

Towards better programming

A Manual on Communication for Water Supply and Environmental Sanitation Programmes

Water, Environment and Sanitation Technical Guidelines No. 7

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**A Manual on Communication
for Water Supply and
Environmental Sanitation
Programmes**

United Nations Children's Fund
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A Manual on Communication for Water Supply and Environmental Sanitation

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Table of Contents

ACKNOWLEDGEMENTS	III
PREFACE	IV
CHAPTER I: DEFINITION OF TERMS.....	1
CHAPTER II. INTRODUCTION	3
A. WHAT DO WE KNOW?.....	4
1. <i>Information and Mass Media Channels.....</i>	4
2. <i>Which Channels Influence Behaviour</i>	4
3. <i>Everybody Does Not Accept Things at the Same Time</i>	5
4. <i>Rights-based Programming, Our New Commitment</i>	5
5. <i>How Does Behaviour Develop?.....</i>	6
6. <i>A Word of Warning</i>	7
7. <i>A Brief Summary</i>	8
B. DEFINING PARTICIPANT GROUPS	8
1. <i>Defining Programme Participants</i>	8
2. <i>Degrees of Participation</i>	9
CHAPTER III. HOW TO PROCEED.....	13
A. DEVELOP SITUATION ASSESSMENT.....	14
A.1. <i>Establish or Reactivate an Inter-sectoral Working Group or Team.....</i>	14
A.2. <i>Review Status of Ongoing WES Advocacy, Social Mobilisation, Communication, Training and Related Community Activities at All Levels</i>	15
A.3. <i>Review All Existing Behavioural Data, Focus Group Data, KAP (Knowledge, Attitudes and Practices) Studies, Relevant Field Monitoring And Evaluation Reports.</i>	16
A.4. <i>Identify missing information.....</i>	16
A.5. <i>Decide the best methodologies for collecting information.</i>	18
B. COMMUNICATION ANALYSIS	19
B.1. <i>Problem Analysis - Statement.....</i>	19
B.2. <i>Behaviour Analysis</i>	21
B.3. <i>Participant Analysis.....</i>	28
B.4. <i>Channel Analysis.....</i>	32
B.5. <i>Communication Objectives.....</i>	35
B.6. <i>Developing Strategies and Activities.....</i>	37
B.7. <i>Monitoring and Evaluation Indicators.....</i>	39
B.8. <i>Summary</i>	43
C. PROGRAMME DESIGN.....	43
C.1. <i>Design Strategy</i>	43
C.2. <i>Message Design and Development</i>	44
C.3. <i>Formative Research and Pre-testing.....</i>	45
C.4. <i>Putting the Communication Plan Together.</i>	47
D. ONE LAST WORD: FROM PLAN TO ACTION: MAKING IT WORK	50
D.1. <i>Carry Out Training and Capacity-Building</i>	50
D.2. <i>Carry Out Communication Activities.....</i>	51
D.3. <i>Carry Out Supportive Supervision.....</i>	52
D.4. <i>Monitor Communication Activities and Behaviour Change/Make Mid-Course Corrections and Reinforce Participation</i>	52
D.5. <i>Evaluate Communication Programme During Follow-up Period</i>	53
D.6. <i>Keep Within the Budget.....</i>	54

APPENDIX 1 - SAMPLE TERMS OF REFERENCE: INTER-SECTORAL COMMITTEES OR WORKING GROUPS.....	59
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APPENDIX 2 - MINING FOR BEHAVIOURAL GOLD. CASE STUDY EXAMPLES OF INTERVENTIONS IN ENVIRONMENTAL SANITATION AND HYGIENE	61
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APPENDIX 3 - AIDS FOR MESSAGE DEVELOPMENT	69
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List of Figures

1. Communication for Development Model	1
2. The Behaviour Change Continuum	7
3. The Degrees of Participation	10
4. The ACADA Model	11

List of Boxed Mini Case Studies

1. Process is as Important as the Product; a Case Study in Burkina Faso.....	9
2. Government-initiated Inter-sectoral Cooperation in India Brings Water and Sustainability to Local Communities.....	15
3. Facts for Life, Religious Leaders and Cholera Prevention.....	29
4. Pre-testing in Nepal..... (Continued in Appendix 2)	46
5. Animation Mobilises Community to Mobilise Itself.....	64
6. Community, NGO and Local Authority Take Control of a Sanitation Project.....	65
7. Sanitation and Micro-credit in north-western China.....	65
8. Pre-testing Sanitation Drawings in India	66
9. Caravan for Life: Ecuador.....	66
10. Folk Poets in Bangladesh.....	67
11. Bombay Children Teach Their Neighbours.....	67

List of Tables

1. An Ethical Consideration Stemming from a Behavioural Approach.....	17
2. Problem Statement.....	20
3. The Changeability Grid.....	24
4. Participant – Behaviour Link.....	30
5. Components of Measurable Communication Objectives.....	34
6. Some Examples of What to Monitor.....	40
7. What to Evaluate.....	41
8. Example: The Implementation Plan for Safe Water, Environmental Sanitation and Home Hygiene.....	48
9. The Operational Plan / Implementation Schedule	49

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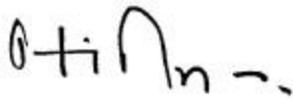
PREFACE

UNICEF Programme Division is pleased to present the Manual on communication for Water Supply, Environment and Sanitation programmes – part of the guidelines series on water, environment and sanitation. The Manual is the result of wide collaboration within UNICEF and with outside professionals in the communication and WES sectors. It provides a broad overview of state-of-the-art programming for behaviour development communication.

The original programme guidelines for WES were produced more than ten years ago and stressed what was at that time UNICEF's principal activity in the sector: drilling and handpump technologies. These programming areas remain important and thus continue to be covered in the Guidelines Series. However, experience from the WES and other sectors such as the health and education sectors, and lessons learned, have led us to make programming changes in the sector with a paradigm shift towards sanitation and hygiene education for behaviour change as well as community management of the water environment. Thus, the improvement of the water and environmental sanitation conditions and related practices also require a shift in programme strategies: a greater focus on inter-sectoral and multi-disciplinary approaches and a need to understand the target group's priorities, knowledge and practice vis-à-vis specific behaviour and inhibiting factors.

This orientation has meant that country programmes now need to be equipped to make that shift. Thus, this Manual, with a focus on sound principles in programme communication, will provide guidance on how to incorporate adequate communication and behaviour change approaches in water and environmental sanitation programmes. Above all, it is a practical guide for implementing the operational strategies outlined in the Board-approved WES Strategy Paper (UNICEF Strategies in Water and Environmental Sanitation – E/ICEF/95/17). As such, it is an important tool for field professionals in the implementation of UNICEF Programme Priorities, and the acceleration of progress towards the goals established at the World Summit for Children.

We, in Programme Division, look forward to receiving your comments on this publication in particular and suggestions and ideas on how to improve our support to WES interventions in general.



*Sadig Rasheed
Director, Programme Division
UNICEF New York
October 1999*

CHAPTER I: DEFINITION OF TERMS¹

In an effort to bring communication terminology in line with the UNICEF Communication Policy, UNICEF communication officers defined the following terms at the 1998 global meeting. As now defined, the **overriding term for communication initiatives is "communication for development"**, replacing the former term, "social mobilisation". Social mobilisation is one of the three strategies a programme officer can select when undertaking a communication for development programme. Depending upon the problem, what behaviours or group actions would ameliorate the problem, and who can best carry out these behaviours, the programme officer would select from advocacy, social mobilisation and programme communication. These strategies are defined below and a methodology to use these strategies effectively is explained in these guidelines.

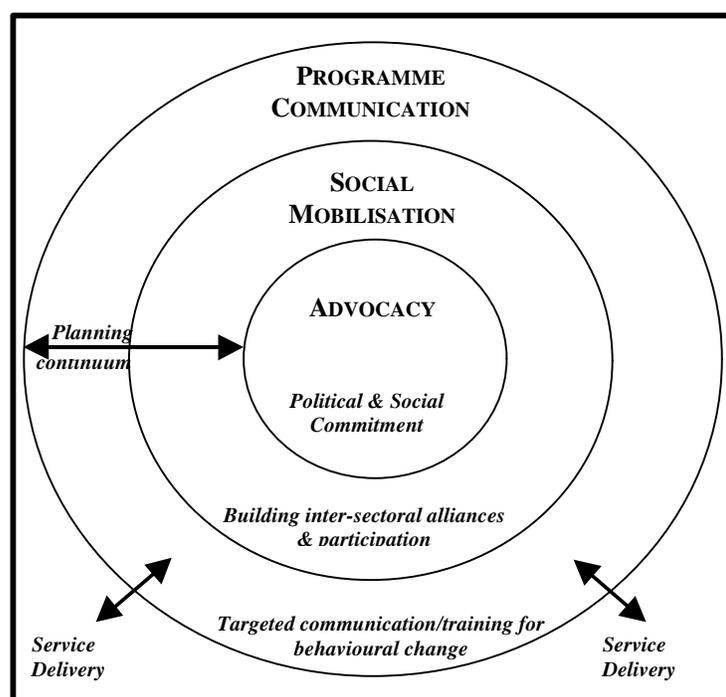


Figure 1: Communication for development model

Communication for Development is a researched and planned process that is crucial for social transformation. It operates through three main strategies; *advocacy* to raise resources and political and social leadership commitment for development goals; *social mobilisation* for

¹ These definitions are adapted from the forthcoming publication "Communication for Development Guidelines", UNICEF, New York 1999.

wider participation and ownership; and *programme communication* for changes in knowledge, attitude and practice of specific participants in programmes. When combined with the development of appropriate *skills* and *capacities*, and the provision of an *enabling environment*, communication plays a central role in positive behaviour development, behaviour change and empowerment of individuals and groups.

Advocacy is a process of gathering, organizing and formulating information into argument, to be communicated through various interpersonal and media channels to political and social leaders with a view to gaining their commitment to and active support of a development programme.

Social mobilisation is a process of bringing together all feasible inter-sectoral social partners to determine felt-need, raise demand for and sustain progress towards a particular development objective.

Programme communication is a research-based, consultative process of addressing knowledge, attitudes and practices of specific groups of programme participants in order to develop or change those behaviours that have impact on development objectives.

Community participation is a development process based on dialogue, consultation with and empowerment of people in a community to identify their own problems, decide how best to overcome them, and make plans or seek appropriate solutions and assistance.

Programme participants refers to the individuals, families, communities and various partners to whom the communication programme is aimed and with whom it needs to work to achieve desired outcomes and problem resolution. Previously, these people were referred to as beneficiary groups, target groups or audiences. However, given UNICEF's rights-based programming approach, this Manual uses the terminology of participant group rather than target or audience or beneficiary. This better connotes the concept that these individuals and groups are not just passive recipients of communication messages but are actors and stakeholders who play a critical role in the change process.

CHAPTER II. INTRODUCTION

Water and Environmental Sanitation are two areas of programme interventions that have accumulated an enviable body of experience by focusing activities toward development of sustained recommended behaviours — Examples of these are given throughout this Manual in the Mini Case Study Boxes.

Much good work has also been accomplished in other programme areas, especially in immunisation and oral rehydration therapy. But there are several systematic differences:

- 1) (a) communication for immunization interventions has largely been in the form of campaigns; (b) the behaviours recommended are not those that families have to sustain throughout a lifetime;
- 2) oral rehydration therapy is practised in response to a specific event: the onset of diarrhoea or dysentery within a community or a family.

However, behaviours² for water supply and environmental sanitation activities mean that **individuals and communities must develop daily practices sustainable throughout a lifetime**. In order to sustain these practices, it is necessary to not only provide knowledge and skills to individuals and families and to reinforce and monitor those behaviours locally, but also to establish community and national systems of supply and maintenance of materials and equipment.

Thus, interventions don't begin and end with an individual or with a family. Interventions must involve districts, regions and countries.

Water supply and environmental sanitation professionals worldwide have evolved a body of imaginative inventiveness, variety and practicality that is the envy of many other programme interventions.

This Manual will attempt to build upon that wealth of experience for you. It will use a modified Triple A framework (Assessment – Analysis – Action) within a context of communication models and theories that have been successfully applied in a variety of cultural settings and interventions.³

² Behaviour and Practice are used interchangeably in the Manual.

³ The United Nations Children's Fund approach is to identify the elements of theories and models of communication relevant to a particular social issue, and to apply to interventions as needed.

A. What Do We Know?

Before we begin a step-by-step guide for using communication for behaviour development, let us very briefly review what the research, the empirical experience and the theory of communication and behaviour development tell us.

1. Information and Mass Media Channels

Knowledge is important. But knowledge alone influences the behaviour of a very small percentage of any population. Therefore, “giving knowledge” (whatever that means) should be a strategy and approach for a carefully researched segment of any population – perhaps six to ten per cent. This will be elaborated below in 3: Everybody Does Not Accept Things at the Same Time.

Information transmitted through the electronic (and printed) mass media has an equally limited effect. The ability of mass media to influence behaviours through the transmission of information alone is applicable to the limited percentage we mentioned above and depends on certain conditions and characteristics of the population for whom it is intended.

The best bet is to use mass media (and traditional media) to model recommended behaviours - to show people how to act; and to stimulate discussion among families, friends and communities.⁴

2. Which Channels Influence Behaviour

People have the most direct influence on our behaviours, either directly or when the mass media demonstrate other *people like ourselves practising recommended behaviours*. This may seem obvious, and it is. The question is: why don't we use the obvious in development interventions? Humankind is influenced by friends, neighbours, people we admire, the groups we join. Therefore, these are valuable and – more important – available resources that should be used to encourage people to develop recommended behaviours.

This is why the most successful efforts to develop sustained recommended behaviours have been those that have enlisted satisfied acceptors, local networks, local influential people, community training programmes and, the most important factor of all: that which has encouraged communities to participate in planning, implementing, monitoring and improving their own interventions.

The literature is extremely rich in successful examples of this and should be a very relevant resource to you as a front-line worker.

⁴ For a full discussion of this, please consult the following: Bandura, A. (1994), “Social cognitive theory and mass communication.” In J. Bryant & D. Zillman (Eds.) *Media effects: Advances in theory and research* (pp. 61-90). Mahwah, NJ: Erlbaum. Also a brief summary by Dr. Albert Bandura, *Social Modeling and Self-Efficacy* in A report on the Second International Conference on Entertainment and Social Change. Johns Hopkins University Center for Communication Programs (JHU/CCO) August, 1998.

3. Everybody Does Not Accept Things at the Same Time

It will not be a surprise to learn that people react differently to adopting new behaviours. The empirical evidence on this phenomenon is vast, encompassing many cultures.⁵ This research is important to know because it helps us determine strategic communication approaches to large population groups.

The primary characteristic is the rate at which various groups within a society adopt a practice. It is useful to know that some groups of people tend to adopt new ideas and practices more readily than others (Innovators & Early Acceptors) and some are more cautious than others (Late Acceptors or the Resistors). The most cautious, certainly, will have some very good reasons for not readily accepting new behaviours. These are the people with the most to lose, the fewest resources to invest. Unless we can guarantee that our water and environmental sanitation programmes will not cause them to squander the few precious resources they have AND will ultimately benefit them – they will not be interested.

Further, each of these groups responds to communication inputs in different ways. Thus it is essential for every intervention programme to know how people thus far have received an intervention: (1) **how many** of the total population are using it (practising the recommended behaviour), (2) precisely **who are those** who have been practising it and (3) **what characteristics** these people share.

It is obvious that an information programme through the mass media will affect the behaviours of the Innovators and perhaps the Early Acceptors. It will not have much influence on the behaviours of many other groups in the population. Thus, in order to communicate effectively with the Late Majority you will have to use a communication strategy that is very different.

For readers with a public health background, it will be obvious that immunization programmes that achieved “herd immunity” - i.e.: 85 per cent of a population – had reached the Innovators, of course, the Early Acceptors, the Early Majority and most of the Late Majority. In the 1980s and early 1990s many people were satisfied with that result. Now this outcome is no longer sufficient since it excludes the people who have the greatest need for the benefits of development (the most difficult to reach or most disadvantaged).

4. Rights-based Programming, Our New Commitment

We have entered a new era. Our programming is “rights based.” One implication of rights based programming is equal and fair treatment for **all** people. This includes – and in fact should focus on – those least served and hardest to reach geographically, psychologically, socially and economically. We are speaking of the remaining Late Acceptors and the Resistors.

⁵ This discussion is heavily indebted to Dr. Everett Rogers, whose pioneering work and ongoing revisions of the theory, *Diffusion of Innovations* have been applied. See *Diffusion of Innovations*, Fourth Edition, by Everett B. Rogers, The Free Press, 1995.

We are speaking of those with the most to lose if an intervention doesn't work. We are speaking of those who probably want to protect the little that they have by following the "tried and true." Our obligation is especially to these groups. Your research will need to identify them and **work together with them**, to discover what aspects of your intervention they doubt the most; what they need to know more about; and how your intervention can best meet their needs. All the steps and procedures recommended in this Manual include everybody, women and men, as well as children.⁶

The focus of your communication inputs will be to (1) give the assurance and information that participants require, (2) to model the behaviours they need to see, (3) to teach the skills they need to acquire. With them you will need to explore the channels they most prefer, the messages they most want to hear, the people they most trust.

Of course, you can do none of this without research.

Please remember that your objective is to develop recommended behaviours relevant to people adopting the intervention you are responsible for.

5. How Does Behaviour Develop?

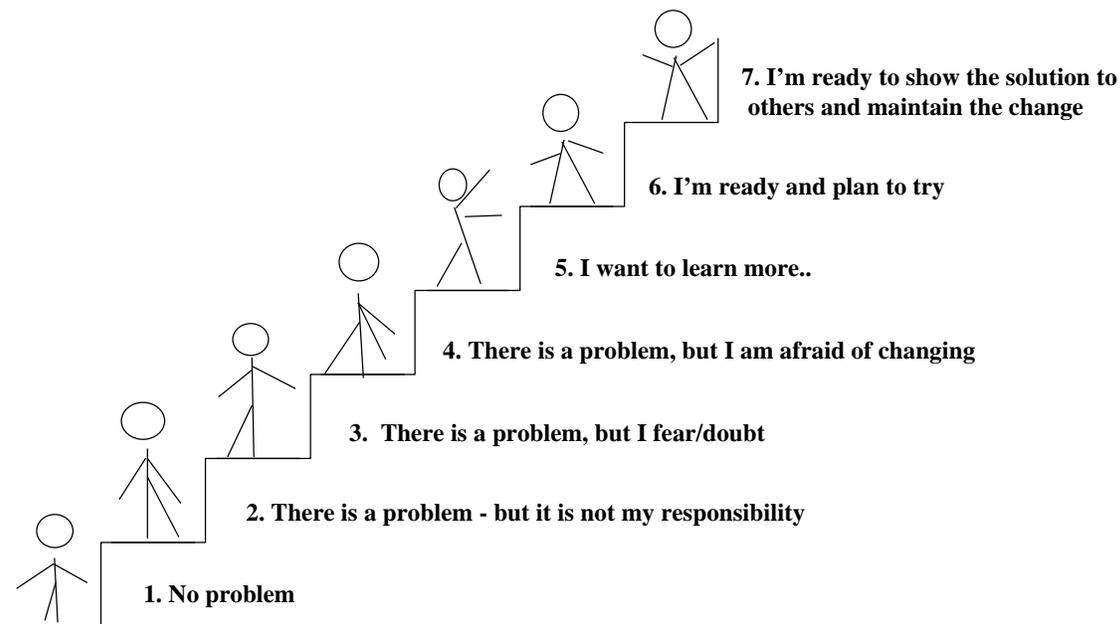
One of the most valuable tools at our disposal is knowledge of the process – the stages – by which different behaviours develop. With this knowledge, we can research participant groups⁷ to find out the stage(s) they have reached and plan our communication strategies accordingly.

There is great debate about how many stages of behaviour development there are. In practice, the number of stages is not important. What is important is to know that people do not suddenly begin to do something they have never done before. They learn. They weigh the benefits of doing it or not doing it. They look around to see if any one else is doing it – and if their community accepts those people. They learn the skills to do it. They apply it to their own lives. They evaluate whether it is worthwhile to continue practising it. They may reject it. OR they may encourage others to follow their example (Figure 2).

⁶ For a full exploration of the issues related to gender in safe water and environmental sanitation programmes, the reader is referred to Programme Division-Guidelines Series, *Towards Better Programming – A Manual on Mainstreaming Gender in Water, Environment and Sanitation Programming*; Water, Environment and Sanitation Guidelines Series – No 4.

⁷ The conventional term is "target group." But the implication of using this term is completely the reverse of what people in development are trying to do. We are not shooting an intervention into the midst of a passive group of people. We are encouraging everybody to take responsibility for deciding on the merits of an intervention and – if it meets the community's criteria – to join in a partnership to implement the intervention. Therefore, we work with *participant* groups, not *target* groups.

Figure 2: Behaviour Change Continuum



Not all these may happen in the sequence suggested above. Some may occur simultaneously. Or people may skip a stage or two. What is important for you is knowing the stage people, or even a community, has reached in accepting the intervention – e.g., safe water or environmental sanitation – you are working with. If you know the stage, you can design communication interventions that address the communication needs required by that stage.

6. A Word of Warning

The combination of communication inputs you use will be largely determined by your particular intervention and the needs of the participant groups you are serving.

Thus: **testing and experimentation are the key to achieving your communication goals.** There is no substitute for research or information about the participant groups. There is no substitute for hard-nosed decisions about which strategies and channels to use based on focus group discussions, survey research and even research involving experimental designs.

You have many allies. There is probably a lot of data already available from marketing and advertising companies. They may be willing to provide this on a *pro-bono* basis. If not, buy it as you would any supply item. Commission research from institutes and universities. The results will be of use to every programme area. You know your context best.

7. A Brief Summary

Here is a useful ruler to begin measuring your activities. People will adopt a recommended behaviour if:

- they know about it
- they can easily access it
- they feel it will do them some good
- they perceive it is cheaper to practice it than not to practice it
- they perceive friends and neighbours are in favour of it
- they see friends and neighbours using it
- they can understand how to use it
- they feel competent and comfortable using it
- they are confident that this behaviour will bring the desired results
- they will not lose what they have (resources and prestige) by adopting it
- they are included in the decision-making about implementing (e.g. identifying the problem, looking for solutions, etc.)

These factors should form the core approaches to all communication inputs if the services are available, the supplies are in place, personnel are trained to offer the services, people know how to use the intervention and the social networks have been informed.

B. Defining Participant Groups

1. Defining Programme Participants

This Manual will stress the importance of the participation of communities in every step of our work. Of course, we are advocating an inter-sectoral collaboration with colleagues in UNICEF and government, NGOs and all localities. This is to be expected. However, in many corners of development work there is still a tendency to treat the people we serve as “recipients” or as “beneficiaries.” The people we serve may be described that way, but that view alone is patronising in the extreme. It is entirely antithetical to a rights-based programming approach.

The people we serve are PARTICIPANTS in every aspect of their lives. Water and environmental sanitation programming recognized this long ago. It is important for communication practitioners or specialists within the framework of Water and Environmental Sanitation to recognize this as well. Further, steps must be taken to involve every community⁸ – urban and rural – to participate in all aspects of these programmes. The degree of participation may differ, due to aspects beyond your control, but UNICEF cannot in good conscience programme without attempting to involve communities in every facet of the process. The example below cites some interesting realities.

⁸ Participants and communities are linked (ie., participants live within communities, therefore participation should be both at the individual and the collective level).

Box 1: Process is as Important as the Product - A Case Study in Burkina Faso⁹

In Burkina Faso the first stage of a programme - to empower communities, especially women, to manage their environment – was a Participatory Rural Appraisal (PRA) that enabled communities to understand local realities and determine priorities.

They identified water supply, increased agricultural production, control of Guinea Worm and other diseases as primary needs. They considered approaches to two levels of planning: 1) activities to be organised mostly by the communities themselves, such as house-to-house distribution of water filters to combat dracunculiasis; and 2) activities needing external support such as the installation of boreholes to supply water.

Completing its first stage, the key elements for sustainability were found to be in place: 1) institutional arrangements and collaborative partnerships at different levels and 2) the involvement of women in all aspects of the programme.

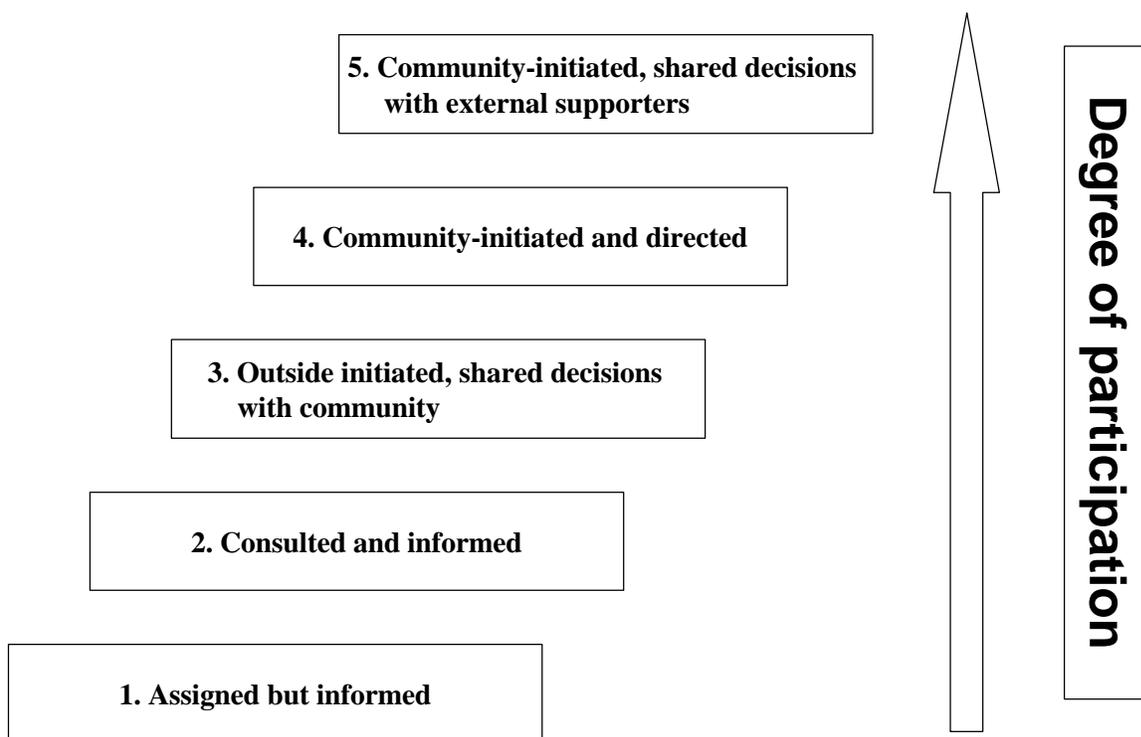
Ironically, the slow implementation rate was recognized as an inherent characteristic of community-based sustainable programming and also cited as the main problem. The community had taken to heart the project objectives and the process-oriented concepts of PRA were adhered to at every step. No activity was initiated before a PRA and the project to date has focused on aspects of community organizing and mobilizing of women, collaborating and building partnerships. The project document has been translated into local languages and discussion has spread to more villages. PRA has enhanced existing knowledge and experience of community members, reinforced their awareness and sense of responsibility toward natural resource management and the capacity to take action. As the project continues, its focus may well change depending on newly understood realities and new priorities expressed by the community.

2. Degrees of Participation

The growing documentation on children's rights and children's participation has developed some very succinct and meaningful explanations and approaches, which depict the processes of participation. The following is a very helpful visualization that may be applied to a full range of development interventions. It is particularly helpful to our discussion in the previous paragraphs and examples.

⁹ Source: *Second Donor Report on the Sahelian Initiative: Primary Environmental Care for Children and Women in the Sahel*, UNICEF WCARO, Abidjan, June 1995. Cited in *A Child's Right to Sustainable Development*, UNICEF, New York 1997.

Figure 3: Degrees of Participation ¹⁰



Manipulation, decoration and tokenism

Manipulation, decoration and tokenism are debatable levels of participation still in discussion and are not included here. Examples of manipulation, decoration and tokenism include instances where communities: do what the external "experts" or authorities suggest they do but they have no real understanding of the issues; when they take part in "events," or when participants are asked to say what they think about an issue, but have little or no choice about the channels or methods available to express those views or the scope of the ideas they can express.

- 1. Assigned but informed*
Authorities or experts decide on the project and communities volunteer to participate. Communities understand the project and decide why they should be involved; and, authorities confirm that communities' views are respected.

¹⁰ Adapted from *Children's Participation - The theory and practice of involving young citizens in development and environmental care*, by Roger Hart. UNICEF, Earthscan Publications Ltd., London 1997.

2. *Consulted and informed*
The project is designed and run by authorities and/or experts but the community is consulted. Community understands the process fully. Their opinions are taken seriously by the authorities and/or experts.

3. *Authority/expert-initiated, decisions shared with community*
Authorities have the initial idea, but communities are involved in every step of the planning and implementation. Not only are their views considered, but they are involved in taking decisions.

4. *Community-initiated and directed*
Community has the initial idea and decides how the project is to be carried out. Authorities and experts are available but do not take charge.

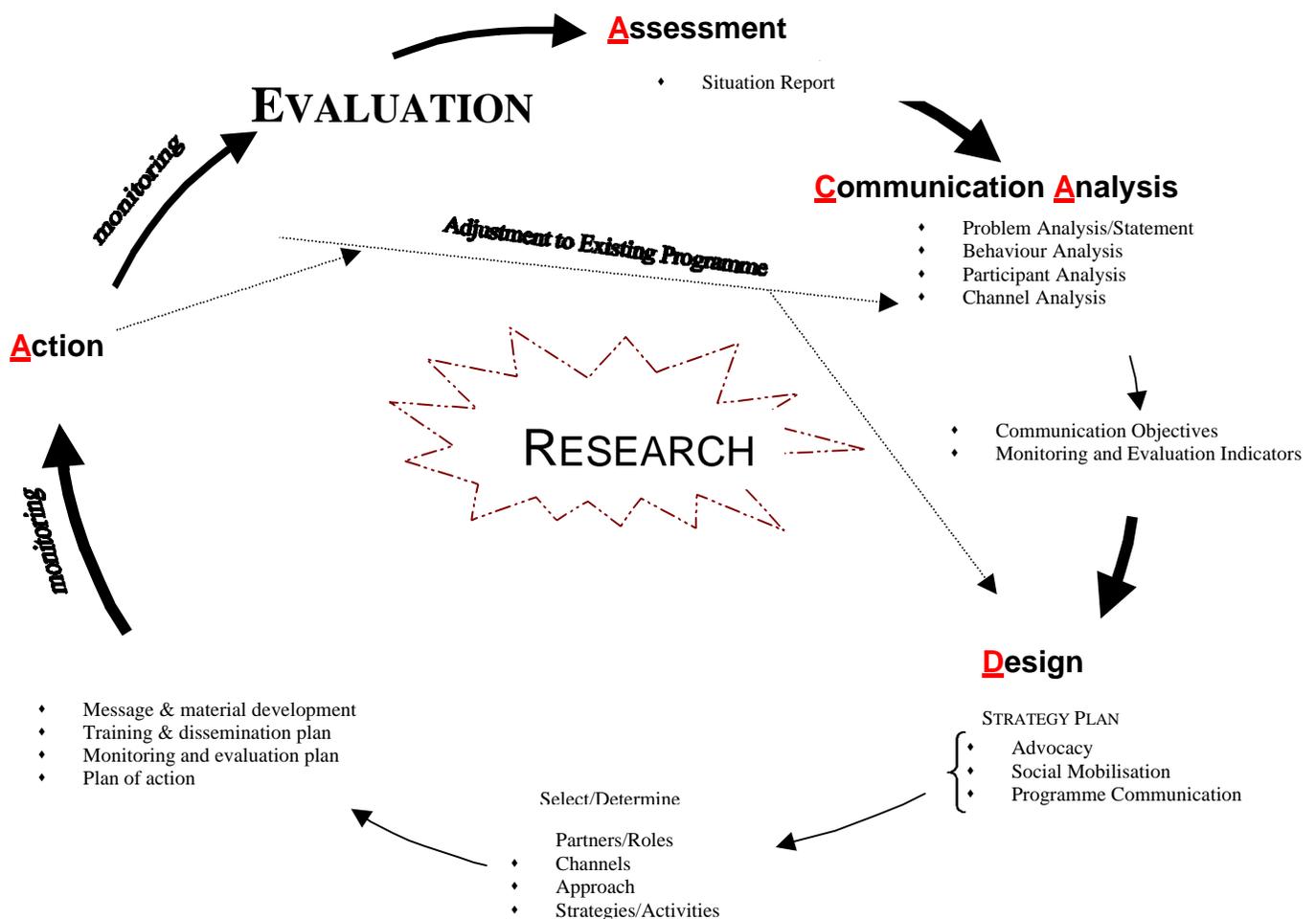
5. *Community-initiated, shared decisions with authorities and experts*
Communities have the ideas, set up the project and come to authorities for clarification, advice, discussion and support. The experts do not direct but offer their expertise for the community members to consider.

CHAPTER III. HOW TO PROCEED

For many years, UNICEF has used the Triple-A steps of assessment, analysis and action to plan communication programmes. Recently, this familiar model has been expanded for communication purposes to ACADA: **A**ssessment, **C**ommunication **A**nalysis, programme **D**esign, and **A**ction. By following this methodology, the programme officer uses systematically-gathered data to link the development problem to viable solutions by promoting the practice of feasible behaviours on the part of various participant groups and organisations. This process helps the programme officer and a multidisciplinary team to plan, carry out and monitor a behaviourally-focused communication programme.

Let us share with you a diagram, which attempts to visualise this:

Figure 4 - ACADA Model



Based on the above diagram, we suggest a series of steps. We would like to stress that the planning, implementing and assessing of communication inputs are not really a series of discreet, independent steps. In fact, everything is inter-related. For example, as you set objectives you are really taking the first steps toward monitoring and evaluation. As you conduct your Assessment, you are also beginning the behavioural analysis of various participant groups.

A. Develop Situation Assessment

A.1. Establish or Reactivate an Inter-sectoral Working Group or Team

Who is going to oversee the work of this intervention? The single communication officer or programme officer for water and environmental sanitation alone cannot possibly do it. You need an inter-sectoral team, a working group (including, perhaps, some representatives of NGOs and the private sector) who can help with the decision-making and all facets of implementing the project.

Using a team in all steps of the methodology acknowledges the complexity of issues involved in achieving behaviour change through communication, and **begins to build the partnerships** necessary to sustain the progress made by the current programme. It will likely be necessary to have teams at various geographic levels of implementation. This will depend on the programming environment of the country in which you are working.

Possible team members include representatives from relevant government ministries such as health, education, environment, social services and women's affairs; from leading NGOs and religious groups; from various professions such as doctors, midwives, pharmacists, architects, water and sanitation engineers, and school teachers; from the field of communication such as broadcasters and journalists; representatives from marketing and advertising companies; researchers from private groups and universities; representatives from other donors and UN agencies as well as sectoral officers in the UNICEF field office.

Needless to say, this working group should help, not hinder, in attempts to bring about the recommended behaviours required. In Appendix 1 we have suggested a Terms of Reference (TOR) for such a committee. **DO NOT USE THIS TOR UNLESS IT REFLECTS THE REALITY AND POSSIBILITIES OF YOUR SITUATION. These are only guidelines for your own thinking.**

Inter-sectoral collaboration starts at the very outset of your organisational planning. It must continue throughout the duration of your intervention. Box 2 illustrates this:

Box 2: Government-initiated Inter-sectoral Cooperation in India Brings Water and Sustainability to Local Communities. ¹¹

A devastating drought in Jhabua District of Madhya Pradesh, India, in 1985, prompted the central Government to shift its thinking from short-term public relief to long-term drought-proof policies and programmes. Jhabua was selected as a pilot district to introduce a new strategy of integrated water resource management under the National Drinking Water Mission. The programme was driven by Inter-sectoral action and a wide-ranging partnership of district and subdistrict administrations, national scientific organisations and locally elected representatives, school teachers and health workers.

Employment opportunities were provided for 150,000 people, two thirds of which were related to water management, digging trenches and pits for afforestation. The programme focused on ensuring sustainability of water supply rather than immediate needs for drinking water and sanitation. A related objective was to eradicate the guinea worm disease (dracunculiasis) still plaguing pockets of the area.

The project doubled irrigation areas, enabled the formation of irrigation cooperatives, raised income levels and reduced the seasonal rural-urban migration. Linking health, productivity, water and the environment, resulted in the total eradication of guinea worm disease in the district. Strategies included enlisting women in their capacity as water carriers; social mobilisation; forming district, subdistrict and village action committees, and the use of popular local media such as street theatre; training to coordinate inter-sectoral action, and managing eradication campaigns.

The guinea worm eradication campaign successfully utilised people's action. The water management efforts were run by the State with local people also providing wage labour. The key lesson was the need to involve people directly in the environmental reconstruction and improvement of their own land and water resources. This is a good example of community-based management of water resources.

A.2. Review Status of Ongoing WES Advocacy, Social Mobilisation, Communication, Training and Related Community Activities at All Levels

You are probably not starting these activities from scratch. Since the late 1960s, there has probably been a large number of activities in safe water supply and environmental sanitation carried out in the country where you are now working.

What has been learned from that experience?

What you need to do is to systematically analyse the experience by reviewing all available materials.

- A) Make an inventory of all communication materials that have been produced and that have been used or are currently being used. This includes everything from posters and pamphlets to radio and television programmes. Look at all training guidelines and learning materials.
- B) Make sure the groups for which these are intended are well-defined. The following variables must be clearly defined: location, language group, sex, age cohort(s), socio-economic status. If not, you may have to make some educated judgements as to whom they were intended for.

¹¹ P. Gopalakrishnan, *Waterfront*. WES, UNICEF New York, March 1994.

- C) List objectives of each of these materials. (See Section IV on Communication Objectives for a streamlined way of doing this.) If objectives are not available, you must make a decision: *what do I think the objectives of each input are?*
- D) Read reports on the use of these materials. There may be pre-testing reports available; however, don't be surprised if there are not. There may be some evaluation studies or training assessments available.
- E) If these are not available, engage an institute or a research company to test these materials to see if they do what they were designed to do. In other words, you should consider outsourcing. It is here that your committee should be able to help. If the committee is broad-based enough, they will have sources who can test these materials for you.

A.3. Review All Existing Behavioural Data, Focus Group Data, KAP (Knowledge, Attitudes and Practices) Studies, Relevant Field Monitoring And Evaluation Reports.

Identify all available research materials about previous programmes as well as research that describes the participant groups with whom you'll be working. These should include:

- A) All evaluation reports;
- B) research reports on current practices and habits regarding water usage and sanitation practices;
- C) research on cultural values of participant groups, not limited to water and sanitation practices, but on the range of factors that they value. For example, what religious practices do they follow? How do these affect their daily lives? What are the formalities and practices of interaction between people? What roles do women play? How are children perceived? How are the elderly perceived? What is the role and pattern of land ownership?
- D) research on traditional behaviours and practices that are consonant with the suggested interventions or that may mitigate acceptance of the intervention.

A.4. Identify missing information.

What don't you know about participant groups?

Here you will have to schedule a rather wide range of research activities that will continue through many of the steps listed below. Not only is this research, it is the beginning of your monitoring and evaluation process. Here you are gathering information to be used as baseline data – not all of it, of course, but especially the data that describe people's current practices.

- A) What are the behaviours and practices of participating communities vis-à-vis safe water and environmental sanitation?
- B) How do people feel about alternative practices and the requisite technologies?
- C) Apart from these issues: who are the leaders in each community? From what type of leader would people accept advice with respect to safe water supply and environmental sanitation?

When you have successfully described people's current practices you can decide:

- (1) What current practices are related to the problem?
- (2) Are any approximations (i.e., similarities) to the ideal behaviours being performed?
- (3) What consequences are generated by current practices?
- (4) What current practices/behaviours should be encouraged and expanded?
- (5) Do programme participants perform any competing behaviours?
- (6) Which practices/behaviours need to be modified?
- (7) Which practices/behaviours need to be changed altogether?
- (8) Do programme participants have the skills and resources necessary to perform target behaviours?

Section C (below) suggests methodologies for analysing current behaviours and making informed judgements in setting realistic objectives. Some behaviours that you would like to recommend may just not be possible for people to practice. Therefore, we need to categorize behaviours into “ideal” behaviours and “feasible” ones. If it is *possible* for people to do it, that behaviour should become a programme objective.

We also suggest that you prioritise behaviours. Please see Section B.2.3

Table 1: An Ethical Consideration Stemming from a Behavioural Approach

At this point you and your Committee may be asking: “*what right have we to intervene in a community’s life and change its practices and behaviours? Is this not a violation of peoples’ human rights? Is this not a manipulative and authoritarian practice on the part of “do-gooders” in development?*”

Such questions are always on our mind. These are issues that you must constantly raise to keep you ethically in balance.

We would suggest the following responses.

- 1. You are not imposing alien behaviours on communities.
- 2. You are not imposing negative, anti-social behaviours on communities.
- 3. Community consultation is one of the most crucial steps in the process. This means extensive dialogues with communities to help work through ethical issues, as well.
- 4. The process of developing recommended behaviours gives people choices. It does not impose behaviours on anyone.
- 5. At any step in the process, the community has (or families have) the option to reject the intervention you are suggesting. This is their right (unless by doing so it harms other families in close proximity).

A.5. Decide the best methodologies for collecting information.

An important principle is to focus on community-level participatory research activities in selected communities among those targeted for WES interventions. Decide which factors related to communication analysis processes should be included here.

How are you going to collect the information you need? Since we are talking about partnerships, community participation and rights-based programming, however, we feel we have an obligation **to stress the need** for establishing at the very beginning of your activities the need **for participatory research**. By its very nature, it becomes an integral and ongoing part of the communication programming process.

That is to say: participatory discussions in which you explore a community's feelings about safe water supply and environmental sanitation. These would also include current practices, beliefs and information about the power structure in the community.

Here, those of you working in safe water and environmental sanitation, have your colleagues, worldwide, to thank for being the earliest pioneers in developing these methodologies as applied to “WES” interventions.

These colleagues took risks. Previously, it was thought to be risky to dialogue with communities; to give “non-experts” a voice in interventions that depended on “experts” [such as yourselves] for installation and implementation; to be told by communities that the decisions of the “experts” were wrong; to be told, “No thank you, we don’t want *this* technology. We want technology X.”

These colleagues searched the development literature and called upon the pioneers in other fields - such as agriculture, politics, population and micro-credit schemes for women – to assist in adopting methodologies that would give communities a voice in their own safe water and environmental sanitation programmes.

The following summary documents look at some current WES programmes and reveal the rich inter-cultural applications of these participatory approaches.

The WES Technical Guidelines No. 2, *Community Participation and Management of Towards Better Programming: A Handbook on Water*¹² contains a very useful and clear emphasis on community management as well as a focus on involving women in water supply programmes.

The WES Technical Guidelines No. 3, *Community Participation of Towards Better Programming: A Sanitation Handbook*¹³ is rich in practical case studies that suggest a number of participatory techniques.

¹² Water, Environment and Sanitation Technical Guidelines Series, No 2 , UNICEF Programme Division, New York 1999.

¹³ Water, Environment and Sanitation Technical Guidelines Series – No 3; EHP Applied Study No 5; UNICEF/Programme Division in Collaboration with USAID’s Environmental Health Project, New York 1997.

Meeting report of the UNICEF Workshop on Environmental Sanitation and Hygiene (New York 10 – 13 June 1998) documents country studies with a wide range of safe water and environmental sanitation interventions based primarily on participatory strategies. These are summarised in Appendix 2 “Mining for Behavioural Gold.”

*Facilitator’s Manual for the Workshop on Strengthening Participatory Attitudes in Communication and Development*¹⁴ based on programming experience summarises participation within an adult learning framework.

If the above documents cannot meet your needs in learning about participation, we recommend *Tools for Community Participation; A Manual for Training Trainers in Participatory Techniques*.¹⁵ Particularly powerful in this document is the description of the SARAR resistance to change continuum, which has found its way into many of the very best¹⁶ UNICEF-assisted safe water and environmental sanitation interventions.

Apart from the above, a review of the general WES — advocacy, social mobilisation, communication and training-related literature from other countries — is an important part of the assessment phase. Appendix 2 helps you begin this review.

B. Communication Analysis

B.1. Problem Analysis - Statement

In your country programme documentation, especially in the Situation Analysis, there is probably a very clear description of health problems, nutritional problems. Very likely these are linked to the lack of safe water or unhealthy environmental sanitation conditions and practices. Thus, the information for the communication problem statement and analysis will not be very much different from what is described in the country programme Situation Analysis.

However, for safe water and environmental sanitation communication, the analysis (and statement) require a degree of precision that the various sector analyses and problem statements lack. Let us briefly review the process.

One should begin analysis with the development problem itself, rather than discussing which media to use or what messages to disseminate. Only after painting a clear picture of the problem, will it become evident which groups of people, practising particular behaviours with

¹⁴ *Facilitator’s Manual for the Workshop on Strengthening Participatory Attitudes in Communication and Development*, Programme Communication and Social Mobilisation Section, UNICEF Programme Division, New York, September 1996.

¹⁵ Srinivasan, Lyra. *Tools for Community Participation; A Manual for Training Trainers in Participatory Techniques*. PROWESS/UNDP, New York 1990.

¹⁶ By using the term “best” we mean those programmes that have achieved (or are achieving) their stated objectives through the process of participation: community consultation, decision-making, implementation, monitoring and evaluation.

appropriate resources, need to be involved in the communication programme. Analysis also helps to develop messages and strategies that more effectively introduce, teach or reinforce performance of desired behaviour. **Problem analysis** should answer the following questions:

1. What is happening (*what are people doing/not doing*) that is a problem?
2. Where and when does it usually take place?
3. Whom does it affect?
4. What are the primary effects of the problem?
5. What are the possible causes?

The statement should also include any supply and service delivery issues that contribute to the problem. Results from the research will help to quantify the scope of the problem and what segments of the population are most affected.

The **problem statement** should be put in terms of **what people are or are not doing** so that it will be clear what aspects of the problem a communication programme can address. For example, in helping with a diarrhoeal disease reduction campaign, the research data might steer the programme officer and National Inter-sectoral Committee (the team) to state the problem in terms of low use of home fluids and/or lack of acceptance of oral rehydration salt packets as well as a reluctance to continue breastfeeding for infants or feeding of carbohydrates to young children. It may be determined that these factors are rooted in traditional habits and practices, and that health influentials (midwives, traditional healers, etc.) feel threatened by “new” ideas, etc.

Since each of these problems involve different groups of participants, they will necessitate different communication strategies and messages. Depending on the country’s resources and communication capacity, the team may proceed with both communication tasks immediately, be forced to choose between the two, or put them in priority order to tackle one immediately and the other in the future.

Thus, your problem statement might look something like this:

Table 2: Problem Statement

<p><i>“During episodes of diarrhoea, mothers are withholding food and liquids and discontinuing breast feeding of infants instead of increasing small doses of fluids, continuing breast feeding and letting children eat carbohydrates. Ninety-four per cent of women recognize the differences between diarrhoea and dysentery and want to be able to take action to relieve the distress their children experience. The few who know what to do are largely urban, more affluent and educated. During diarrhoeal episodes, their children do not loose weight or suffer from malnutrition, and therefore are not priority targets for this intervention.</i></p>
<p><i>“The research shows children of low-income, less-educated rural women have the highest incidence of diarrhoea and malnutrition during episodes of diarrhoea. Yet these women, with limited access to safe water supply and with virtually no environmental sanitation facilities, have expressed the need for safe water supply. They want more knowledge about environmental sanitation. The communities have expressed willingness to help with funding as well as with the installation and maintenance.</i></p>
<p><i>There is also evidence to suggest that there are traditional beliefs and practices that are associated with causes for and treatment of diarrhoea. These practices may not fully support the recommended practices advocated by project interventions.”</i></p>

B.2. Behaviour Analysis

The next step is to review all the possible causes of the problem and distinguish behavioural causes from non-behavioural causes. Behaviours are the central issue to all our work in communication. Thus, we will take a lot of time discussing behavioural analysis.

Steps To Behavioural Analysis

B.2.1. ANALYSE THE PROBLEM AND DEFINE THE IDEAL BEHAVIOUR.

Analysis of existing behaviour and/or the lack of appropriate behaviour will move the planning process forward. Begin by asking these questions:

What behaviours related to the problem are participants presently performing? Which ones are similar to ideal behaviours? Which ones compete with desired behaviours?

What are the barriers to desired behaviours? Is the absence of desired behaviours due to a skills deficit (lack of skills necessary to perform the behaviour) or to a performance deficit (e.g. existing conditions and resources do not support learned behaviour)?

What are the factors encouraging desired behaviours?

What consequences exist for both desired and competing behaviours? If performing priority behaviours produces few, if any, positive results for participants, what can a communication programme do temporarily to provide incentives for participants to try and adopt desired behaviours?

Answers to these questions help to shift the focus from what information should be disseminated to what behaviours need to be taught, developed (promoted) and/or discouraged in order to ameliorate the development problem. (You will remember our opening remarks about the role of information in changing behaviour. If not, see pages 3-7)

This information will also help to define which communication strategies you need to pursue: programme communication; advocacy; social mobilisation, etc. In fact all three have behaviour development as objective, and usually programmes utilise a combination of these strategies.

A communication programme that has used valuable financial, human and social resources will be considered more cost-effective and successful if it can show that people have actually changed what they are doing. For example, a programme that shows an increase in families that have installed latrines, are using them and are keeping them clean will be seen as more successful than one that achieved a majority of families that *believe* using latrines is a healthy practice but their own behaviour has not changed significantly (i.e., they haven't purchased, installed or used a latrine.)

In order to organise the analysis of behaviour for a communication programme, three categories of behaviour will be considered:

- (1) *ideal behaviours* (all behaviours that would ameliorate a particular aspect of the development problem. For example, ideal behaviours will be the medically correct practices recommended by the profession),
- (2) *current practices* (the most prevalent behaviours related to the problem), and
- (3) *priority behaviours* (feasible behaviours that will have major impact on the problem).

The priority behaviours will become the focus of intervention, and those that the communication programme will introduce, teach and/or support.

B.2.2. REVIEW ASSESSMENT RESEARCH REGARDING CURRENT PRACTICES.

This is the time to review the data collected concerning the beliefs, knowledge and current practices of each participant group associated with the problem. This review will help the programme officer and inter-sectoral committee understand the scope of existing behaviours and what factors maintain them. More specifically, what events (such as child's age, symptoms, etc.) trigger current behaviour, and what positive or negative outcomes are immediately apparent that should be identified?

The research should also provide data on the extent to which current practices differ from the ideal behaviour and/or why participants engage in behaviours that compete with the ideal behaviour. For example, many women may use latrines when at home, but continue to use the fields when working. Or they may engage in the competing behaviour of washing their hands in water from protected sources before preparing meals, but washing vegetables in water from traditional sources before serving them raw. Exploring what barriers keep them from using latrines consistently and what immediate advantages are gained from washing vegetables with water from traditional sources will help communicators plan successful strategies.

B.2.3. SELECT PRIORITY BEHAVIOURS.

Priority behaviours are the minimum number of behaviours your communication inputs will address to achieve some discernible impact on the development problem. From the ideal behaviour list, all behaviours that are not feasible or have little impact on the problem must first be excluded, so that the final list of behaviours is manageable and acceptable to participants. In addition, the greater the resemblance of priority behaviours with current practices, the more likely the communication programme will be in achieving wider adoption of priority behaviours.

Only a few priority behaviours will become the focus of the communication programme. Below are questions that will help guide the elimination process. These questions are best answered by directly observing participants performing the behaviours. If direct observation is not possible, other sources of information are: self-report from participants or communication team members trying the behaviours themselves.

1. *Does the ideal behaviour have a demonstrated impact on the specific development problem?* If it does not, it should not be selected as a priority behaviour.

2. *Is the ideal behaviour feasible for participants to perform?* An in-depth understanding of the participants is necessary if one is to understand constraints to performing the behaviour.

Does the ideal behaviour produce negative outcomes for the person performing it?

Is the ideal behaviour incompatible with the person's current behaviour or with sociocultural norms or acceptable practice?

Does the ideal behaviour require an unrealistic rate of frequency or duration?

Does the ideal behaviour have too high a cost in time, energy, social status, money or materials?

Is the ideal behaviour too complex and not easily divided into a small number of steps? Behaviours that appear simple (increased hand-washing to lower the incidence of childhood diarrhoea), usually involve a complex set of decisions and actions, and possibly more resources (hand-washing before food preparation, after changing the baby, after own defecation, require many more litres of extra water, soap, clean towel, etc.) than may be currently available. Communicators must understand these issues thoroughly so they do not bombard participants with too many complex behaviours to perform.

3. *Are any existing behaviours approximations to the ideal behaviour?* Can these behaviours be shaped into an effective solution to the problem with training, skill development or promotion? Communication programmes have a much better chance of success if they can build upon what people are already doing.

B.2.4. RATE BEHAVIOURS.

When analysing the list of ideal behaviours to reduce it to a short list of priority behaviours, it is useful to rate each behaviour. The Behaviour Analysis Scale (adapted from Green, Kreuter, Deeds and Partridge, 1980) suggests nine criteria against which a potential priority behaviour can be judged: impact on the problem, positive consequences, compatibility, frequency, duration, cost, approximations, complexity and observability. The programme officer and team rate each behaviour from 1 to 5 (low to high) for each criterion. The resulting score helps planners see which of the many behaviours have the most potential impact on the problem, yet are feasible. This is not a rigorous scientific method, but more of a tool to guide the often thorny decision-making process to arrive at a short list of priority behaviours.

Many behaviours may be important to the development problem but still may not be appropriate priority behaviours. A good summary grid is the changeability grid, which shows how to put behaviours under consideration in priority order.

Table 3: Changeability grid

	MORE IMPORTANT	LESS IMPORTANT
MORE CHANGEABLE	<p>Priority 1</p> <p><i>More changeable and important behaviours</i> High priority for programme focus</p>	<p>Priority 3</p> <p><i>More changeable, but less important behaviours</i> Low priority except to demonstrate change for “political” purposes</p>
LESS CHANGEABLE	<p>Priority 2</p> <p><i>Less changeable but important behaviours</i> Priority for innovative (pilot) programme</p>	<p>Priority 4</p> <p><i>Less changeable and less important behaviours</i> Low priority</p>

The elimination process is painful and often requires compromise between impact on the problem and feasibility of action or intervention.

The programme officer and inter-sectoral committee members should see these discussions as a mechanism to look closely at the behaviours they wish to change in order to avoid costly mistakes later in the programme.

The programme officer and inter-sectoral committees should now have a short list of feasible behaviours that have established impact on the problem and are amenable to change.

It is important to remember that you should **limit the priority behaviours to not more than three or four**.

B.2.5. DETERMINE BEHAVIOURAL CONSEQUENCES AND ANTECEDENTS

The next step is to analyse each behaviour according to its antecedents (i.e., events or conditions that trigger the behaviour), and its consequences, (i.e., events or conditions that are seen as resulting from having performed the behaviour). Positive consequences can occur immediately following a behaviour or can be delayed; they can be concrete and readily observable or abstract; and they can be important to the participant (salient) or have little importance when they occur. The consequences of a behaviour can have great impact on performance of the behaviour over the long term and so should be taken into consideration in the analysis and planning process.

B.2.5.1. Types of Negative Consequences that Influence Behaviour.

a) When Performance Is Immediately Punishing

In this case, a person actually receives perceptible punishment for performing the correct behaviour. Punishment may come from individuals in his or her social network, from professionals (health workers, extension agents) or from the behaviour itself. For example, a husband may be unhappy if dinner is not ready because his wife spent the day at the health centre getting their child immunized; doctors may scold a mother for waiting too long before bringing in a sick child; or if oral rehydration solution is given too rapidly, it can cause vomiting.

Communication Implications of this Behavioural Factor

One of your responsibilities as a communication planner will be to anticipate the “punishment” factor through primary research and prepare ways to counteract this.

It will be necessary to “immunize” the participants to this possibility. Through either face-to-face sessions, community-level training sessions or modelling through the mass media, you can provide responses to the primary participant group: “when s/he says _____, I can say _____.” You can also have local influentials bring concerned people together and discuss the possible negative outcomes of implementing recommended behaviours, and brainstorm ways of dealing with these possibilities.

b) When Performance Creates No Immediate Results

Because of their preventive nature, many priority behaviours in child survival programmes have no immediate, salient consequences that the person performing the behaviour can readily perceive. For example, a mother may not be able to see that the incidence of diarrhoea has decreased because her family is using the latrine and the family members are all washing their hands after defecating and before eating.

Communication Implications of this Behavioural Factor

There are two important pieces of action that have to be in place before any intervention begins. The first is the honest admission by programme people that the effects of this intervention are not immediate, but are long term. That is the reality. This reality must be repeated and reinforced by health professionals and community opinion leaders (influentials.)

The second is establishing a local level (family level, community level) monitoring system, so that people will be able to measure any changes that occur. Of course, they must know the extent of the current problem, the baseline: how many families experience episodes of diarrhoea, for example, and how often during a certain period of time. They also have to be aware that they should be monitoring progress against the baseline. By this means of empowerment, people will be able to identify for themselves when change begins to occur. (This is why we stress participation at all stages.)

c) When Non-performance Is More Rewarding than Performance

In many instances, household responsibilities and work outside the home compete with a parent’s time to perform desired behaviours; thus, it often becomes rewarding in the short

term NOT to carry out prescribed practices. For example, when a mother does NOT participate in the community sanitation committee or training for handpump maintenance, she has gained valuable time to work in the family garden and does not have to have someone look after the children left at home while she is at the community centre. The positive consequences of environmental sanitation or safe water supply are too delayed to influence the immediate decision to stay at home.

Communication Implications of this Behavioural Factor

We suggest three strategies that could be effective here:

1) The positive use of peer pressure to motivate the primary participant group to practice the recommended behaviour; that, and monitoring by responsible people in the community. The use of satisfied acceptors is also recommended. Of course, if practising the behaviour has become the social norm, peer pressure becomes easier. If not, then selected satisfied acceptors and responsible people in the village will have to be asked to participate in motivating the “mother” – in this case – to practice the recommended behaviour.

2) Bring personalisation of risk into play: messages to the mother (all she is trying to do is find time to work in the garden) that stress the negative consequences to her (and the child) of not following the recommended behaviour.

3) Bring to her attention (through face-to-face sessions? through the mass media? through posters? pamphlets? training sessions?) testimonials from women just like her. These testimonials can say: “I used to feel that _____. Then I realised that if I did that, _____ would occur. So now I _____”.

However, if you have done the research well, these non-performance problems can be anticipated.

d) When Other Behaviours Are More Rewarding

Behaviours that compete with recommended behaviours are often more rewarding in the short term to perform. For example, using formula for infant feeding is seen as more socially desirable and allows others to feed the baby, freeing up the mother to do other important tasks.

Communication Implications of this Behavioural Factor

Again, your baseline behavioural research should have anticipated this problem and permitted you to test – through focus groups – ways to meet it. We suggest to utilise the same strategies enumerated above for the previous issue.

e) When Behaviour Is Too Complex, Difficult or Costly

Whether complexity, difficulty and cost are seen as antecedents (predisposing factors) or as consequences, their association with the behaviour greatly influences its performance. If a desired behaviour takes large amounts of time and resources, and in the end does not seem to produce any positive change, it will be hard to convince participants to perform it. One of the

biggest challenges in programmes to promote oral rehydration is that obtaining the salts, and mixing and administering the solution several times a day, make it a costly behaviour. And when, after all this effort, the mother perceives that it had little or no effect on the course of diarrhoea, it is unlikely that she will repeat this behaviour without some extra intervention to reduce the behavioural cost and/or increase rewards.

Communication Implications of this Behavioural Factor

This issue seems to go to the very heart of programme planning, doesn't it? If planners have not made provisions for the supplies and equipment to be in place, your communication efforts are doomed. You just don't have a programme. It's that simple. You will also destroy all credibility you may have established through the planning process. **NEVER, EVER, INITIATE A COMMUNICATION PROGRAMME WITHOUT ALL OTHER ELEMENTS IN PLACE.** That is the first issue.

The second issue is the one of self-confidence, self-efficacy. We have underscored previously the need for people to feel confident that they CAN perform the recommended behaviour. This takes training, systematic community sessions where the practice is given the opportunity to become perfect. Moreover, once people have learned how to do something, we need to positively reinforce their skills. This can be done through trained community workers, local satisfied acceptors, local experts, etc. See questions below in C.1 and 2.

B.2.5.2. Anticipate Negative Behavioural Issues. Some Questions to Ask.

You can anticipate most of these issues by consulting with participant groups. This can be done directly with communities or through mechanisms such as focus group discussions with small sample groups that are representative of the participant groups you are serving.

In addition to looking at the antecedents and consequences of priority behaviours, the programme officer and the inter-sectoral committee should consider the following questions for broader determinants that affect the performance of desired behaviours:

1. Is the product or service to be used acceptable and accessible to programme participants? If yes, how? If not, why?
2. Are policies and legislation in place to support the practice of priority behaviours? If not, what should be done to put them in place?
3. Are the practices of professionals, partners and other allies related to the development problem compatible with the practice of the priority behaviour?
4. Are priority behaviours compatible with existing social norms?

From this identification of priority behaviours and their determinants, it will become clearer whom to select as programme participants. *Participant analysis* will help to define more precisely (segment) the programme participant group, and to identify other participants and partners critical in creating a supportive environment for practising desired behaviour over the long term.

B.3. Participant Analysis

The purpose of participant analysis is to identify relevant participant groups, their characteristics, and what resources each group can access to bring about and maintain the practice of desired behaviours. Different communication strategies, messages and content for dialogue will be needed to address programme objectives for each group.

Research will undoubtedly show that several different groups of people or organisations will need to participate in actual behaviour development activities and in creating a supportive environment to maintain the recommended behaviours .

B.3.1. BENEFICIARIES:

Who suffers most from the problem and will directly benefit from programme interventions? These people are also called the **primary participants**.

B.3.2. SECONDARY PROGRAMME PARTICIPANTS:

Those with the most influence on the beneficiaries AND who must be involved and respond to communication interventions. We also may want to identify other individuals who can support primary participants in carrying out priority behaviours.

B.3.3. PARTNERS AND ALLIES:

Those organisations, groups and networks that can support programme participants. What political/social/professional leaders can create a supportive environment that supports the adoption of priority behaviours? What legislation, policies or professional practices need to be changed to create a positive environment for the performance of recommended behaviours?

From this you will clearly see that your communication inputs extend to a much wider circle of partners than communities that may be participating in safe water supply or environmental sanitation activities.

Thus, in order to ultimately focus on the community, we also need to look at the legislature, lawmakers, national decision-makers (as well as community decisions-makers), people who have influence on decision-makers, as well as people who have influence on and within communities — for example, religious leaders.

There are many activities to plan for: we have to **advocate** with decision-makers at all levels; we have to use **social mobilisation** techniques to create climates wherein safe water and environmental sanitation activities can take place; through both **advocacy and social mobilisation** we have to create partners and allies across many social groups in the society we are serving – nationally, regionally and in communities.

Box 3 - Facts for Life, Religious Leaders, and Cholera Prevention.¹⁷

In the predominantly Roman Catholic Philippines, four Muslim provinces have a wide degree of autonomy. The southern region of Mindanao is rural, with 21 million people in 83 towns and 2,000 villages. Since 1988 UNICEF has supported efforts to reduce child mortality through an Area-based Child Survival and Development Programme.

A handbook based on *Facts for Life* and the *Koran* has been developed to help religious leaders and teachers, including ustadhs and ulamas, support this programme.

Researchers sponsored by UNICEF, the University of South Mindanao and Mindanao State University, interviewed 200 imams. They found that imams would like to do more on health and development but were waiting to be asked.

Dr. Abas Candao, Executive Secretary to the Regional Governor, says that working through religious teachers helps make up for a shortage of trained health workers and helps to overcome suspicions. His personal experience dates back to 1970 when he was qualifying as a doctor and went to help with a cholera epidemic in Buluan, Maguindanao.

“For three days and nights I had no sleep. Patients were lying all over the floor. I helped here and there, and then I thought we should try to boil the water and to disinfect the wells. Nobody would let me add anything to the water and nobody would let me give vaccinations. Nobody would listen to me.

“The next day was a Friday and at noon prayers I visited the imam and talked to him. I told him who my parents were and where I came from. He allowed me to talk before prayers. to tell them what I wanted to do. Then they came for vaccinations and allowed me to chlorinate the wells.”

An Example

Let us work through a process using the case we presented earlier. The Problem Statement reads:

Table 2: Problem Statement

“During episodes of diarrhoea, mothers are withholding food and liquids and discontinuing breast-feeding of infants instead of increasing small doses of fluids, continuing breastfeeding and letting children eat carbohydrates. Ninety-four per cent of women recognize the differences between diarrhoea and dysentery and want to be able to take action to relieve the distress their children experience. The few who know what to do are largely urban, more affluent and educated. During diarrhoeal episodes, their children do not loose weight or suffer from malnutrition and, therefore, are not priority targets for this intervention.

“The research shows that children of low-income, less-educated rural women have the highest incidence of diarrhoea and malnutrition during episodes of diarrhoea. Yet these women, with limited access to safe water supply and with virtually no environmental sanitation facilities, have expressed the need for safe water supply. They want more knowledge about environmental sanitation. The communities have expressed willingness to help with funding as well as with the installation and maintenance.

There is also evidence to suggest that there are traditional beliefs and practices that are associated with causes for and treatment of diarrhoea. These practices may not fully support the recommended practices advocated by project interventions.”

¹⁷ *Facts for Life: Lessons from Experience*. pp. 94, 95, UNICEF, New York 1996.

In this case, although disadvantaged rural women with young children might be the primary participants (*the beneficiaries*) in a programme to decrease diarrhoeal disease, additional participants in the programme might be other female family members, and husbands or male family members (*secondary programme participants*). In addition to these household members, others who would have an impact on mothers' behaviours might be friends, neighbours and health workers (also secondary programme participants). Those impacting on male household members might be community leaders, agricultural extension agents, political and religious leaders (*partners and allies*).

B.3.4. PARTICIPANT BEHAVIOUR LINK

Many people have roles in developing the behaviours of the primary participant group. The following analysis is helpful in spelling this out:

Table 4: Participant-Behaviour Link (example)

PARTICIPANT-BEHAVIOUR LINK	
Programme Participants	Recommended, Feasible Behaviours
Primary	
Disadvantaged Rural Women with Young Children	<ol style="list-style-type: none"> 1. Use the latrine for defecation; 2. Wash hands after use, before preparing meals, before eating; 3. Prepare fluids for children during episodes of diarrhoea; 4. Continue to feed children carbohydrates during episodes of diarrhoea; 5. Use safe water supply facilities exclusively.
Secondary	
1. Other Female Family Members	Support the mother in the recommended behaviours described.
2. Husbands or Male Family Members	Support the mother in the recommended behaviours described; Find ways to improve household sanitation; e.g., installation of latrines; assisting community in installing safe water supply; bringing water source closer to house.
3. Friends, Neighbours and Health Workers	<ol style="list-style-type: none"> 1. Support all the recommended behaviours and model them; 2. Promote those behaviours throughout the community (to ensure they become the norm).
Partners & Allies	
1. Community Leaders, Agricultural Extension Agents, Political and Religious Leaders	<p>ALL:</p> <ol style="list-style-type: none"> 1. Support all the recommended behaviours; 2. Promote those behaviours throughout the community (to ensure they become the norm). <p>Health Workers</p> <ol style="list-style-type: none"> 1. Ensure that supplies and equipment are available (such as latrines, spare parts, ORT packets, posters and teaching/training materials); 2. Carry out small group meetings to teach recommended hygiene practices. <p>Political and Religious Leaders:</p> <p>Ensure that the public proclamations of political and religious issues support these behaviours.</p>

Adapted from *A Toolbox for Building Health Communication Capacity*, HEALTHCOM, Academy for Educational Development, Washington, DC, 1995

To review: We need to ask the questions:

1. *What individuals can support programme participants in carrying out priority behaviours?* If programme participants are mothers of infants, for example, secondary participants might be male partners, older children, female family members, midwife/health worker, other women in the community co/operative, etc.
2. *What organisations, groups or networks can support participants?* Examples are the local religious group or an NGO with a programme operating in the town.
3. *What political, social, and/or professional leaders can create a more supportive environment for the adoption of priority behaviours?* These people might be the appropriate ministry at the national level or a media or sports personality who would promote the social acceptability of priority behaviours.

When analysis reveals that political leaders or professional organisations must be involved in the programme, their role should also be phrased as behaviours or actions that they will perform. These behaviours or actions should go through the same scrutiny for complexity, feasibility, changeability, barriers to and factors encouraging correct behaviour as in the selection of priority behaviours for programme participants.

B.3.5. PARTICIPANT PROFILE¹⁸:

The next step in participant analysis is the development/creation of a participant profile. Possible criteria for defining programme participants: a) Objective measures that include person-specific characteristics such as age, income, sex, etc., and development of problem-specific characteristics such as contact with the health system, past behaviours, access to products etc.; and, b) Subjective measures that include characteristics such as self-confidence, perceived risk, media preference, relevant knowledge, perceived benefits, etc.

You will see that such a profile includes measures of both:

- 1) The stages of behaviour development relative to the intervention you are proposing;
- 2) The adoption group the respondent falls into *vis-à-vis* the acceptance of the intervention.

When you have this information, you are ready to begin planning the communication strategy and selecting the channels that will be used.

¹⁸ For more information, refer to the *Toolbox for Building Health Communication Capacity*, HEALTHCOM, Academy for Educational Development, Washington, DC, 1995.

B.4. Channel Analysis

The problem has now been defined, priority behaviours identified for programme participants, supporting participants and partners, and the barriers that need to be overcome as well as benefits that need to be promoted to perform these behaviours are known.

The last step of the analysis is to identify appropriate communication channels to reach participants with selected messages, and involve participants in appropriate communication activities (meetings, training programmes, counselling sessions, etc.). Here are some initial questions the team should answer in a channel analysis:

B.4.1. VIS-À-VIS PROGRAMME PARTICIPANTS:

1. For this development problem, what are the programme participants' most credible information sources?
2. What communication channels are best suited to reach participants?
3. What are participants' media usage habits: Which media do they use and how frequently do they use them? Which media do people trust? Have faith in?
4. What is their level of literacy and in what language?
5. What traditional media are available and what is their popularity with programme participants?
6. What are the interpersonal communication practices in the programme participants' community?
7. What are the various local formal and informal networks available?

B.4.2. VIS-À-VIS LOCAL COMMUNICATION CAPACITY:

1. What communication channel(s) are best suited to the messages selected to achieve communication objectives?
2. What are the major mass media in this country, their coverage (reach), cost and control? Which media are the most credible and for which topics?
3. How frequently do (a) the printed media publish? (b) the electronic media broadcast?
4. What media organisations or institutions are there and how effective are they?
5. What institutions or organisations have research and training capacity in mass media or interpersonal communication?
6. What skills exist locally in audio-visual production, graphic art, design or print?
7. What messages, materials and channels have been used in the past and what was their effectiveness in bringing about behaviour change?

In addition to these questions, you should review the 'effectiveness' and the strengths and limitations of various communication channels. This information will then have to **be adapted to the social setting you are working in, partially in response to the questions asked above, partially on the basis of data from local research organisations** (institutes,

advertising and marketing companies, departments of sociology and anthropology, the government's information ministry.)

“Effectiveness” is defined as a channel's ability to get people to: remember information received; change behaviour(s), and to be motivated to tell other people about new things they have learned. A channel is also considered effective if it provides timely information, creates a climate for change, is credible, efficiently reaches small or large groups of people and is cost-effective.

B.4.3. BRIEF OVERVIEW OF STRENGTHS AND LIMITATIONS OF EACH CHANNEL OF COMMUNICATION.¹⁹:

B.4.3.1. Interpersonal

(Examples: individual counselling, “satisfied acceptors,” community-level animation/motivation sessions, small group discussions, peer education, home visitations, etc.)

Strengths:

- Provides credibility to messages
- Provides detailed information
- Creates supportive environment
- Provides opportunity to discuss sensitive, personal topics
- Creates support at community level for recommended behaviours, ideas, products
- Allows immediate feedback on ideas, messages, practices, etc.

Limitations:

- Time-consuming with a high cost per person/contact
- Reaches small number of individuals
- Requires practical skills-training and support of field workers

B.4.3.2. Graphics and Audiovisual (as support material primarily)

(Posters [as aids], flipcharts, slides, overhead projections, tape recordings, specifically tailored video presentations)

Strengths:

- Provides timely reminders and attracts the attention of the participant group at the place of exposure
- Provides basic information on the product and its benefits
- Is handy and reusable
- Provides accurate, standardized information
- Gives confidence and credibility to person communicating messages

¹⁹ For more detailed information on strengths and weaknesses of communication channels, refer to the *Communication for Development Guidelines*, UNICEF, New York 1999.

May be distributed to areas not penetrated by mass media

Limitations:

May not be cost-effective

Training necessary for effective design, development and production

Communicators often seduced by “ease” of production

B.4.3.3. Mass Media

(Electronic media: radio, television, cinema, video [for mass consumption]; newspapers, magazines, journals, posters [in public places]; recordings of popular music)

Strengths:

Reaches many people

Provides for frequency of messages

Can create a demand for services or products on the part of innovators, early acceptors and some of the early majority.

Reinforces important messages delivered through interpersonal communication channels

Stimulates discussion of topics among family, friends and neighbours

Reaches those of limited literacy

Can provide protective impersonality in dealing with sensitive issues

Limitations:

May have limited rural distribution

Difficult to tailor programme to special groups

Difficult to obtain group feedback

Requires access to radio, TV, cinema, print media, etc.

B.4.3.4. Traditional Media

(Street theatre, indigenous dramatic forms, puppets, opera, dance, storytelling, town criers, songs, etc.)

Strengths:

Can use local jargon and slang

Puts messages and situations in familiar context

More personally relevant than other media

Uses local talent and gets community involved

Potential to be self-sustaining at low/no cost

Stimulates discussion of topics among families, friends, neighbours, within the community.

Limitations:

Reaches relatively small group

May not be available when needed

Requires investment in training and support

May have difficulty broaching issues which may be highly sensitive locally
Difficult to guarantee and monitor consistent accuracy of messages.

B.4.4. THE RULES FOR SELECTING CHANNELS ARE BASIC BUT VERY IMPORTANT, AND INCLUDE THE FOLLOWING:

1. Select channels that **reflect the patterns of use** of the specific participant group, not the tastes of the communication officer, team or other decision-makers. Almost all communicators have their “favourite media”, whether radio, video or puppets. In order to have an impact, however, the channels selected **must be those that reach their group with the greatest degree of frequency, effectiveness and credibility.**
2. Recognize that the **different channels play different roles.**
3. Use **several channels simultaneously.** The integrated use of multiple channels increases the coverage, frequency and impact of communication messages.
4. Select media that are within the **programme’s human and financial resources.**
5. Select channels that are **accessible and appropriate** to programme participants:
 - a) Radio messages should be scheduled for those radio stations that programme participants actually listen to and at broadcast times when they actually listen.
 - b) Print materials, even without text, should be used only for literate or semiliterate participants who are accustomed to learning through written and visual materials.
 - c) Interpersonal communication should be provided reliably by credible sources.

Results of channel analysis will tell the team/working group which channels are best suited to the messages and participants, and whether local capacity needs to be strengthened in order to carry out the communication programme.

B.5. Communication Objectives

Probably every reader of this Manual is very familiar with the process of formulating objectives for country programmes, sectoral programmes and projects. Work in formulating objectives is an integral part of every country programming process. You are all familiar with the **hierarchy of objectives** that form the logic of the programmes.

It is not our intention to review the hierarchy of objectives or define such terms as input or output objectives, process objectives, outcome objectives, etc. We are going to speak only about communication objectives as they relate to the process of developing or changing behaviours.

A communication programme objective will **state the anticipated impact communication activities** will have on the development problem. As stated earlier, *communication for development alone cannot solve a development problem.* Nevertheless, by

focusing on aspects of the problem amenable to change through communication, communication programme objectives become linked to the objectives of the broader development programme. In this way, communication becomes an essential and effective partner in the broader, multi-sectoral effort to ameliorate the development problem.

Most broadly, *programme goals* specify the expected overall impact of the multisectoral programme activities to which the communication programme will contribute. For example, X per cent reduction in morbidity and mortality rates by (date).

More specifically, *programme objectives* define expected results of the development programme activities to which the communication programme will contribute. For example, X per cent decrease in reported cases of diarrhoea in (region, country) by (date).

Therefore, *communication objectives* indicate the expected change in knowledge, attitudes and practice (behaviours) related to the development problem in various programme participant groups as an end result of the communication programme. For example, X per cent of caretakers of children 1) can state the method of preparing oral rehydration salts (knowledge) and 2) can actually demonstrate how to prepare ORS from fluids available at home (behaviour).

B.5.1. COMPONENTS OF A MEASURABLE COMMUNICATION OBJECTIVE

Communication objectives identify **how participants' and partners' behaviours will develop or change, to what extent and over what period of time**. Emphasis should be on activities or phenomena (recall, demonstrate a skill, state a belief or an attitude) that can be observed or measured directly and have significant impact on the development problem. Although increases in knowledge and a more positive attitude are possible changes a communication programme can produce, until programme participants actually change some behaviour (perhaps as a result of more knowledge), there will be no impact on the development problem.

You should be able to write a communication objectives by completing the following format

Table 5: Components of a Measurable Communication Objective

1. WHAT	2. WHO	3. WHERE	4. HOW MUCH (MANY?) By What Means?	5. WHEN
Baseline and/or a Realistic Stated Change over the Baseline (<i>in terms of knowledge, attitudes, practices or beliefs</i>)	Clear and precise participant group	Clear geographic location of the participant group	Measurable and/or Observable Results	Clearly Defined Time Period (<i>Time-bound</i>)

The well-conceived communication objective will also be **SMART**. That is:

1. **S**imple and clear,
2. **M**easurable,
3. **A**ttainable,
4. **R**easonable,
5. **T**ime and location specific.

Objectives will be easier to monitor and evaluate if they are structured using clear, action words that lend themselves to measurement, as opposed to qualitative words. For example:

ACTION WORDS

Complete
Use
Try/attempt
Define
Enumerate
Prepare/make
List/organise
Design/arrange
Compare

QUALITATIVE WORDS

Internalise
Understand
Appreciate
Value
Enjoy
Motivate
Sensitise
Realise
Decide

Some objectives may be qualitative in nature, but the qualitative aspects of the objective are always linked to a behaviour that is observable and has impact on the development problem.

The following is an example of a SMART communication objective.

By the end of the year 2000 there will be an increase from 60 per cent to 80 per cent in the number of rural caregivers with children less than five years in the two southern provinces (X and Y) who are able to cite the three ways that diarrhoea and dysentery are transmitted.

By writing the objectives, the programme officer and inter-sectoral committee will know where the communication programme is going, and identify how the programme will get there.

B.6. Developing Strategies and Activities

We achieve our communication objective by developing strategies and activities. A strategy is a short statement or phrase indicating general methodology to be used to achieve the objective. An activity amplifies a strategy giving it the details needed to make it implementable. For example taking the above objective:

By the end of the year 2000 there will be an increase from 60 per cent to 80 per cent in the number of rural caregivers with children less than five years in the two southern provinces (X and Y) who are able to cite the three ways that diarrhoea and dysentery are transmitted.

The strategy will depend on the combined results of the previous analyses. In the case of the example mentioned above - and assuming that the rural caregivers are literate, have access to mass media, and that health workers are available to reach them with interpersonal communication — The strategy could be: *Using print/mass media and interpersonal communication (health workers) to disseminate key message to rural caregivers.*

Activities would give the strategy greater definition and are broken into individual units to be scheduled and implemented on an action plan. For example two activities to support the above mentioned strategy could include: Activity 1: Train health workers to disseminate messages at health facilities and in the community. Activity 2: Using formative research, develop print materials to be displayed and distributed at relevant locations and health facilities.

A sub-objective and media input should be constructed for each communication activity within each of the communication strategies: Advocacy, social mobilisation and programme communication. Often this is overlooked, relegated to an appendix or dismissed without the rigor that is required when it comes to these implementation details. This is a very important step in developing the details of your communication activities. Without this step your implementation becomes sloppy.²⁰

For example, a communication sub-objective for two clinic posters designed for rural mothers who come to clinics could be:

Sub-Objectives: Seventy-five per cent of rural caregivers in the clinics who notice the poster recall two media inputs (poster and slogan):

Poster 1: Hand-washing prevents spread of bacteria from faeces;

Poster 2: The three instances in which hand-washing is most essential are:

- a) before preparing meals,
- b) before eating meals,
- c) after using the toilet.

Poster 1

Slogan: “Protect yourself and your family. Wash your hands after using the latrine.”

Visual: Poster of woman washing her hands outside a latrine.

²⁰ Please refer to the UNICEF *Communication for Development Guidelines* (quoted) for further information on pre-testing.

Poster 2

Slogan: “Protect yourself and your family. Wash your hands before preparing meals; before eating; and after using the toilet.”

Visual: Picture of food on the table and family washing hands at the basin.

B.7. Monitoring and Evaluation Indicators

With well-designed communication objectives, half of the work in planning monitoring and evaluation is finished. How? Well, to begin, let’s review the work we have just finished in the previous section.

Look at the first example. What would you monitor about that poster? What indicators? It seems clear that we should ask people leaving clinics:

1. If they remember seeing the poster and the topic of the poster;
2. If they can recall how to prevent the spread of bacteria from faecal matter; (If they say “hand-washing,” we can ask – prompting them:
3. “When are the best times to wash your hands?”
4. If they respond:
 - a) before preparing meals,
 - b) before eating meals,
 - c) after using the toilet,Then we might want to ask:
5. “Where did you learn this information?” If they say “from a poster in the clinic” We might want to probe even further:
6. “What did the poster look like?”

If, using the above approach, 75 per cent of the women can answer the questions correctly, you can be happy with this particular communication medium. However, as we have said, one poster alone is probably not going to provoke a lasting change on anyone’s behaviour. It will take multidisciplinary, multifaceted, well-coordinated communication and programme interventions to achieve that.

Nonetheless how shall we monitor and evaluate? You will want to answer the questions:

<p>MONITORING</p> <p>What is Happening and How?</p>
--

<p>EVALUATION</p> <p>What are the results of the communication intervention?</p>

B.7.1. INDICATORS IN GENERAL

Many programme and behavioural indicators could be selected for monitoring and evaluation purposes during assessment process. Levels of current behaviours, desired behaviours, competing behaviours and undesirable behaviours of various programme participants are some of the indicators which should have been measured during assessment in order to establish a pre-programme baseline.

Selected indicators will then be re-measured periodically during the programme (monitoring) and again, in some pre-designated follow-up period (evaluation). During the design phase, as specific communication activities are planned, the inter-sectoral committee will want to add certain indicators to both the monitoring and evaluation design.

B.7.2. MONITORING INDICATORS

For **monitoring**, indicators would cover either logistics or interim effects of the programme. For example, if the communication programme now includes radio spots, indicators for logistics would be time and frequency of broadcasts (did they go according to schedule) and reach: numbers of programme participants who heard the broadcasts. Interim effects measured in this programme would be the percentage of those listening who can state information presented correctly and the percentage of those who intend to do recommended behaviours. Monitoring would also measure the number of programme participants who actually perform recommended behaviours, comparing those exposed to communication messages and those who are not.

Table 6:

SOME EXAMPLES OF WHAT TO MONITOR	
A.	Logistics
	1) Materials production and pre-testing
	2) Distribution systems
	Print products
	Audio
	Visual
B.	Mass Media Broadcasts (were they aired as planned, were they heard by intended beneficiaries?)
	1) Radio
	2) Television
	3) Video
C.)	Interpersonal Communication Activities
	1) Establishing networks
	2) Peer group education, visitation activities
	3) Community level group meetings
D)	Indigenous, Local Media Activities
	1) Number of folk groups, theatre groups, puppet groups, etc., trained; number of performances given; amount of information audiences can recall, etc.
	2) Number of festivals incorporating WES demonstrations;
	3) Number of local town-criers trained.
E)	Interim effects
	1) Changes in knowledge
	2) Changes or developments in practices and behaviours
	3) Improvements in targeted interventions (e.g.: health, education, etc.)

B.7.3. EVALUATION INDICATORS

Table 7:

WHAT TO EVALUATE: QUESTIONS EVALUATION SHOULD ANSWER (BASED ON PROGRAMME OBJECTIVES)	
1.	What change has occurred?
2.	How, when and with which groups did the changes occur?
3.	What aspects of the communication interventions contributed to these changes?
4.	What aspects of the communication interventions should be changed to improve results/management?
5.	How cost-efficient were the communication interventions?
6.	How did the results of these communication interventions compare with results of other similar interventions?

In designing the communication programme evaluation, process, impact and outcome indicators are important.

Process evaluation measures the *extent to which the communication programme was delivered as planned*. (Most of these indicators will be the same as those selected for monitoring.)

Impact evaluation measures short-term or medium-term effects of a programme. It attempts to look both at what *influence communication activities have had on behaviour* and what *influence those behaviours have had on the development problem*.

Outcome evaluation puts an emphasis on long-term effects and is research designed to account for programme accomplishments and long-term effectiveness.

Example: *Diarrhoeal Disease Control (CDD) Programme*

Process questions:

How often are health education sessions devoted to CDD, held at the CDD centre, or in the villages?

What Oral Rehydration Therapy (ORT) messages are developed and how and how often are they disseminated through different communication channels?

How do mothers feel about the quality of counselling provided by local health workers?

Impact questions:

How many mothers know the signs of dehydration?

How many families have potable water available to them?

What per cent of mothers wash their hands before preparing family meals, especially food for their children?

Outcome questions:

What is the incidence and prevalence of diarrhoeal diseases in a specified community?
What is the current infant mortality rate by cause?

B.7.4. MULTIPLE INDICATOR CLUSTER SURVEYS 2 (MICS2)

The reader will have noted few of the above indicators are among the five included on the survey instrument of the Second Multiple Indicator Cluster Surveys (MICS2) relative to water and sanitation. There are several reasons for this. First, the MICS2 is a standardised instrument designed to assess selected indicators, which partially serve as proxies to measure progress toward end-decade goals. Second, as of this writing, the MICS2 is already an enormous survey instrument covering many facets of health, nutrition and some education.

There are many things the MICS2 cannot even attempt to measure. Chief among them are *indicators of the process of developing new behaviours* -- the very thing that this Manual stresses. Therefore, the measuring of these processes will fall to you as the programme people responsible for stimulating communities – both urban and rural – to participate in improving their own health behaviours. These behaviours for you are those related to the **use of safe water and environmental sanitation**.

Let us reiterate one very important point by asking two questions:

- 1) Is the installation of an acceptable or safe water source the final objective of a water programme?
- 2) Is the installation of a sanitary waste disposal technology the final objective of a sanitation programme?

Hopefully, you have answered those two questions with a resounding “**NO!**”

In terms of developing sustainable, enduring, healthful behaviours - the final objectives are what? **Sustained and proper use of the facilities**. The USAGE is the final objective of your communication programme. Improved healthful behaviours are the goal.

At this stage of planning the programme officer and inter-sectoral committee should carefully draw up a monitoring plan that:

- specifies reporting levels (national, provincial, district, health facility, community, etc.)
- designates reporting officers and volunteers
- determines reporting intervals
- determines what will be reported (different reporting formats may be needed at different levels)
- determines the procedure for reporting to the next level
- indicates procedures by which higher levels will provide feedback and support to lower levels

- provides guidance on how monitoring information will be used (locally by lower level stations and nationally, at the head office).

You will not need or want to collect all the data that will become available. First of all, it is unnecessary and, secondly, it will be too much work to gather and analyse. Even if collected, it will not be analysed. Therefore, you must find some way to prioritise.

Now you have completed the heart of your programme with the participation of many sectors, and – most importantly – with the participation of the participant groups you are serving with this intervention.

We are now ready to start designing the full programme.

B.8. Summary

From this communication analysis process, the programme officer and inter-sectoral committee should have identified the problem, behaviours, participants, determinants and channels. They will also have analysed the linkages between them: what behaviours performed by whom contribute to the problem with what effect, and what behaviours performed by whom with appropriate support given through selected channels will provide a solution to the problem. They would have developed objectives and indicators for each of the communication activities in the different strategies of advocacy, social mobilisation and programme communication. The following section on *programme design* will use this analysis to guide channel selection, message development, and other programme components.

C. Programme Design

C.1. Design Strategy

You have completed the research on participant groups. You know something about their:

- a) practices and behaviours in regard to the intervention you are working with; (all the current behaviours, alternative behaviours, antecedents and consequent behaviours, etc.);
- b) socio-economic characteristics;
- c) geographic location or locality;
- d) (hopefully) which “mass media” they have access to and that they prefer;
- e) which traditional media is available to them and which they prefer;
- f) which “small” media they prefer;
- g) who the “change agents” are in their communities (which extension workers, including health workers and safe water supply and environmental sanitation workers);
- h) who the local and regional opinion, religious, political leaders are;

- i) which national figures are particularly admired locally;
- j) what the various social networks are in the communities and who belongs to which ones;
- k) what the various interest groups are: women's groups, youth organisations, religious groups, cultural groups, sports groups, political groups, etc.

and probably many other things that we have not listed here.

Not only you know these people well, but - after the participatory approaches that have been employed - THEY know YOU well, AND the interventions you have been discussing. We have now almost come to the core of the creative and scientific process of developing communication inputs. But there are some things you still need to know before you can begin to fully implement your plan.

We need to start experimenting—trying out approaches, strategies and individual media through the process of formative research. These media will be based on your behavioural objectives (in which we include learning objectives as well as attitudinal objectives). To a certain extent your choices of approaches, strategies, channels and media will be based on informed creative choices, even “gut” feelings, which you will test as you develop messages.

Nowhere do all these factors become **more important** than in the **development of messages** as part of our proposed communication strategies.

Ask yourself the question: “If I want to achieve _____ (a certain behaviour), what would be the best way to do it?” Then, go to groups of participants and ask them the same question: “If we want to encourage behaviour _____, what is the best way to do so?”

Here, we must digress for just a brief moment to talk about the building blocks of message design and development.

C.2. Message Design and Development

One of the first steps in planning communication inputs is a discussion of the psychosocial aspects of messages that need to be tested. These aspects will change depending on

- 1) the participant group(s) with whom we were working
- 2) the medium
- 3) the nature of intervention

For example, colours and music designed for adolescents may not have the same impact as colours and music for mothers with three children. A traditional folk medium may be appropriate for some interventions but not for others.

Of course, you may have touched upon these factors in your baseline research. That will be extremely valuable. However, most of these factors **need to be retested in the context of the message they are attempting to convey.**

The empirical literature is flooded with both amusing as well as extremely worrisome examples of messages that not only have failed to convey the intended meaning, but that had devastating negative impacts on development interventions because a symbol, a colour, a word, a piece of music was misused. We cannot be more forceful than to say: **if you are not testing all the psychosocial aspects of communication inputs, you are risking almost assured failure.**

We need to say a word about **tones** of messages. In addition to approaches (see below), the tone of a message very much dictates how people learn. For example, in some cultures humour has a great impact on people's ability to learn. In some cultures people respond (i.e. they remember and may be willing to change behaviours) to messages that are highly fear-inducing.

In other situations, it is the association with a stimulus that helps people remember messages: a song, a jingle, a clever poem, a funny character in a soap opera. This is where creativity and research form a very happy marriage. Your creative team should generate wonderful, even crazy ideas, many of which may be discarded or put aside until a later date. These ideas will be tested, refined and perhaps used. This is where the experience from the movement that uses "edutainment" is very important: all the programmes from "Soul City", for example, or from Children's Television Workshop are created on the basis of educational objectives and test the product of that creativity.

Some of the **approaches** you could use are persuading, informing, entertaining, educating, empowering or facilitating. Some suggestions for different appeals are: emotional vs. rational, positive vs. negative, direct vs. indirect, humour vs. serious, etc.

What each of these factors means in the context of the culture and society you are working in remains to be defined by the researchers on your Communication Team.

We are now entering the stage of Formative Research — another crucial step in the development of your communication plan.

C.3. Formative Research and Pre-testing²¹

Formative research includes, but is not limited to, pre-testing. Formative research may be seen as a broader process in which you **test** concepts, psychosocial factors, approaches, etc., **in general**. Please keep in mind at all times that each input - whether it is part of the advocacy, social mobilisation or programme communication strategy - must be tested.

²¹ Please refer to the UNICEF *Communication for Development Guidelines* or consult with the UNICEF Communication Officer for more detailed information.

Without pre-testing, most communication efforts become inefficient and detached from programme participants. They will reflect instead the notions of communication officers, ministry officials or creative specialists who assume that they “know the group” sufficiently enough to decide what material is best for them.

Box 4: Pre-testing in Nepal

Pre-testing in Nepal. ²² Ane Haaland in Asia (Nepal) and Andreas Fugelsang in several African countries were pioneers during the 1970’s in applying Pre-testing to development communication. Haaland’s experience is particularly interesting for water and sanitation programming. Working with the National Development Service in 1976 Haaland and a team surveyed 400 adult villagers to measure the extent to which visual literacy is learned. They found that understanding images is a learned skill, connected with cultural background.

One picture, part of a sequence demonstrating preparation of ORS, showed three hands over a water container. A dotted line extends from each hand ending in an arrow, which reaches the top of the container. Only 68 out of 410 villagers (16.8 per cent) recognised it as hands putting something into a pot. Six out of 10 villagers failed to recognise hands at all. In another visual designed to show the link between polluting water and gastro-intestinal illness, a man squats on a hill defecating. An arrow goes from him to another man gathering water in a pot lower on the hillside than the first man. Another arrow points to a man drinking from the pot. A fourth arrow points to a man holding his stomach against pain. Only one out of 89 villagers understood the message from looking at the picture. Another poster used a cartoon strip. The first panel had two men, on a hillside. The man at the left is squatting and defecating in a stream. The man slightly lower than him is gathering water. The second panel shows a man drinking the water. The third panel shows a man clutching his stomach (presumably in pain.) Few villagers realised the pictures were related. Fewer than half looked at the left-hand picture first.

Steps in Pre-testing:

- make a prototype;
- take it to participant groups and ask, observe, discuss and measure to see if they understand it
- ask them how to improve it
- go back to the office and modify the medium
- test it again
- modify it again
- produce a final version

No matter what design you use to pre-test, you should follow these two basic rules:

Pre-test materials on representatives of programme participants, matching them for group characteristics such as ethnic group, region, and socio-economic status; and for individual characteristics such as age, sex, and number of children.

²² *Facts for Life: Lessons from Experience*, pp. 105 – 107. UNICEF, New York 1996.

Prepare questions and instruments, and train interviewers ahead of time so that pre-testing sessions are uniformly conducted and cover the same issues with all respondents.

Questions to respondents should be tailored to fit the material being tested and the level of sophistication of the respondents. In general, questions should cover comprehension, attractiveness, acceptance, personal involvement and inducement to action.

C.4. Putting the Communication Plan Together.

You have selected the participant groups to whom your safe water and environmental sanitation intervention is addressed. By now you should know A LOT about them through the research you have conducted. You know the behaviours and practices to recommend and advocate.

You know the channels and media you want to use — interpersonal for developing behaviours of most people; the mass and traditional media for modelling behaviours and giving some information; asking influential people at all levels to give testimonials and give support for the intervention, thus establishing social norms and creating a climate for change.

Now: who's going to do what, and when are they going to do it? You need to make an implementation plan. We will continue with the CDD - environmental sanitation example.

Table 8 - Example: Implementation Plan for Safe, Water, Environmental Sanitation and Home Hygiene

COMMUNICATION STRATEGY	PARTICIPANTS/ GROUPS	MESSAGES	CHANNELS	COMMUNICATION MATERIALS	M & E INDICATORS
ADVOCACY	Political and Religious Leaders at national, regional and community levels	<ul style="list-style-type: none"> - Advantages of available safe water supply and sanitary latrines to the individual, the family, the community and the nation 	<ul style="list-style-type: none"> - Individual meetings with senior leaders; - Small group meetings with regional and local leaders. - Reinforcement materials 	<ul style="list-style-type: none"> - Pamphlets containing advantages of interventions and social costs without them. - Testimonials from leaders of neighbouring countries. - Speaking points 	<ul style="list-style-type: none"> - Number of times mentioned in public statements. - Number of meetings conducted by these leaders on this topic. - Number of interventions being implemented.
SOCIAL MOBILISATION	<ul style="list-style-type: none"> - Inter-sectoral central and regional planners groups. - Community leaders - NGOs and CSOs. 	<ul style="list-style-type: none"> - Learn the role of inter-sectoral cooperation. - Learn how to analyse ways to break cycles of infection. - How to request safe water supply 	<ul style="list-style-type: none"> - Inter-sectoral meetings. - Research reports. - Community meetings. - Field observation visits to “model” communities - Demonstration sessions. 	<ul style="list-style-type: none"> - Pamphlets. - Reports: research as well as of “model” communities. - Agendas for community meetings. - Activity guide for community meetings. - Posters on how to break the cycle of infection. - Posters re: hand washing. - Request forms. 	<ul style="list-style-type: none"> - Number of meetings held. - Number of pamphlets, posters produced, distributed and used. - Number of field visits. - Number of water, sanitation systems installed and used. - Reduction in DD.
PROGRAMME COMMUNICATION	<ul style="list-style-type: none"> - Community leaders and members. - Households. - Child caregivers. - Hand pump maintenance volunteers. 	<ul style="list-style-type: none"> - Install latrines. - Use “safe” water. - Wash hands. - Use ORT. - Bury garbage. 	<ul style="list-style-type: none"> - Small group meetings. - Visits by satisfied acceptors. - Monitoring by health workers. - Series of radio and television spots. - Performances by traditional media. 	<ul style="list-style-type: none"> - Agenda for community meetings. - Counselling guide and script for interpersonal sessions. - Monitoring scripts for health workers. - Posters for health and community centres. - Radio and television spots series showing families, friends, neighbours, communities dealing with environmental sanitation and hygiene issues. - Traditional media dealing with environmental sanitation and hygiene issues. 	<ul style="list-style-type: none"> - Number of meetings held. - Number of household visits (by health workers and satisfied acceptors). - Monitoring reports. - Number of radio and television spots aired. - Percentage of participant group members who have heard or seen the spots. - Number of participants who can remember the messages and talk about them. - Number of traditional media performances. - Number of people who have seen the traditional media performances. - Number of people who can remember the content. - Number of water, sanitation systems installed and used. - Number of properly maintained handpumps - Reduction in DD
TRAINING	<ul style="list-style-type: none"> - Health workers. - Community workers. - Community leaders. - Households. - Handpump maintenance volunteers. 	<ul style="list-style-type: none"> - How to counsel. - How to install and maintain handpumps. - How to store and request spare parts. - How to install and maintain sanitary latrines. 	Small group training sessions.	<ul style="list-style-type: none"> - Training guidelines for all levels. - Role-plays for all. - Booklets and posters for handpump maintenance. - Reporting formats for community and health workers. - Storage and request forms for spare parts 	<ul style="list-style-type: none"> - Number of training sessions. - Number of households using ORT. - Number of counselling sessions. - Number of volunteers. - Number of water, sanitation systems installed and correctly used. - Reduction in DD.

It is important for the final implementation plan to be a product of team effort. The process of drawing up the plan will validate the various contributions partners and other team members have made in research, preparing plans or designing strategies. It is also a way for everyone to buy into the communication programme and to assure its smooth operation. We would suggest something like Table 9 presents. (Again, we have used our example for Control of Diarrhoeal Diseases through provision of safe water and environmental sanitation.)

Table 9 - Example: The Operational Plan/Implementation Schedule

STRATEGY	ACTIVITY	J	F	M	A	M	J	J	A	S	O	N	D	ACTION BY...
ADVOCACY	Develop, Test, Distribute -Pamphlets containing advantages of interventions and social costs without them. -Speaking points - Testimonials from leaders in neighbouring countries. Hold individual meetings Conduct small group meetings Monitor	X	X	X	X									Com. Committee <i>(need to distribute tasks among specific professional disciplines)</i> Sr. gov't. staff UNICEF Rep Com. Committee
SOCIAL MOBILISATION	Develop, Test, Distribute -Pamphlets -Posters on how to break the cycle of infection. -Posters re: hand washing -Reports: research as well as of "model" communities -Agendas for community meetings. -Activity guide for community meetings. -Request forms Contact model communities and schedule visits Conduct central and regional meetings Conduct community meetings Conduct small group meetings Monitor	X	X	X	X									Com. Committee Regional Staff Central, Reg. Staff Reg., Dist. Staff Dist. Staff Com Committee
PROGRAMME COMMUNICATION	Develop, Test, Distribute -Agenda for community meetings -Counselling guide and script for interpersonal sessions -Monitoring scripts for health workers -Posters for health and community centres Develop and Test -Radio and television spots series (showing families, friends, neighbours, communities dealing with environmental sanitation and hygiene issues) -Traditional Media dealing with environmental sanitation and hygiene issues Air and perform above Conduct interpersonal counselling sessions Monitor	X	X											Com. Committee Com. Committee with national and regional media institutions Media institutions Com Committee
TRAINING	Develop, Test, Distribute, Train -Training guidelines for all levels -Role-plays for all -Reinforcement materials for all training -Booklets and posters for handpump maintenance -Reporting formats for community and health workers - Storage and request forms for spare parts Conduct training sessions Monitor	X	X	X	X	X	X	X	X					Com. Committee Central, regional, district training institutions in all sectors. Community grps Com. Committee

D. One Last Word: From Plan to ACTION: Making it Work

You have drawn up an implementation plan and schedule, showing each communication activity on a time line. Materials, broadcast spots and training modules have been finalised and produced, incorporating pre-testing results in the final design, although these steps are rarely completed at the same time (or on time!). However, all components of the communication programme must be ready for use when the programme moves into the fourth and final step of the methodology, ACTION. Because programmes almost never go exactly according to plan, you will often need to return to the design phase to make mid-course corrections.

The ACTION phase has the following components:

- Carry out training and capacity-building
- Carry out communication activities
- Carry out supportive supervision
- Monitor communication activities and behaviour change
- Make mid-course corrections and reinforce participation
- Evaluate communication programme during follow-up period
- Keep within the budget

D.1. Carry Out Training and Capacity-Building

Implementing the communication programme involves many participants and partners. They must have a well-defined role plus adequate skills and resources to fulfil their part in the programme. Your assessment must have shown where skill deficits lie and where service delivery (whether in health, social services, communication, etc.) is weak. Analysis should also have shown which groups would therefore benefit from training and capacity building. Keep in mind that other groups will need orientation to the communication materials and messages used in the activities they are implementing.

Short-term training and orientation are used when participants and partners learn how to implement their part of the communication programme. Categories of those who should receive orientation and short term training are:

Partners—to learn their role and responsibilities in implementing communication activities; resource and information sharing;

Trainers—to learn participatory training methods; to master new content area; to train supportive supervision;

Supervisors—to learn supportive supervision strategies and techniques, and use of supervisory tools;

Front line staff—to learn use of new materials, messages and methods

For example, in short-term training or orientation, health workers would learn new clinic procedures to analyse the cases of diarrhoea or dysentery; supervisors would practice using new checklists to evaluate staff performance; volunteers would learn when, where and how to report their communication activities (going door-to-door); district directors would learn how to collect and compile monitoring data; and radio personnel would learn the schedule of broadcasts and how they support communication objectives.

Long-term training and capacity-building are used when assessment shows skills deficits that would impede the behaviour change process, and service delivery weaknesses that would make impossible to respond adequately to increased demand or to maintain behaviours over the long term. Designing this type of training programme is an important part of communication but is beyond the scope of this Manual. Here, in the action phase of the communication programme, all training will be carried out before other communication activities begin. Examples of capacity-building and long-term training are:

- Partners — adding new activities to their repertoire; making administrative and personnel changes; utilizing new resources;
- Service delivery — acquiring and utilising new equipment or products; expanding or improving centres; changing some aspect of service delivery;
- Supervisors — adding funding and time for supervision; developing supervisory programme; learning supportive supervision skills and monitoring;
- Front line staff — learning interpersonal communication skills and messages; improving technical skills; using new equipment or products; self-monitoring.

D.2. Carry Out Communication Activities

In carrying out the communication activities found in the implementation plan, the programme officer should:

Distribute print materials, cassettes, films and other communication materials to designated locations.

Orient partners who will implement communication activities. For example, make sure radio personnel have received correct cassettes, know which spots to air and when, and how to fill out the monitoring form.

Distribute advocacy materials to leaders; conduct advocacy activities.

Assure adequate press coverage if appropriate.

Assure message delivery and other communication activities occur as scheduled (phasing).

Collect and compile monitoring data.

Assure supportive supervision for interpersonal communication activities.

D.3. Carry Out Supportive Supervision

When programmes rely on interpersonal communication to teach, promote and reinforce complex behaviours, supportive supervision becomes a crucial element in maintaining quality communication. Whether communicators are trained health workers, matrons in the community or educated religious leaders, they all need some degree of reinforcement of and feedback on their communication efforts.

For example, a communication programme during a flood, when cholera may be a threat, might rely both on:

- mass media to announce preventive and corrective measures, and
- health workers to communicate effectively with mothers (delivering messages on ORT and making ORS),

all the while handling an increased caseload.

In order to keep these health workers' performance at levels achieved in their communication training, supportive supervision would become a critical component of the communication programme. Here, it is important to see that supervision is being carried out as planned and that supervisors are getting adequate support for their efforts.

D.4. Monitor Communication Activities and Behaviour Change, Make Mid-Course Corrections and Reinforce Participation

The following are main steps to follow when carrying out the monitoring component of the implementation plan:

Distribute monitoring forms/checklists to appropriate participants

Train participants in use of monitoring forms and checklists:

Indicate where and when to send forms to next level.

Monitor both communication activities (airing of radio spots; use of flip charts; distribution of fliers; mobile units making stops; training sessions completed) and behaviour change (mothers mixing ORS packets correctly; pharmacists selling condoms; demand for infant formula; enrolment figures for girls in third grade;).

Collect monitoring forms and checklists; compile data, graph them when appropriate.

Organize and conduct feedback sessions at several levels (at ministry, district and local levels) to share data from monitoring. Use these sessions to reinforce positive participation and to gather suggestions for programme improvements. These can be formal meetings and workshops at the ministerial or district level, or informal sessions with individual supervisors and staff.

Organize and conduct planning sessions (as necessary) to make mid-course corrections to the communication programme.
Disseminate monitoring results as appropriate.

Earlier, we spoke about making clear the assumptions we used for media and channel selection. As you monitor, you may discover that in actual practice, some of your assumptions are wrong; participants are not responding as planned because of factors that were not identified during the formative research stage.

In the example we used earlier, you will recall that we planned to advocate with political and religious leaders using individual meetings and small group discussions. The results of the focus group work suggested this. However, suppose that during the monitoring process you discover that, in reality, political leaders are not as altruistic as the selected focus group political leaders appeared to be? In real life they ask you: if safe water supply and environmental sanitation programmes are so important:

- 1) why have you not given them a chance to go to neighbouring countries to see what is going on there?
- 2) how has supporting such programmes furthered the political careers of the leaders in those countries — the leaders who have advocated these programmes?
- 3) how will supporting such programmes further their own political careers?
- 4) what if their constituents do not respond favourably to implementing their programmes?
- 5) what if a political rival mocks her/him for wanting to impose a “foreign idea” on local customs and practices?
- 6) why have they not been given fora at major public gatherings so they can be seen to bring “progress” and “development” to their people?

Thus, these people are personalising the programme in ways that were not apparent during the baseline research. They are looking at safe water supply and environmental sanitation programmes as ways to further their own ambitions. Thus, you must now change your assumptions and adjust your strategies accordingly.

D.5. Evaluate Communication Programme During Follow-up Period

In the preceding steps of the communication methodology, indicators for evaluation were selected, baseline measures taken, and an evaluation plan developed. Often, impact evaluation of a communication programme is undertaken by outside research specialists, so that the programme officer and the inter-sectoral committee are only responsible for selecting and giving input to the evaluators and/or assuring the logistics of their evaluation. To foster a more participatory process, below are general steps to follow when carrying out evaluation:

Involve evaluators and representatives of participant groups in communication programme design and selection of programme and behavioural indicators;

Review evaluation plan (programme officer and Communication Committee) and decide when impact evaluation will be conducted;
 Design, pre-test and produce evaluation instruments;
 Train data collectors;
 Resolve informed consent issues;
 Assure logistics and budget for all steps of evaluation (design, data collection, data analysis, report writing, and presentation of findings) are there;
 Organize and carry out presentation of findings;
 Disseminate findings as appropriate;
 Apply “lessons learned” to design and implementation of future communication programmes.

D.6. Keep Within the Budget

Below are categories of major costs for a communication programme. Based on previous experience in the particular country and best estimates for new activities or new suppliers, the programme officer and the inter-sectoral committee should have clear financial guidelines to follow. Actual costs should be closely monitored during planning and action, so that the communication programme stays within its budget.

<u>Activities</u>	<u>Costs To Be Estimated</u>
Communication research and planning	- Salaries/consultant fees - Training for data collection - Travel allowances for field work - Transportation - Supplies - Data processing and analysis - Report writing - Meetings for planning
Monitoring and evaluation	- Development of monitoring forms/checklists - Orientation of monitors - Distribution and collection of monitoring forms/checklists - Compilation of data; organisation of feedback session(s) - Evaluator's fee/salaries
Training/capacity-building	- Curriculum development - Consultants' and trainers' fees - Transportation - Per diem/accommodation for participants - Training materials - Equipment - Rental, hiring of training site

- | | | |
|-----------------------------------|---|--------------------------------------|
| Production of print materials | - | Graphic design |
| | - | Copywriting |
| | - | Editing |
| | - | Typesetting |
| | - | Colour separation |
| | - | Pre-testing |
| | - | Distribution costs |
| Production of broadcast materials | - | Producers' and technicians' salaries |
| | - | Copywriting fees |
| | - | Artist fees |
| | - | Studio/equipment rental |
| | - | Air time |
| Special events | - | Stickers, T-shirts, prizes, balloons |
| | - | Press conferences |
| | - | Hire of public address systems |
| | - | Transport |

IV. APPENDICES

APPENDIX 1

SAMPLE TERMS OF REFERENCE²³: INTER-SECTORAL COMMITTEES OR WORKING GROUPS

The role of the National, Regional, District and Ward Inter-sectoral Committee (Working Group) is to plan, coordinate and ensure successful implementation and management of communication activities for programmes of safe water supply and environmental sanitation. The tasks are to:

- Develop national, regional, district and even community-level communication plans for establishing, monitoring and reinforcing recommended behaviours;
- Participate in identifying issues and problems relating to communication activities;
- Participate in planning and management of communication research activities in collaboration with water and environmental sanitation staff and other resource persons; use research findings to develop strategies and plans for addressing identified issues in the water and environmental sanitation programme;
- Oversee implementation of communication for community participation and management activities, and for motivational activities; inputs such as training, small, traditional and mass media; use of community networks for information, motivation and monitoring purposes;
- Plan and supervise implementation of major communication initiatives, such as national communication activities;
- Mobilise resources for communication programmes internationally, nationally and within local communities;
- Facilitate formation of national and lower level committees and other structures to support the safe water supply and environmental sanitation communication programme;
- Develop and implement training and other capacity-building activities that will strengthen communication related to safe water supply and environmental sanitation at all levels;

²³ Based on the *Communication Handbook for Polio Eradication and Routine EPI*, Working Draft – Version 1, UNICEF and WHO, Release Date February 1998. This is to be used only for guidance in drafting your own working group or communication team or committee's TOR

- Supervise and coordinate safe water supply and environmental sanitation communication activities throughout the country;
- Facilitate monitoring, evaluation and utilization of data collected to improve planning of safe water supply and environmental sanitation communication activities at all levels;
- Ensure that the safe water supply and environmental sanitation communication programme is managed efficiently and effectively.

Membership

The national inter-sectoral committee should be multidisciplinary in nature, with broad membership, to enable mobilisation of community support and resources from a wide base. The committee should include representatives of lower levels.

Lower levels

Lower-level communication committees – regional, district(s), wards (which may be community-level, depending on the local structures) should draw members from similar organisations operating at their level.

When there are multiple levels, it is suggested that the national group takes care of capacity-building, research and coordinated planning, supervision, monitoring and evaluation. Regional and district groups should develop communication plans relevant to their immediate catchment areas. Some functions will be similar to those of the national level committees, with the difference that they are operating at a lower level and supporting safe water supply and environmental sanitation activities at a lower level.

APPENDIX 2

MINING FOR BEHAVIOURAL GOLD. CASE STUDY EXAMPLES OF INTERVENTIONS IN ENVIRONMENTAL SANITATION AND HYGIENE ²⁴

The following is not an attempt to further abstract what is already abstracted and published by UNICEF. What we are highlighting in the following pages are some examples of interesting interventions from the perception of the authors of this Manual (and therefore may have overlooked many other interesting and important experiences). Please order the original documents for a complete review.

Better still, you should try to get in touch with the programme people responsible and ask their advice, request their materials, their plans, etc. As always, the richness of a programme officer's experience is your most valuable resource.

We just would like to call your attention to some brief examples. The original reports themselves are refreshingly honest and descriptive of what "worked" and what "didn't work" in the social context of the interventions. (How many reports are honest about something "not working"?)

We will NOT use the words "successful" or "unsuccessful" because we know those words have only limited meaning for us working in behavioural development initiatives where the dynamics of social change are in constant flux and we must continually modify our activities to meet the changing dynamics.

The positive benefits of a "non-success" may eventually far outweigh the immediate context of an intervention if we can learn from the "non-success" and adjust, adapt and apply elements that will help us realise our objectives within the contexts we are working in.

Enough of that. Let us look at the summary.

²⁴ Workshop on Environmental Sanitation and Hygiene, New York, 10 – 13 June 1998. UNICEF.

The Gold Mine

Interesting Elements	Intervention, Social Setting, Country
<ol style="list-style-type: none"> 1. Integrated, multisectoral, multichannel and media elements: “Infomercials”, 2. Interpersonal communication by and for children as well as for health workers, religious leaders, NGOs; 3. Advocacy aimed at lowest level of local government; 4. Sani-mart for skill-building of local masons and to be used as delivery point as a communication medium. 	<p>Bangladesh National communication strategy for sanitation, hygiene and safe water use.</p>
<ol style="list-style-type: none"> 1. Advocacy to senior urban administrators; 2. Integrated, multisectoral service delivery; 3. Community participation for self-study of garbage problem, self-generated solutions, organizing garbage pick-ups, etc.; 4. To reduce children working and playing in garbage dumps. 	<p>Brazil Garbage and Citizenship: an administrative urban environment experience with a focus on social issues.</p>
<ol style="list-style-type: none"> 1. Behavioural objectives limited to two: hand washing with soap, disposal of children’s stools in potties and latrines; 2. Installation of community committees; 3. Hygiene messages in health centres, radio and local street theatres; neighbourhood hygiene commissions (female volunteers with visual reminder sheets); discussion in health centres and neighbourhoods (using a poster series); primary schools; 4. Emphasis on formative research to develop all information for use in channels. 	<p>Burkina Faso (Bobo Dioulasso)</p>
<ol style="list-style-type: none"> 1. Push-pull strategy: push = advocacy with senior officials, establishing regulations, research and development of affordable technology; promotion of inter-sectoral linkages; 2. pull = social marketing and social mobilisation, using primary schools as entry points for community participation; 3. Problem identification at community levels using participatory techniques. 	<p>China “3 in 1 Package”</p>
<ol style="list-style-type: none"> 1. Education and technical training in health and sanitation helped communities; 2. Horizontal linking (inter-sectoral) of different initiatives within settlements; 3. Vital community participation including an innovative network of health promoters selected by their communities; new models of community-based day-care centres; 4. Community participation MUST be integrated with other institutions. 	<p>Guatemala Urban Environmental Sanitation Project.</p>
<ol style="list-style-type: none"> 1. Closely linked with religious and cultural values of communities to promote hygiene practices; 2. Although all segments of communities (including families and gov’t. agencies) must be actively involved, there is an emphasis on religious leaders; 3. Female cadres trained to deliver hygiene messages; 4. Necessary to have support of religious establishment at every step. 	<p>Indonesia <i>Gerakan Jumaat Bersih</i> (Clean Friday Movement) in West Lombok</p>
<ol style="list-style-type: none"> 1. Integrated three projects: rural water supply, hygiene education and sanitation, and support to eradication of dracunculiasis; 2. Reinforced community participation; strengthened positive contribution of animation activities; introduced hygiene education in school curriculum. 	<p>Mali</p>
<ol style="list-style-type: none"> 1. Integrated WES programme into basic education; 2. Significant environment improvement in schools; girls have privacy; schools are models for households to install and use latrines; 3. Community involvement in latrine programmes based on favourable reception and use in schools. 	<p>Nigeria WES in school</p>

Interesting Elements	Intervention, Social Setting, Country
<ol style="list-style-type: none"> 1. Baseline studies of latrine use, beliefs and hygiene practices; 2. Strong inter-sectoral institutional linkages established; 3. Community empowerment and women's involvement crucial; 4. Need for initial subsidy for the very poor (rights-based programming); 5. SANPLAT now a household name. 	<p>Nigeria Sanitation promotion using SANPLAT – low cost appropriate latrine technology.</p>
<ol style="list-style-type: none"> 1. Interaction (stressing advocacy) with government and communities on key interventions; 2. Development of action plans with all levels of implementors; 3. Establish core groups to provide leadership; 4. Technical support and administrative coordination; 5. Establish cost-sharing; 6. Community implementation. 	<p>Nigeria Urban sanitation and waste management in Ibadan.</p>
<ol style="list-style-type: none"> 1. Define “sanitation” holistically to link nutrition, education and health, counselling workers in promoting sanitation and hygiene behaviour analysis within the context of community level IMCI and ECCD initiatives; 2. Mapping priority behaviour areas (latrines, home births, home care for children 0 –3; care of Cholera and HIV/AIDS patients); 3. Participatory community planning; 4. Build capacity for community analysis; 5. Assess traditional health behaviour; perception mapping to visualise and analyse individually perceived causal relationships; 6. Marketing of SANPLAT shape of the drophole and footplates resembles a hare, therefore the identifier. 	<p>Tanzania Hare and Tortoise: Sanitation and Hygiene Promotion.</p>
<ol style="list-style-type: none"> 1. Dual nature of intervention: <ol style="list-style-type: none"> A) Top down in that advocacy was carried out throughout the country at all political and bureaucratic levels to build support and define what the problems were; B) Simultaneously, social marketing techniques were used to define community problems, develop plans and define objectives for behaviour change; 2. Strong commitment at all levels was instrumental. 	<p>Uganda Sanitation Promotion.</p>
<ol style="list-style-type: none"> 1. Commitment and involvement of local People's Committee was key; social mobilisation and project communication conducted by mass organisations (i.e., women and youth organisations) are effective; 2. Without people's participation in planning, communication and financing, the project could not expand and its facilities would not be used. 	<p>Viet Nam Intensive Sanitation Project.</p>
<ol style="list-style-type: none"> 1. Strategy was developed through workshops to build consensus on a sanitation definition, identify issues, analyse the situation, draft the strategy and develop multi-year plan; 2. At village level, organisers trained in participation have started to create a demand for WASHE. 	<p>Zambia WASHE (Water, Sanitation and Hygiene Education Programme).</p>
<ol style="list-style-type: none"> 1. Represents a shift from didactic technical model to a participatory social model; 2. All health workers should use participatory methods in their training sessions with community groups; 3. Assurance of quality training; 4. Better indicators needed; 5. Project needs to start small and grow. 	<p>Zimbabwe Participatory Hygiene Education and Sanitation.</p>

BEYOND GOLD

We had mentioned earlier that the history of water and environmental sanitation programming is ground-breaking in many aspects of communication for behaviour development and change. We have provided a few of these aspects in the text but could not accommodate as many as we would have liked to call to your attention. Hopefully, the following boxes will also be of interest.

Box 5 - Animation Mobilises Community to Mobilise Itself ²⁵

In the 1980s a water well, bucket and drawing rope were provided to a local community in the Mayamba District of Sierra Leone. When the bucket broke and the rope snapped, the community went back to drinking water from the streams, ponds and swamps. Comprised of small rural agricultural populations with traditional rulers (chiefs) and top-down instructions, the populations were not participating in development activities. They were fatalistic, uncritical of their situations and unconfident of their own skills.

In 1992, community animation was introduced by the UNICEF country office in Freetown to change community attitudes and involve residents in diagnosing and developing strategies to solve their own problems.

Self-reliance and sustainability require awareness of local realities. Animators, identified and trained, conducted house-to-house “listening surveys” followed by meetings and dialogues with families to help them identify problems they would like to change. This set in motion a process of investigation, reflection and analysis to stimulate the community to explore those realities that could be changed and initiatives they could undertake. In several villages, communities have now established committees to run and maintain water wells; another has dug and is properly using and maintaining two wells; in a third, the community recognized the problem of post-harvest losses and constructed two drying floors without outside assistance.

Communities have continued to mobilise resources. Community farms have been initiated in two villages. Part of the harvest was sold to purchase materials; the community consumed part and the rest was stored for the next season.

Effectiveness and sustainability of the programme hinged directly on the animators’ own attitudes and knowledge of the communities. On the one hand, familiarity encourages trust; on the other, in some cases it reinforced a tendency to perpetuate top-down responses and the rush to identify problems and traditional solutions. In some cases, the animators allowed the communities to depend on them, defeating the purpose of self-reliance.

²⁵ *Social Mobilisation through Animation for Participatory Development in Sierra Leone: A report prepared by E. Braima Joseph, UNICEF Freetown. Reported in A Child’s Right to Sustainable Development. UNICEF, New York 1997.*

BEYOND GOLD

Box 6 - Community, NGO and Local Authority Take Control of a Sanitation Project ²⁶

In 1985 the government of India launched a rural sanitation programme. Despite major support and subsidized latrines, this programme did not really take off. A Knowledge, Attitude and Practice (KAP) survey conducted jointly by UNICEF and the Government of India clearly showed that nearly 85 per cent of the free toilets were not being used. With the active support of the state government, UNICEF initiated a project based on social mobilisation in Midnapore District, in West Bengal. The District President assumed leadership of the project and, with the help of the NGO, Ramakrishna Mission Rural Development Unit, organised youth clubs in every village to promote hygiene education, and used employed youth to increase adult education and immunisation camps. With UNICEF support to provide soft loans for toilets, the poorest of the poor built the latrines themselves; hardware and training for construction was supplied by the youth clubs.

Without subsidies the programme grew and expanded to another six districts in West Bengal. The unique components of the Midnapore Sanitation Programme are decentralization, community participation, NGO involvement, and cooperation between the different governments and people's movements. The communication component was handled entirely by the NGO and the people themselves, with little external support required. The whole programme was based on local culture and customs. The total population covered in a period of around five years was approximately 10 million people.

Box 7 - Sanitation and Micro-credit in north western China ²⁷

It is snowing in the small village of Yongjing Province, northwestern China, where a multisectoral health team runs a mini-workshop, group meeting about sanitation. A group of housewives who are members of a local micro-credit project have come voluntarily to this meeting held in a village health centre, heated by a single wooden stove.

The women are divided into small groups. Each group is given a set of cards containing rather roughly sketched pictures of potential sanitation problems. The groups are asked to choose which situations apply to this village. If there are other situations, the women are asked to sketch them. The women complete the task and then share them with each other. A group of potentially problematic situations is agreed upon.

They are given another set of pictures, which show the health problems resulting from each sanitation problem, and are asked to match the problem to the resulting health problem. They do this and share the results. The health worker on the team further explains the reasons for this relationship.

They are then given a set of cards depicting interventions that would break the cycle of infection. They are asked to place these cards between the relevant sanitation problems and resulting health situations. When this is completed, the health worker explains interventions and invites discussions.

The women are then asked which interventions they feel they could establish in their community. The costs are discussed, together with the supply, labour and maintenance implications. They agree to ask the village committee to implement several interventions, which the micro-credit society will underwrite.

²⁶ *Integrated Sanitation Project Midnapore*, UNICEF, India Country Office, Water and Sanitation Section and Gourisankar Ghosh. UNICEF, New York. Reported in *A Child's Right to Sustainable Development*. UNICEF, New York 1997.

²⁷ Barrie, Lisa; Scandlen, Guy B. Field Visit to Yongjing County, Gansu Province, to review communications activities implemented by UNICEF-assisted projects, 19 - 24 February 1998, UNICEF Beijing.

BEYOND GOLD

Box 8 - Pre-testing Sanitation Drawings in India ²⁸

Indi Rana was the communication consultant to the UNICEF/DANIDA Orissa Drinking Water project in India. He insisted on pre-testing drawings with the local community despite objections about time and money. The results humbled him.

He found that drawings based on an understanding of perspective confused rural people. When the participants drew pictures, they drew images that had multiple perspectives (i.e., more than one viewpoint) and that contained a story within a single frame. Every ancient culture develops art in this manner. Egyptian hieroglyphics portray stories within one picture, as do the Bayeux tapestries.

He found that a poster showing women going to the field to defecate, while a man used a latrine, would not be effective because the woman (in the foreground) was bigger than the man and must therefore be behaving more correctly. A picture of a woman feeding her small child with a spoon was understood as a woman feeding her husband. Here, the size of the figure was disregarded.

Rana concluded that visual material should imitate the art of the villagers and that village women could themselves help to illustrate pictures.

Box 9 - Caravan for Life: Ecuador ²⁹

In Ecuador, community theatre people worked with staff in the UNICEF office in Quito to devise a show containing health messages for people in the poorest areas of the country. A sort of travelling circus without a tent was put together to move through the poorer areas of several provinces, bringing entertainment and education under the slogan “artists working for life.” Artists included singers, actors, mimes, clowns, sculptors, puppeteers, magicians and jugglers. They became known as the caravan of joy, caravan of hope, or caravan of health.

The major themes were vaccination, acute respiratory infection, diarrhoeal diseases, education, breastfeeding and children’s rights. Special shows on cholera, sanitation and other issues were prepared.

In all, approximately 2,000 shows seen by a million people were presented during a five-year period. Currently, there are six caravans funded by local artists in five provinces of the country. The simple language of the entertainers has paid off. There was a significant increase in knowledge about immunization and oral rehydration therapy for children with diarrhoea.

²⁸ *Facts for Life: Lessons from Experience*. p. 111, UNICEF, New York 1996.

²⁹ *Ibid.*, p. 116.

BEYOND GOLD

Box 10 - Folk Poets in Bangladesh ³⁰

In the early 1990s, UNICEF Bangladesh began to work with “traditional roving poets”, recognizing that the poets were reaching families that programmes were failing to reach in remote rural areas. These poets represented an existing and effective communication channel.

Poets write stories and copy them. Hawkers take them to cities and towns on market day and read them aloud where rural people gather, for example, at the railway station. Perhaps 150 people may listen to each reading and, out of these, 20 or 30 buy a copy to take home. That night after dinner, a homestead of 50 to 100 people listen to the poem being read aloud.

Since the stories are meant to entertain and not instruct, at first this did not appear as a promising channel for *Facts for Life* hygiene messages. The poets were persuaded to attend a workshop where they were asked if they would add a four-to-eight line message at the end of each poem.

The poems succeeded in reaching large numbers of people because of their long tradition, because they were entertaining, and because they were inexpensive. The poets said that if their poems were printed on better paper, people would think the poems were difficult to read.

During the life of the project, *Facts for Life* reached a new audience of tens of thousands of people while the circulation of the poems and the prestige of the poets increased.

Box 11 - Bombay Children Teach Their Neighbours ³¹

In Malvani, a Bombay suburb, a Child-to-Child programme was set up in 1986 to train 175 children as health educators. Each was asked to “adopt” five families and pass on knowledge and skills.

Based on a survey, project staff devised a list of topics and activities to help children understand and apply information. Children carried out health checks on each other, conducted community health surveys and encouraged neighbours to attend health centres.

The credibility of the children grew and adults began referring to them as “mini-doctors.” An evaluation showed:

- a) Children retained knowledge, particularly when a disease was prevalent in a community;
- b) Parents could remember few details, but became well-versed in treatment and prevention;
- c) "Adopted" neighbours remembered little, but were more likely to use health centres;
- d) Children were more alert, curious, expressive and communicative, as well as cleaner and more concerned about personal hygiene.

There were drawbacks. Children were worried about missing “real” lessons, and parents were reluctant to allow children to stay after school. Classes are now part of the curriculum and taught by teachers rather than health workers. The programme is being introduced into Bombay’s municipal schools.

³⁰ Ibid.

³¹ Ibid, p. 72

APPENDIX 3

AIDS FOR MESSAGE DEVELOPMENT³²

³² For more in-depth information on aids for message development, please refer to the UNICEF *Communication for Development Guidelines*, quoted.

QUALITIES OF EFFECTIVE COMMUNICATION MATERIALS

1. Establish a personality. Effective communication messages give the material a vivid, appealing personality that helps them stand out from the crowd. Like a friendly face, they signal genuine values in likeable ways. Building a personality takes consistency and time. Your messages, packaging, promotion (print materials and others), and product design must all speak with the same voice. But once created, this personality can be the most valuable and enduring asset of a product or intervention.

2. Position the material. Effective communication must make clear how the material fits into the participant group's life. Positioning picks the area in which the product is most likely to succeed.

3. Feature the most compelling benefit. Effective communication materials address real needs. They speak as competitively as the facts and good taste allow. They may use imagery, but technique should never compete with the main message and the benefit.

4. Break the pattern. Effective communication materials excite the ear and the eye with a look and sound of their own. They separate themselves from surrounding communication, just as they separate the product from competing products.

5. Generate trust. Members of a group will not try out a behaviour they hear about from someone they do not trust. Credibility should never be replaced by creativity. Trust is not necessarily a product of innovation. Trust is generated by tone, presentation, serious images, credibility, and a solid foundation.

6. Appeal to both the heart and the head. No decision to try something new is made entirely in the mind. Effective communication materials and messages, therefore, must do more than present practical reasons to try a behaviour. They must invest the message with real emotional value consistent with the product's personality.

7. Materials respond to communication strategy. Often, materials lose the very reason why they were created: to be translators of the communication strategy. Be sure to check that whatever is produced is in fact an accurate response to the purpose of the communication. Does it maintain focus? Is it directed to your participant group? Does it deal with the defined health problem? Is it addressing the feasible behaviours?

HOW THE PUBLIC PERCEIVES HEALTH MESSAGES

Thinking about how the public perceives health messages before message development can help assure that the public will hear and heed the information you want to convey. Factors affecting public acceptance of health messages include the following:

Health risk is an intangible concept. Many people do not understand the concept of relative risk, and so personal decisions may be based on faulty reasoning.

The public responds to easy solutions. The ability to act to reduce or eliminate an identified risk not only can lessen actual risk but can abate the fear, denial, or mistrust that may result from new health information.

People want absolute answers. Some people do not understand probabilities. They want concrete information on which they can base decisions. Therefore, you must carefully and clearly present your information to both the public and the media.

The public may react unfavourably to fear. Frightening information, which sometimes cannot be avoided, may result in personal denial, disproportionate levels of hysteria, anxiety, and feelings of helplessness.

The public relies on the verity of science. The public believes in scientists for reliable information. Thus, it may tend to believe a scientist's endorsement of health products.

The public has other priorities. New health information may not be integrated as one of an individual's priorities. For many people, intangible health information cannot compete with more tangible daily problems.

Individuals do not feel personally susceptible. The public has a strong tendency to underestimate personal risk. This is particularly true for young people.

The public holds contradictory beliefs. Even though an individual may believe that "it can't happen to me," he or she can still believe that "everything causes cancer," and, therefore, there is no way to avoid cancer "when your time comes," and no need to alter personal behaviour.

The public lacks a future orientation. The public, especially lower socio-economic groups, has trouble relating to a future concept, and many health risk messages foretell of outcomes in their future.

The public needs to personalise new information. New risk information is frequently described according to its effect on society. The individual needs to translate that information into personal risk to understand it.

The public does not understand science dynamics or technical terms. Technical and medical terminology is poorly understood by the public. Therefore, individuals lack the

basic tools required to understand and interpret health information that depends on data to be fully comprehensible.

GUIDELINES FOR DESIGNING RADIO SPOTS

BASIC GUIDELINES:

If you have to design radio spots or judge the quality of the drafts presented to you, the following guidelines will be useful:

1. **Present one idea.** Each radio spot should have one main message, which should be repeated several times within the material.
2. **Use a credible source.** Feature a source of information that is suggested by the participant group as appropriate.
3. **Break the mold.** Try innovative ideas and formats.
4. **Touch the heart as well as the mind of the listener.** Make the listener *feel* something after hearing the spot or programme — happy, confident that they can do something — but make them *feel*.
5. **Stretch the listener's imagination.** The voices, music and sound effects can and should evoke pictures and create images in the listener's mind.
6. **Write for the ear.** Radio should have the same natural, spontaneous sound as conversation.
7. **Write to the individual.** Imagine the face of a person within your participant group and write for that person.
8. **Ask listeners to take action.** Be explicit about what the listeners can do to resolve their problem.
9. **Provide consistency.** Develop a similarity of sound in all of your radio materials, providing continuity to the radio materials.

EXAMPLE OF A RADIO CREATIVE BRIEF

Medium Radio

Format Five 30-second spots

Message Make Measles History - tactical/informational

Participant Group Parents

Communication Objective Create doubt to combat complacency

Obstacles

- . Think children have had measles; why they need a shot
- . Do not believe measles is a problem

Support Points

- . Measles still exist; last year there were more than 4,000 cases
- . Measles biggest killer
- . Many diseases look like measles; cannot be sure your child has had it
- . Never need another measles shot

Tone Authoritative, dramatic, convincing

Creative Considerations Portray voice of health specialist; mention Ministry of Health; must use the phrase "*Make Measles History*" at least once in every spot.

NINETEEN PRINCIPLES FOR DESIGNING PRINT MATERIALS

Note: The principles marked with an (*) are particularly important when producing print material for pre-literate rural groups.

Design/Layout

- 1*. Present only one message per illustration.
2. Limit the number of concepts and pages on materials.
- 3*. Make the materials interactive whenever possible.
4. Leave plenty of white space.
- 5*. Arrange messages in the sequence that is most logical to the group.
6. Use illustrations to help explain the text.

Illustrations

- 7*. Use appropriate styles: (1) photographs without unnecessary detail, (2) complete drawings of figures when possible, and (3) line drawings.
8. Use simple illustrations.
9. Use familiar images that represent objects and situations to which the participant group can relate.
10. Use realistic illustrations.
11. Illustrate objects in scale and in context whenever possible.
12. If symbols are used, pretest them with members of your participant group.
13. Use appropriate colours.

Text

14. Use a positive approach. Negative approaches are very limited in impact, tend to turn off the participant group, and will not sustain an impact over time.
15. Use the same language and vocabulary as your participant group, as found in formative research. Limit the number of languages in the same material.
16. Repeat the basic message at least twice in each page of messages.
17. Select a type style and size that are easy to read. Italic and sans serif typefaces are more difficult to read. Use a 14-point font for text, 18-point for subtitles, and 24-point for titles.
18. Use upper and lower case letters.

Supervision

19. Without careful supervision, it is very easy to receive materials with wrong colours, incorrect alignment, or careless print jobs. It is best to have an experienced member of your team providing close supervision.

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