYP)—this is a calculation of how many of each type of contraceptive are distributed over a certain period and can be calculated using the number of each type of contraceptive distributed by the clinic.
- Number of new FP acceptors (the number of persons who accept for the first time in their lives any contraceptive method offered by the program; to be reported for a defined period (e.g., one year). Can be gathered from service statistics.

Here is one example of an indicator of progress toward the desired behavior change:

- Number of women 18–49 years old requesting information about FP during antenatal or MCH visits.

Some ways to evaluate a behavior change strategy

To evaluate the effectiveness of the activities and overall strategy, one or more of the following methods or methods mentioned above may be selected:

- **Baseline and follow-up surveys**. These can be simple, very focused questionnaires designed and pretested to get just the information you really need to evaluate your strategy.
- **FP statistics**. By reviewing service statistics each month, staff can see if FP uptake is increasing, if certain types of clients (e.g. new mothers) are adopting FP, which methods are most used, etc.
- **Interview clients** who were exposed to the activity. Did they understand it? Can they recall the information conveyed? How did the activity affect their decision whether to use the product or practice the behavior? If it was print material or a video: Do they still have it? When do they use it? Have they shown it or given it to friends?
- **Hold group discussions** to obtain feedback on activities from clients as well as service providers.
- **Observe** health workers and program administrators to evaluate how well they are carrying out their part of the activity and whether it is making any difference.
- **Attend a clinic posing as a client to find** out how service providers interact with clients.
- **Conduct intercept interviews** with clients or potential clients outside the clinic setting to see what messages they heard and whether or not they were exposed to the activity.
- Observe clients practicing a new behavior that is promoted by the activity, such as mixing oral rehydration solution or preparing infant weaning food.
- **Ask clients** how they learned about the service.
- **Ask trainees** what was useful about the activity.
- **Conduct a survey**. Audience awareness surveys are frequently used. For instance, people may be asked if they have heard a radio program or spot during a specified period of time. *Pre- and post-surveys* are a standard technique used to measure the impact of an intervention the on individual's knowledge, attitudes and practices. *Exit surveys* ask clients about their experience at a clinic.

When using any of these techniques, it is okay to ask for suggestions for improving the behavior change approach. Ideally, you would also have a "control" population that did not "receive" the intervention—this would allow you to more clearly show that any changes were most likely due to your intervention, but this is not always feasible.

When this stage of evaluation is completed, project staff will better understand how well the activities are understood and accepted, and whether the effectiveness of the activities justifies their cost.

Adapted from:

- Monitoring and Evaluation by Janet Shapiro (email: nellshap@hixnet.co.za) http://www.civicus.org/new/media/Monitoring%20and%20Evaluation.pdf (accessed 11/10/11)
- MEASURE Evaluation PRH, http://www.cpc.unc.edu/measure/prh/rh_indicators/specific/fp (accessed 11/10/11)
- Gill K, Emah E, Fua I. A Guide to Participatory Monitoring of Behavior Change Communication for HIV/AIDS: Getting the Community and Program Staff Involved in Assessing and Improving Programs

Closing

Total Suggested Time
30 minutes

LEARNING OBJECTIVES

By the end of this session, participants will:

1. Get an indication of how much they learned during the training and what areas they might need to work on. [Or: Determine post-training knowledge about developing BC strategies.]
2. Have had the opportunity to express their views on the training workshop.

Training Methods

Post-test, discussion, game

Supplies Needed

- HO – Pre/Post-Test (orginally introduced during Welcome and Introduction)
- TA – Pre/Post-Test Key (orginally introduced during Welcome and Introduction)
- HO – Workshop Evaluation
- Return participants' marked tests to them
- Pre- and Post-test scores

Preparation Needed

Mark the post-tests immediately upon receiving them and compare pre-test to post-test scores. Identify the most improved and the highest scores. Here's how to calculate the percentage change:

Step 1: Take the old value and subtract it from the new value, then divide by the old value.

Step 2: Multiply by 100. That number represents the percent change.

Here's an example:
The local school had 16 teachers in 2008. The next year, there were 12. What is the percent change from 2008 to 2009?

Take 16 and subtract 12. That's 4. Then divide 4 by 16. That's .25. Now multiply by 100 and you get 25. That's the percent change. The number of teachers at local school went down 25 percent from 2008 to 2009.

Adapted from: http://www.ehow.com/how_2165137_calculate-percent-change.html#ixzz0woA18gub

Activity 1 Post-Test (optional)

10 minutes

1. Point out to participants that they have learned a lot in a very short time. Ask them if they feel satisfied with what they learned. Tell them that, as promised, they will now have the opportunity to answer the same questions the answered at the beginning of the workshop.
2. Distribute the test. Ask participants to write their names (or whatever they used for the pre-test) at the top of each page.
3. Tell participants they have exactly 10 minutes to complete the post-test, and tell them when to start. Collect the questionnaires after 10 minutes.

Activity 2 Workshop Evaluation

10 minutes

1. Option 1: Engage participants in a brief discussion of what they liked about the workshop and what can use improvement. This can be done by tossing a ball or something to one participant at a time and asking them to comment.
2. Option 2: Ask participants to complete a workshop evaluation form. Tell them what they write will help improve the training in the future.

Activity 3 Closure

10 minutes

1. Congratulate participants and comment on the post-test as appropriate.
2. Explain that the scores are one indication of what participants learned—the work they do with what they learned is even more important.
3. Comment on facilitators' perceptions of the progress made and what the next steps are (for example, when they will conduct a full Doer/Non-Doer survey).
4. Return pre- and post-tests to participants so they can see how they did.
5. Thank participants for fully engaging in the workshop and congratulate them on their accomplishments.
6. If appropriate, hold a brief closing ceremony where participants receive certificates of completion.
7. Participants may want to give a vote of thanks.

HO – Workshop Evaluation

Date: _____ Location: _____

Workshop Objectives:

At the end of this training, participants should:

- Be able to design and conduct formative research.
- Be able to develop an evidence-based, targeted behavior change strategy to help willing clients adopt family planning.
- Have skills and tools needed to plan for and assess the success of a BC strategy

Please rate the training workshop on each item below using a scale of 1 to 4, with 1 being "Strongly Disagree" and 4 being "Strongly Agree". Please use the comments sections to provide more information about the rating chosen as well as suggestions for improvement.

Statement	**Strongly Agree**	**Agree**	**Disagree**	**Strongly Disagree**
1. The workshop fulfilled its objectives (see above). Comments:	4	3	2	1
2. The workshop was well organized. Comments:	4	3	2	1
3. The workshop was the right length. Comments:	4	3	2	1
4. The order of workshop activities was appropriate. Comments: .	4	3	2	1
5. The activities were effective. Comments:	4	3	2	1
6. The training materials were effective. Comments:	4	3	2	1
7. The facilitators were responsive to participants' needs. Comments:	4	3	2	1

Statement	Strongly Agree	Agree	Disagree	Strongly Disagree
8. There were adequate opportunities for discussion. Comments:	4	3	2	1
9. I am comfortable with my ability to design a Doer/Non-Doer survey questionnaire. Comments:	4	3	2	1
10. I would feel comfortable conducting a Doer/Non-Doer survey. Comments:	4	3	2	1
11. The workshop gave me the skills I need to develop a better behavior change strategy. Comments:	4	3	2	1

List three things you will do differently as a result of this training.

What parts of the training were **least** useful to you?

I need more help with _____

The hardest thing to grasp was _____

Any other comments or suggestions?

Thank you!

Appendix 1 – List of Handouts (HOs) and Training Aids (TAs)

Welcome and Introduction	
Activity 1 – Opening	
Activity 2 – Pre-Test (optional)	HO – Pre/Post-Test TA – Pre/Post-Test Key
Activity 3 – Integrating FP into MCH services	HO – Workshop Schedule HO – Ten Steps to Developing a Behavior Change Strategy TA – FP Integration Role Play Scenarios
Step 1 – Understand Behavior Change	
Activity 1 – Making a Change	
Activity 2 – Stages of Change	TA – Stages of Change Cards (one set)
Activity 3 – Identifying the Steps in the Change Process, Our Roles, and the Community's Role	TA – Process of Planned Change cards (as many sets as there will be small groups)
Activity 4 – Being a Change Agent	HO – Understanding Behavior Change (optional)
Step 2 – Develop a Framework for the Behavior Change Strategy	
Activity – Behavior Change Strategy Overview	HO – Behavior Change Strategy Framework (blank) HO – Six Principles of Designing a Behavior Change Strategy HO – Sample Behavior Change Strategy Based on Doer/Non-Doer Survey Results (optional)
Step 3 – Define the Priority Group and Behavior	
Activity 1 – "Exercise" Exercise	TA – Exercise Statements
Activity 2 – Selecting Priority and Influencing Groups	HO – Five Ways to Describe Your Priority or Influencing Group (sample) HO – Five Ways to Describe Your Priority or Influencing Group (blank)
Activity 3 – Defining the Behavior You Will Promote	HO – Clearly Defining Behaviors
Activity 4 – Things that Drive Behavior	HO – Things that Drive Behavior
Activity 5 – Key Benefits and Obstacles	
Step 4 – Learn More about the Priority Group and Influencing Group	
Activity 1 – Doer/Non-Doer Analysis Overview	TA – Types of Formative Research HO – Accessing Existing FP Research (optional) Activity – Getting Access to Existing Research (optional)
Activity 2 – Adapting the Doer/Non-Doer Survey Questionnaire	HO – Doer/Non-Doer Survey Questionnaire HO – Long-Form Doer/Non-Doer Survey Questionnaire (optional) TA – Doer/Non-Doer Survey Questionnaire Instructions

Step 5 – Field Test the Doer/Non-Doer Survey	
Activity 1 – Discussion and Optional Demonstration	HO – Tips for Effective Interviewing
Activity 2 – Role Play	
Activity 3 – Field Practice and Questionnaire Pre-Test	TA – Doer/Non-Doer Survey Field Test Observation Checklist (optional)
Activity 4 – Tabulating the Results	HO – Coding Guide (blank) HO – Sample Doer/Non-Doer Survey Results
Activity 5 – Making Sense of the Results	Completed coding guides TA – Sample Doer/Non-Doer Survey Results Research findings grid (handout or flipchart)
Step 6 – Plan and Conduct a Doer/Non-Doer Survey	
Activity – Parameters for Conducting the Survey	TA – Doer/Non-Doer Survey Summary (example)
Step 7 – Analyze Data Collected in the Field	
Activity 1 – Tabulating the Results	Completed surveys HO – Coding Guide (as revised during analysis of the field test results)
Activity 2 – Making Sense of the Results	Completed coding guides Research findings grid (handout or flipchart)
Step 8 – Develop your Behavior Change Strategy	
Activity 1 – Identifying Implications of Big Differences	HO – Implications of Big Differences
Activity 2 – Identifying Appropriate Activities	HO – Developing a Behavior Change Strategy HO – Behavior Change Strategy Framework (in process) HO – Beyond Awareness Raising TA – Organizational Experiences with FP Integration TA – Sample Healthy Timing and Spacing of Pregnancy (HTSP) Messages
Step 9 – Implement Your Evidence-Based Strategy	
Activity – Developing an Implementation Plan and Budget	HO – Work Plan HO – Sample Budget
Step 10 – Assess and Adjust Your Strategy	
Activity – Monitor, Evaluate, and Tweak	HO – How to Monitor and Evaluate a Behavior Change Strategy Sample behavior change strategy and assessment findings (from the group's work)
Closing	
Activity 1 – Post-Test (optional)	HO – Pre/Post-Test TA – Pre/Post-Test Key
Activity 2 – Workshop Evaluation	HO – Workshop Evaluation
Activity 3 – Closure	Participants' marked tests Pre- and Post-Test scores

Appendix 2 – Resources

Integration of FP into MCH Programs

- Ringheim, K. Better Together: Linking Family Planning and Community Health for Health Equity and Impact. CORE Group, April 2012
- Delivering Family Planning Messages through Prenatal Care Clinics in Kumi District, Uganda, Anthony K. Mbonye, MD, http://www.aahperd.org/aahe/publications/iejhe/loader.cfm?csModule=security/getfile&pageid=38995
- *Family Planning Integration: Overcoming Barriers to NGO Programming*. www.coregroup.org/storage/documents/Workingpapers/CORE_FP-MCH_Integration_Survey
- Incorporating Male Gender Norms into Family Planning and Reproductive Health Programs: Program Guidance Brief, C-Change, AED/USAID http://stage.c-changeprogram.org/sites/default/files/Gender%20Norms%20Program%20Brief%20Nov09%20FINAL_0.pdf
- Ten Best Public and Private Sector Practices in Reproductive Health and Family Planning in the Europe and Eurasia Region. Private Sector Partnerships-One Abt Associates Inc. 4550 Montgomery Avenue, Suite 800 North Bethesda, MD 20814 USA, September 2008. http://pdf.usaid.gov/pdf_docs/PNADM640.pdf

Formative Research

- Social Marketing for Nutrition and Physical Activity Web Course: Phase 2: Formative Research, U.S. Centers for Disease Control and Prevention, www.cdc.gov/nccdphp/dnpa/socialmarketing/training
- CORE Group, Social and Behavior Change Research, http://www.coregroup.org/our-technical-work/working-groups/social-and-behavior-change/112
- DeCarlo, P., *Completing the Circle: Designing HIV Prevention Programs for Persons of Color with HIV*, Chapter 4: Formative Research. Northern California Grantmakers, 2003. www.aidspartnershipca.org/assets/CompletingTheCircle4.pdf (accessed 11/16/11)

Developing Behavior Change Strategies

- CORE Group, Social and Behavior Change, http://www.coregroup.org/our-technical-work/working-groups/social-and-behavior-change
- AED Social Change Tools and Publications, http://www.globalhealthcommunication.org/tools/strategy/social_change
- Bandura, Albert. Health Promotion from the Perspective of Social Cognitive Theory, http://des.emory.edu/mfp/Bandura1998PH.pdf
- Patterson, K et al. Influencer: The Power to Change Anything
- Influencer Book web site (self-assessment tool and free newsletter), http://www.vitalsmarts.com/influencer_book.aspx
- Community-Based Family Planning, Technical Update #2: Behavior Change, June 2007, http://www.k4health.org/system/files/No2_BCC.pdf
- Peace Corps Social and Behavior Change resources, http://www.k4health.org/toolkits/pc-bcc
- Elder, JP and Estey JD. Behavior change strategies for family planning. Social Science and Medicine, 1992, http://www.ncbi.nlm.nih.gov/pubmed/1411701
- C-Change Country Program Examples, http://c-changeprogram.org/focus-areas/family-planning
- Social Marketing Nutrition and Physical Activity, U.S. Centers for Disease Control and Prevention, http://www.cdc.gov/nccdphp/dnpa/socialmarketing/training/index.htm

Materials Development

- Clear & Simple: Developing Effective Print Materials for Low-Literate Readers, available at: www.nci.nih.gov/cancerinformation/clearandsimple
- Anthony Kouyate, R and Nash-Mercado, A. 2010. *A Guide for Developing Family Planning Messages for Women in the First Year Postpartum*. ACCESS-FP: Baltimore, Maryland. http://www.shopsproject.org/resource-center/a-guide-for-developing-family-planning-messages-for-women-in-the-first-year-postpart or http://www.shopsproject.org/sites/default/files/resources/PPFP%20Message%20Guide.pdf

FP Educational and Counseling Materials

- Sample Healthy Timing and Spacing of Pregnancy (HTSP) Messages, www.esdproj.org/site/DocServer/ESD_PG_spreads.pdf?docID=141
- A guide to family planning for community health workers and their clients, WHO, http://www.coregroup.org/resources/webinars/214-a-guide-to-family-planning-for-chws-and-their-clients
- Community Health Worker Counseling Tool for Family Planning (WHO, USAID, Population Council, under development)
- Counseling guide for FP developed by C-Change project in DRC, http://stage.c-changeprogram.org/resources/family-planning-dialogue-guide-community-relays-drc
- **Facts for Family Planning: A Resource for Standardized FP Messages** (WHO, UNFPA, World Bank, and USAID, under development)

Monitoring and Evaluation

- U.S. Centers for Disease Control and Prevention's Evaluation web page, http://www.cdc.gov/eval/index.htm
- *Monitoring and Evaluation Toolkit, K4Halth, http://www.k4health.org/toolkits/m-and-e*
- *A Guide to Participatory Monitoring of Behavior Change Communication for HIV/AIDS: Getting the Community and Program Staff Involved in Assessing and Improving Programs*, PATH, 2005 http://www.stoptb.org/assets/documents/countries/acsm/HIV-AIDS_BCC_partic%20monit_guide%20(PATH).pdf
- *The 'Most Significant Change' (MSC) Technique: A Guide to Its Use*, Rick Davies and Jess Dart, 2004, http://www.mande.co.uk/docs/MSCGuide.pdf
- The Good Indicators Guide: Understanding how to use and choose indicators. NHS Institute for Innovation and Improvement, Conventry, England, UK, 2008. http://www.who.int/pmnch/topics/health_systems/indicatorsguide/en/index.html or http://www.apho.org.uk/resource/item.aspx?RID=44584

Footnotes

1. Designing for Behavior Change, The CORE Group, 2008
2. Adapted from: International Federation of Red Cross/Red Crescent Societies, Community-Based First Aid materials. A sample style guide can be found at: www.caribbeanredcross.org/what/dm/dipecho/eng-styleguide-mar08.pdf.
3. John A. Ross and William L. Winfrey, "Unmet Need for Contraception in the Developing World and the Former Soviet Union: An Updated Estimate," International Family Planning Perspectives 28, no. 3 (2002)
4. Designing for Behavior Change, The CORE Group, 2008
5. John A. Ross and William L. Winfrey, "Unmet Need for Contraception in the Developing World and the Former Soviet Union: An Updated Estimate," International Family Planning Perspectives 28, no. 3 (2002)

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