C-Modules

UNDERSTANDING THE SITUATION

MODULE

01 2345

A LEARNING PACKAGE FOR SOCIAL AND BEHAVIOR CHANGE COMMUNICATION

PRACTITIONER'S HANDBOOK

USAID
FROM THE AMERICAN PEOPLE

C-CHANGE
COMMUNICATION FOR CHANGE

C-Modules: A Learning Package for Social and Behavior Change Communication (SBCC)

Communication for Change (C-Change) Project
Version 3

May 2012

This publication is made possible by the generous support of the American people through the United States Agency for International Development (USAID) under the terms of Agreement No. GPO-A-00-07-00004-00. The contents are the responsibility of the C-Change project, managed by FHI 360, and do not necessarily reflect the views of USAID or the United States Government.

C-Change is implemented by FHI 360 and its partners: CARE; Internews; Ohio University; IDEO; Center for Media Studies, India; New Concept, India; Soul City, South Africa; Social Surveys, South Africa; and Straight Talk, Uganda.

Contact information:
C-Change
FHI 360
1825 Connecticut Ave., NW, Ste. 800
Washington, D.C., 20009
USA
tel: +1.202.884.8000; fax: +1.202.464.3799
Email: cchangeCS@fhi360.org
Website: www.c-changeproject.org

Overview

The *C-Modules* are designed for the use of research and implementing staff with previous experience in communication theory and programs. Module 1 covers Step 1 of C-Planning—*Understanding the Situation*—and builds on the information and guidance provided in the introductory module, Module 0. This module illustrates how a full analysis of the situation can help build a program around evidence, instead of assumptions and explains how behavior change communication, social mobilization, and/or advocacy can bring about a positive change.

Sessions

A Note on Formatting

In the *C-Modules,* the names of theories and models are in **bolded, dark blue text;** concepts are in *dark blue italics.*

Module 1, Session 1: What is Meant by "Understanding the Situation"?

Understanding the situation is the first step of a systematic SBCC effort in C-Planning. This is essential preparation for program design, since it provides:

- insight into the issue the program is trying to address from many perspectives
- guidance for decisions to be made in Step 2 and for focusing energies and resources

Once the situation is fully understood, it is possible to decide how to:

- focus a program effectively on different groups of people—those affected and those influencing the situation
- address the problem identified and its context through complementary SBCC strategies—advocacy, social mobilization, and/or behavior change communication
- work with partners, allies, and/or gatekeepers

Below is an example of how insights gathered during Step 1 can influence SBCC program design.

> Practitioners may initially assume that high rates of HIV among sex workers should be addressed through condom promotion geared toward the sex workers. However, an analysis may reveal that most sex workers are already using condoms, and that security and police are raping sex workers at night, without using condoms because sex work is illegal. This insight and others might lead practitioners to use *advocacy* to address policy issues. On the other hand, the analysis might reveal that clients of sex workers try to get around using condoms by paying more for unprotected sex. Such findings might lead practitioners to address condom use among male clients and to launch a *policy effort* urging brothel owners to have a condom rule in their establishments.

Completing four tasks will help to understand the situation, before focusing or designing an SBCC program.

1. Organize and summarize what is already known about the situation.
2. Check assumptions by looking at existing research.
3. Review relevant SBCC theories for concepts that can inform and/or guide research.
4. Identify gaps and plan and conduct formative research, if needed.

GRAPHIC: The First Step of a Planning Process for SBCC—Understanding the Situation

SOURCE: Adapted from: Health Communication Partnership, CCP at JHU (2003) the P-Process; McKee et al (2000) the ACADA Model; Parker, Dalrymple, and Durden (1998) the Integrated Strategy Wheel; Roberts et al (1995) the Tool Box for Building Health Communication Capacity; and National Cancer Institute (1989) Health Communication Program Cycle.

SOUTH AFRICA EXAMPLE: Using a Situation Analysis to Determine SBCC Strategies

Please refer to the example in the Introduction (Module 0, session 4, page 21), "Combining Advocacy, Social Mobilization, and Behavior Change Communication," for an overview of the work of the Treatment Action Campaign (TAC) in South Africa.

At the time when access to AIDS treatment in South Africa became a serious problem, TAC recognized the absence of a national HIV and AIDS treatment *policy*, as well as low levels of *awareness* and *readiness for change* among decision-makers. TAC advocated for necessary services that were unavailable, such as treatment for people living with HIV (PLHIV), including prisoners. It was clear that the problem was not simply at the individual behavior level (i.e., individuals choosing not to access treatment), but more of a policy and service-related issue—one requiring a strong advocacy and social mobilization approach.

Theory Corner: Social Movement Theories and Agenda Setting

The TAC example is a good illustration of how an organization can use *agenda-setting* concepts though *policy and media advocacy,* along with tactics from **social movement theories**. *Agenda setting* includes setting the media agenda (what is covered), the public agenda (what people think about), and the policy agenda (regulatory or legislative actions on issues). TAC continues to issue press releases, send messages via social media such as Facebook and Twitter, and put public pressure on legislators and policymakers to recognize and prioritize the issue of access to treatment for PLHIV.

TAC employs mobilization tactics called WUNC displays—concerted public representations of:

- **w**orthiness (of the attention to the issue)
- **u**nity (of the movement members in their concern)
- **n**umbers (of the people concerned)
- **c**ommitments (to change the issue)

WUNC displays are common in social movements. They simultaneously express the goals of an organization, while garnering visibility through public actions and (ideally) press coverage of the actions. According to TAC's website, its mission is to inform and support national advocacy efforts through its branches, thereby providing a platform for people mobilizing and organizing around HIV and related health rights (Treatment Action Campaign 2012). For more information, see: http://www.tac.org.za/community/

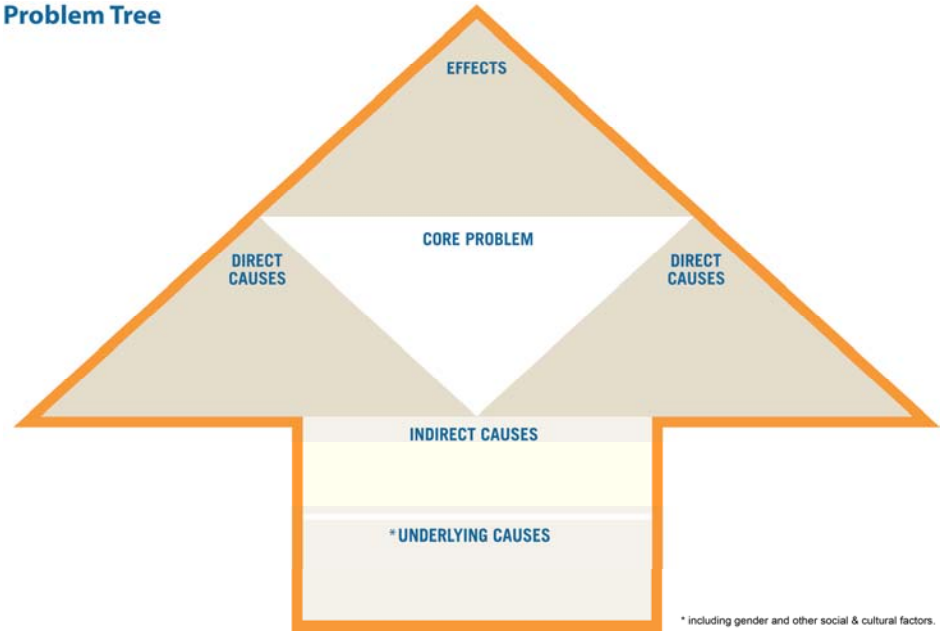
Module 1, Session 2: Layers of Causes and Effects

A problem tree is a useful tool for analyzing a situation. The problem tree is one way to document:

- what SBCC practitioners ***think they know*** about the situation
- what they ***need to find out*** from evidence for the analysis to be complete

Using a problem tree encourages practitioners to take a deeper look at causes, along with a broader view of possible effects and ways to address the problem or situation most effectively. The trunk of the tree is used to state the core problem. The roots and branches exhibit the basic or underlying causes of the problem, and the top of the tree states the effects of the problem.

The trunk and the top of the tree often correspond to the ***levels of analysis*** in the socio-ecological model: individual, interpersonal, community/organizational, and the enabling environment.



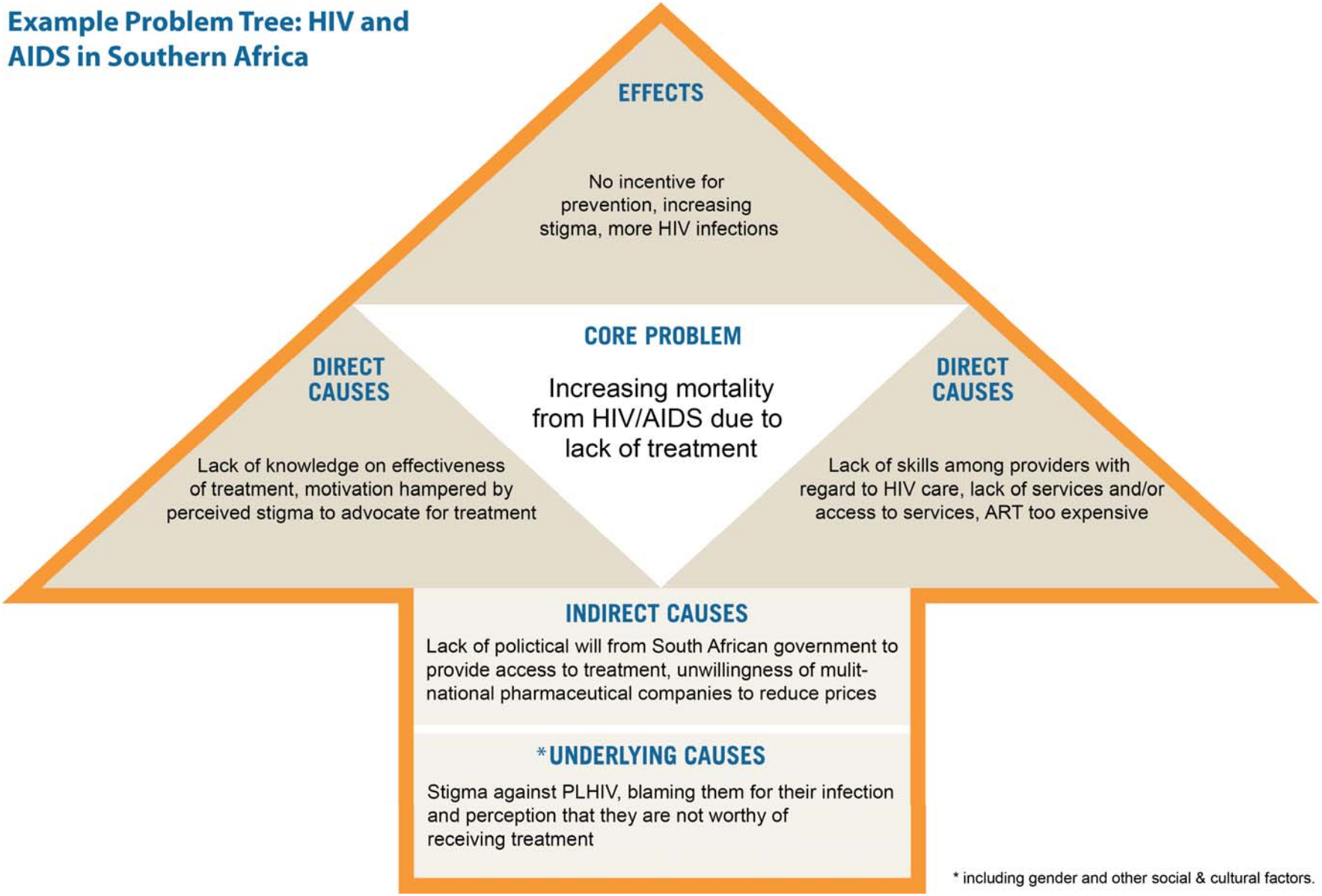
Cross-cutting factors, noted in the branches of the problem tree, serve as the bridge between the different levels. These include:

- direct causes, such as *knowledge, motivation,* and *skills*
- indirect causes, such as *access* to materials and services
- underlying causes, such as *perceived norms* and actual *social norms*

Often, programs fail to do a full, evidence-based analysis and arrive at approaches that tend to address perceived effects of the core problem or assumptions about it, rather than its more fundamental causes. In other words, a limited analysis leads to a limited set of program strategies and interventions.

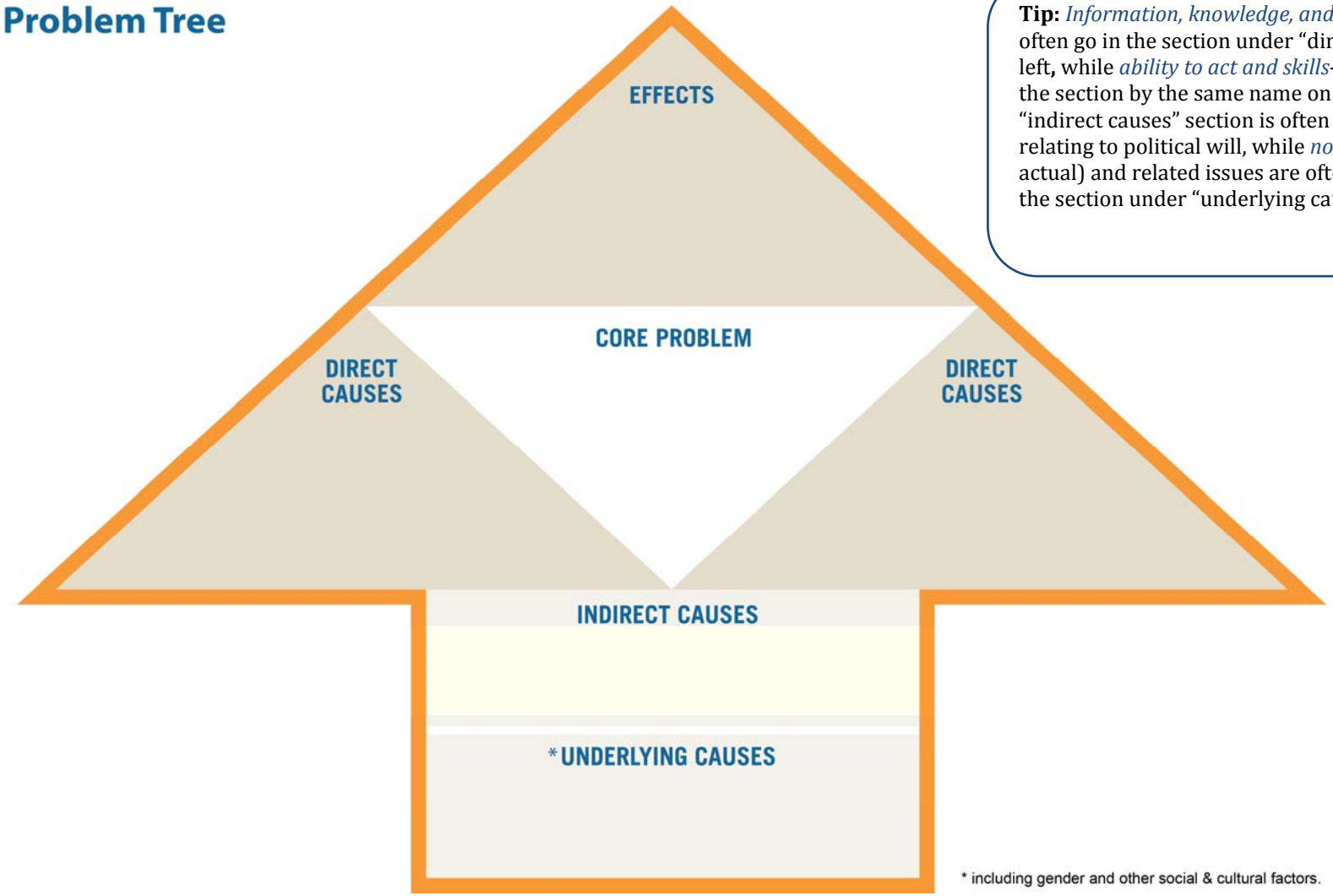
The best start to an SBCC effort and a situation analysis is to consult people who offer different perspectives, including affected individuals, community members, and decision-makers. This will make it possible to produce a deeper and more accurate picture of the situation—or what's going on.

Example Problem Tree: HIV and AIDS in Southern Africa



WORKSHEET: Problem Tree

Directions: Use this worksheet to do your own analysis with the problem tree.



Tip: *Information, knowledge, and motivational issues* often go in the section under "direct causes" on the left, while *ability to act and skills*-related issues go in the section by the same name on the right. The "indirect causes" section is often used to note issues relating to political will, while *norms* (perceived and actual) and related issues are often represented in the section under "underlying causes."

Module 1, Session 3: People Analysis

It's time to step back and take a good look at either the people who are directly affected by the health or development problem or the people who are involved with and influence in some way those directly affected. C-Change's Socio-Ecological Model for Change can be a useful tool for this analysis.

In the center (the self) are listed the people most affected by the problem. Examples might include:

- university students who engage in unprotected sex
- school children suffering from water-borne illnesses
- women living with HIV

In the two intermediate rings (interpersonal and community levels) are persons, community organizations, services, or products that directly influence those most affected (self). Examples might include:

- peers of students who engage in unprotected sex and might get pregnant or cause pregnancy
- school teachers in places with high rates of water-borne illnesses
- partners and friends of women living with HIV and their support groups
- service providers at local clinics who may be overworked and thus unfriendly to clients
- local clinics that regularly experience medicine shortages
- faith leaders who do not support condom promotion for prevention of HIV

In the outermost ring (the enabling environment) are persons, groups, and/or institutions that indirectly influence people in the center (self) and all those in the other rings. Examples might include:

- university authorities who decide how to provide contraceptives around campuses
- national or district school administrators and decision-makers
- officials who determine policies around access to antiretroviral therapy
- legislators and policymakers who make decisions that indirectly but strongly affect others

Gender often goes unaddressed, though it is a key part of any analysis and plays a key role in many situations. For example, women are disproportionately infected by HIV and affected by AIDS; in some cases, married women are infected by husbands. *Gender norms* in many societies give men more sexual freedom to engage with multiple concurrent partners, and *unequal power relations* make it difficult for women to propose condom use to their husbands.

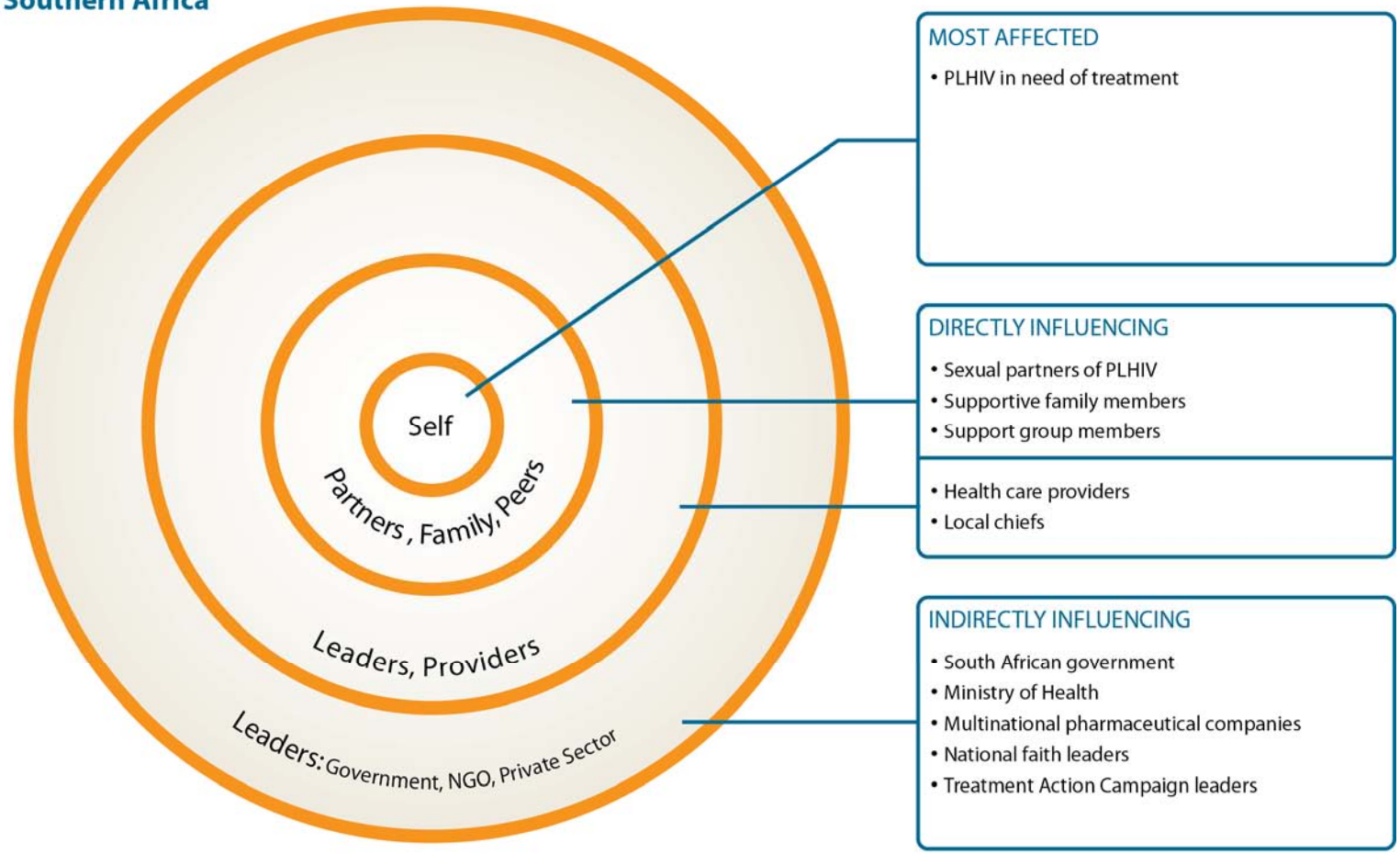
Theory Corner: Culture-Centered and Positive Deviance Approaches

A major concept included in the **Culture-Centered Approach** is that traditional cultural beliefs do not need to be perceived as barriers to social change. Instead, these beliefs can be viewed as assets—resources to be harnessed in change efforts.

Along similar lines, the **Positive Deviance Approach** begins with the idea that the solution to existing challenges most likely already exists within the community. In other words, in any given community, there are often individuals and families who *deviate* from the norm in a positive way. For example, if a village has a 95 percent malnutrition rate for children under age 5, a Positive Deviance Approach would begin with the 5 percent who are not malnourished and attempt to identify promising practices that can be used by the entire community. However, if deviating community members have *access* to additional resources (such as extra farmland), that solution is not applicable. Only practices that can be replicated by everyone in the community are selected and incorporated into programs. In this approach, the *deviating community members are the experts;* it is they (not an *external* expert) who are called upon to share their successful practices with other community members.

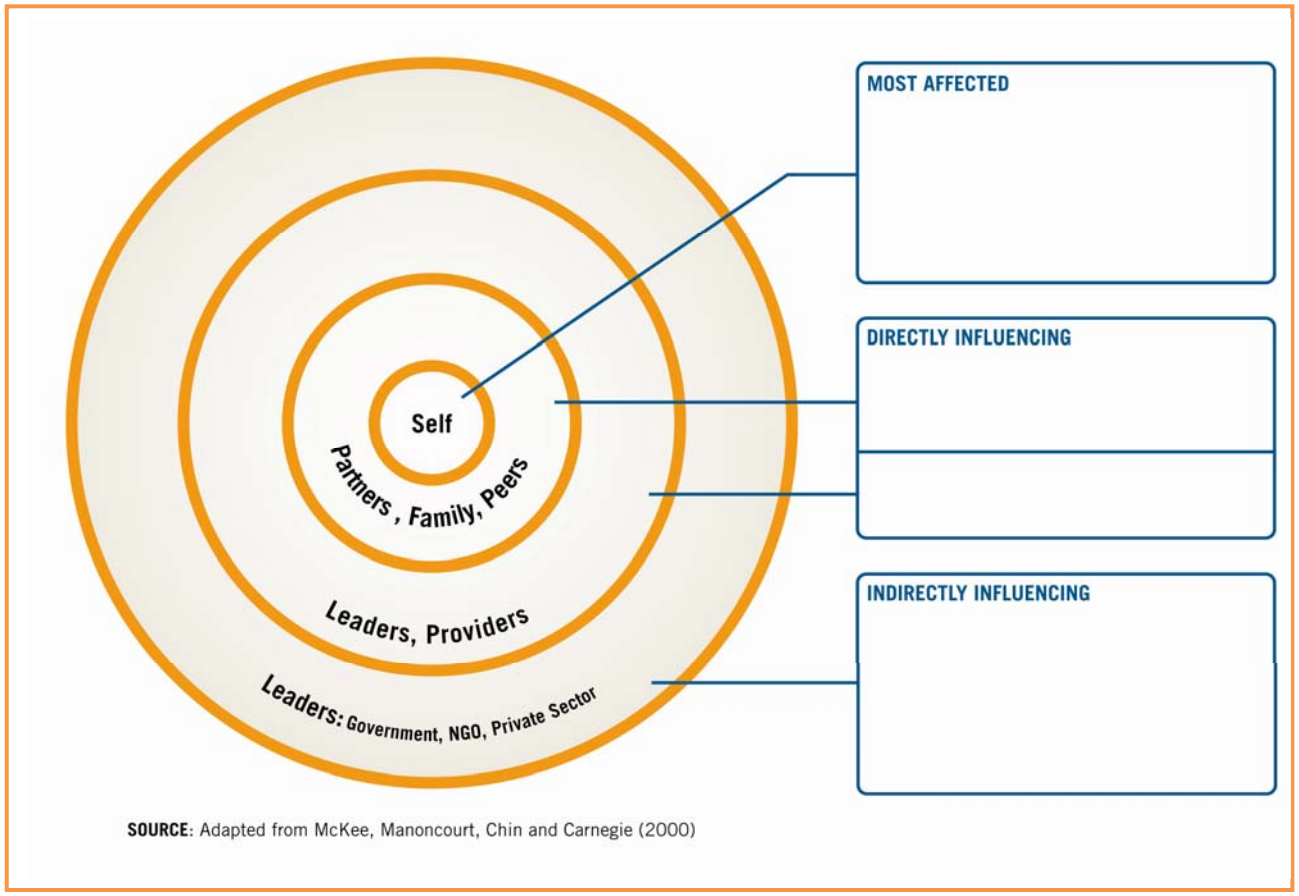
It is important to keep in mind during Step 1 that the goal is to identify people involved in the situation, not to make decisions about which group or groups will be the focus of the SBCC program. Step 2, covered in Module 2, is Focusing & Designing—the process of making strategic decisions about audiences, including segmentation and prioritization. For now, try to name and understand all the people involved, without deciding on specific audiences for the SBCC effort. The following pages offer an example of people analysis and a blank worksheet to be filled out that can help to guide the analysis.

Example People Analysis: HIV and AIDS in Southern Africa



SOURCE: Adapted from McKee, Manoncourt, Chin and Carnegie (2000)

WORKSHEET: People Analysis



Directions:

- In the center is an individual (self). Ask, "***Who are the people most affected by the health or development issue?"*** For example, they might be university students at risk of HIV.
- For the ring next to the center, ask, "***Who are the people who have contact with the individuals in the center ring and directly influence them?"*** These people may also be directly affected by the problem, and could include sexual partners, and friends of the people in the center.
- In the next ring (third from the center), ask***, "Who in the community allows for certain activities and controls resources, access to, demand for, and quality of services and products?"*** These could include clinic workers or community leaders.
- In the outermost, enabling environment ring, ask, "***Who are the people, institutions, or organizations that indirectly influence those in the other rings?"*** These could include churches and religious leaders, business leaders, journalists, policymakers, and officials in the Ministry of Health.

WORKSHEET: A Gender Perspective

Gender has been referred to as "the socially constructed roles, behaviors, activities, and attributes that a given society considers appropriate for men and women" (WHO 2010). Consider the full definition of a gender perspective. Often, gender and sex are understood to be one and the same. In reality, they are quite different. Sex refers to the biological and physiological characteristics that define what men's and women's bodies are physically able to do, while gender refers to what society expects us to do. The result of traditional *gender norms* and roles is that people are often unable to reach their full potential. Both men and women would benefit from a perspective that does not limit what individuals should or should not do (CARE and ICRW 2007).

Respond to the following questions while holding onto a gender perspective and thinking about the cross-cutting factors shown in C-Change's Socio-Ecological Model for Change:

Consider the ***people most affected*** by the health or development issue (the self).

- In what ways might gender make them more likely to be affected?
- In what ways might gender play into their view of the issue?
- How does gender affect their *ability to act* and address the issue?

Consider the people who ***directly influence*** and are in contact with the self—those most affected.

- What is the effect of gender on their sexual partners, family members, coworkers, and friends?
- How does gender affect their relationships?
- How might gender make them more or less likely to support change?

Consider the people who ***indirectly influence*** the self or those most affected, such as journalists, policymakers, religious leaders, and health center directors.

- How does gender affect their roles or influence?
- How does gender affect how they see the situation or how involved they might become with it?

Module 1, Session 4: Context Analysis

Once the key people affected and involved are identified, the rest of the Socio-Ecological Model for Change, including the cross-cutting factors, can be used to check what is known and not known about each group. Here are some questions to ask:

Community, Services, and Products

- What *community assets* can support or impede change? What services and products are accessible at the community level? What is their quality? Do people like them? Is transport available to *access* services? Are transport services and products subsidized so people can access them?

Enabling Environment

- What policies exist that support or impede change? How do political and religious *conventions* and *norms* influence these policies? Is there a *social movement* supporting this change? Are there any opinion leaders who can support or impede the change? How can the program work with them? What is the condition of the economic, technological, and natural environment?

Information

- What *information* does each group receive about the health issue? How timely, accessible, or relevant is it? Through what channels? How do they react to it? What *knowledge* do they need?

Motivation

- What *motivates* people in each group to act? What are their *attitudes* and *beliefs*? What appeals to them? What do they want? How do *gender norms* make them more or less motivated? What key or additional information is missing that could help motivate them?

Ability to Act

- What *life skills* do people in each group have? What *assets*, strengths, resources, or *access* to services or products do they have? How confident are they in their ability to create change *(self-efficacy)*? How do *gender norms* contribute to or constrain their ability to act? Why?

Norms

- What are the deep, underlying *values* of each group, as reflected in *gender norms* and other social and *cultural norms*? How do these norms affect people's *knowledge, attitudes, beliefs, ability to act*, and, ultimately, their behaviors? How do these values and norms influence the health or development problem? Do all the people most affected and those who influence them have the same or different norms? What are the norms?

Answers to these and other questions can often be supplied through existing research, and practitioners should look to those sources first. If there isn't enough information, then they need to consider the best ways to get their own answers to these questions. How to do this and the use of formative research methods will be explored in session 5.

WORKSHEET: Context Analysis

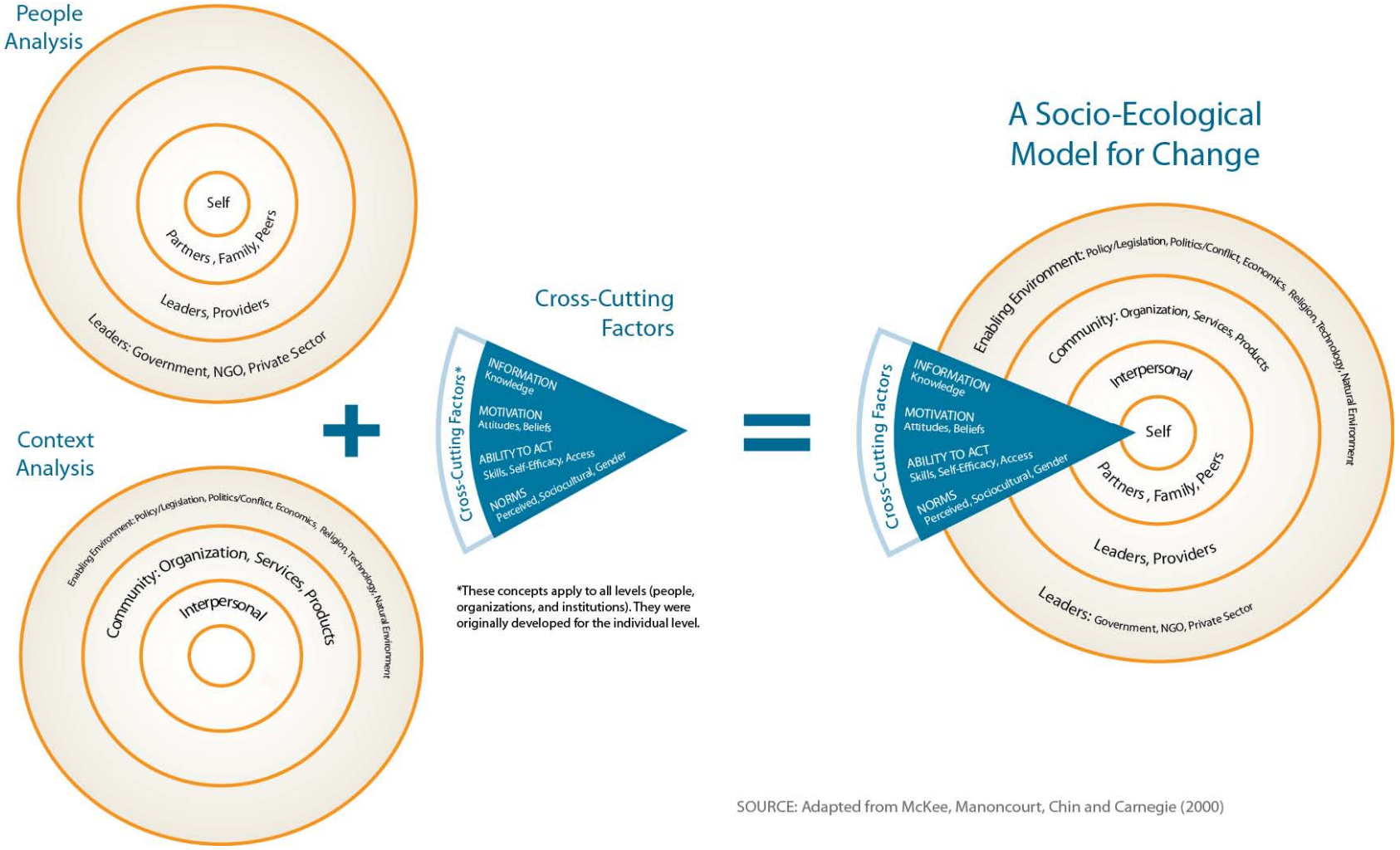
Directions:

- Consider one at a time each of the groups mentioned in the people analysis.
- Use this table to write down what is known about each group. Not every box applies. It might be helpful to indicate where more information is needed.

What Is Known about People's Context	People most affected	People *directly* influencing them	People *indirectly* influencing them
Audience (groups of people from the analysis)			
Community: Organization, Services, and Products			
Enabling Environment: Policy/Legislation, Politics/Conflict, Economics, Religion, Technology, Natural Environment			
Information *(knowledge)*			
Motivation *(attitudes, beliefs)*			
Ability to Act *(skills, self-efficacy, access)*			
Norms *(perceived, socio-cultural, gender)*			

GRAPHIC: Unpacking the Socio-Ecological Model for Change

Review this graphic to see whether people and context analyses are based on the Socio-Ecological Model for Change. Reviewing the table in the Introduction (Module 0, page 25), "The Theoretical Base of the Socio-Ecological Model," may provide some inspiration on how theories can support these analyses.



SOURCE: Adapted from McKee, Manoncourt, Chin and Carnegie (2000)

Module 1, Session 5: Formative Research Gaps and How to Fill Them

As noted in previous sessions, formative research should always be grounded in data so programs are not based on assumptions.

Few issues remain un-researched, so practitioners can save themselves (and communities they work in) significant time and energy by thoroughly reviewing existing sources of data before considering new research.

Look at what has already been written about the health or development issue in the region, and consult relevant sources such as the Demographic and Health Survey (DHS), the Behavioral Surveillance Survey, and other kinds of special studies. Large and small organizations and universities often do research for their own purposes, and much of it is never published. Consider those organizations or government ministries that may have data of interest. Contact them and request available data, some of which could be analyzed further to answer questions about challenges the program is addressing.

At the same time, it is a good idea to find out about any research being planned in the community and explore whether some of the program's research questions could be added. This could help gain a fuller understanding of the situation that the SBCC program aims to address.

Where the research is insufficient or not forthcoming, it may be necessary to conduct formative research, using methods outlined on pages 22–23.

ALBANIA EXAMPLE: Formative Research Gaps and How to Fill Them

Please refer to the Introduction (Module 0, session 1, page 3 and session 4, page 16) for information on C-Change's family planning program in Albania. In the example below, only two audiences—university students and pharmacists—were selected to illustrate formative research needs. For SBCC projects, all audiences need to be considered in the people analysis to obtain a complete picture.

<table>
<tr><td colspan="2">Formative research needs
Information, motivation, ability to act, and norms for university students around the use of modern contraception in Albania
Availability of and access to modern contraceptives in Albania
Quality of interpersonal communication at the point of service (where contraceptives are obtained)</td></tr>
<tr><td>Sample questions for university students:
How many men and women are aware of different modern methods of contraception?
What are their beliefs about the effectiveness of modern and traditional methods?
What prevents them from using modern methods?
How many students discuss contraception with their sexual partners?
How many students discuss contraception with a pharmacist or physician?</td><td>Sample questions for local pharmacists:
What are pharmacists telling women about modern contraception?
How accurate is this information?
What misperceptions do pharmacists have about modern contraception?
What misinformation are pharmacists giving their clients?
What biases exist among pharmacists when it comes to contraception and family planning?</td></tr>
<tr><td>Existing research from the inventory</td><td>Formative research to be designed, as needed</td></tr>
<tr><td>Institute of Public Health (IPH), Albania Ministry of Health, Institute of Statistics (INSTAT), and Centers for Disease Control (CDC). 2005. Reproductive health survey, Albania 2002. Tirana: IPH, INSTAT, and CDC.
INSTAT, IPH, and MEASURE DHS. 2009. Albania demographic and health survey 2008–09. Tirana: INSTAT, IPH, and MEASURE DHS.
PRÖ Shendetit. Two pager: Knowledge and use of modern methods of contraception: 2002 and 2005. Tirana: PRÖ Shendetit.</td><td>Qualitative research
Ten free-flowing focus groups with female university students led by a trained facilitator; use of the pile-sort method to rank contraception methods on various criteria
Quantitative and qualitative research
Surveys with university students at two intervention and two comparison sites; trained interviewers use handheld PDAs (personal digital assistants) to collect data from a sample of students
Face-to-face, quantitative surveys with pharmacists within 200 meters of the university sites; qualitative research with "mystery clients"—trained participants playing the role of women with little or no knowledge about contraception who ask pharmacists open questions about modern contraceptives; use of standardized checklist to address pharmacists' attitudes and style—whether they provide vital and accurate information and referrals to an appropriate physician</td></tr>
</table>

WORKSHEET: Existing Research Inventory

Directions: Fill in the left column of this worksheet with information about existing research and data on the situation. This will inform what goes into the right column and the worksheet on page 19.

Sources of Existing Research	Research Highlights
Census data • •	
Large surveys • •	
Research by government or other large organizations • •	
Research by local or small-scale organizations or programs (often unpublished) • •	

WORKSHEET: Formative Research Gaps and How to Fill Them

Directions:

1. Enter the main formative research needs that emerged from problem tree, people analysis, and context analysis—in other words, what is not known?
2. Write down questions that need to be answered through research about the audiences identified in the people analysis.
3. Write down inventory of research conducted to address questions on the situation.
4. Review unanswered questions, then outline the formative research that needs to be designed and implemented to fully understand the situation.

<table>
<tr><td colspan="2">1. Formative research needs</td></tr>
<tr><td>2. Questions for _____ (audience)</td><td>2. Questions for _____ (audience)</td></tr>
<tr><td>3. Existing research from the inventory</td><td>4. Formative research to be designed, as needed</td></tr>
<tr><td></td><td>Qualitative research

Quantitative research</td></tr>
</table>

Conducting Formative Research

Having carefully reviewed existing data and research, it is time to explore the need for formative research. Such research begins by listing the questions the SBCC program hopes to answer through formative research:

- What programs already exist?
- How feasible is the program we have in mind? How sustainable is it?
- What don't we know about the audience's *knowledge, attitudes, skills, and behaviors*?
- How do *gender norms* influence the program's content and the possible interventions?
- How do *other social norms influence* the situation?

Some research questions call for quantitative data (such as the percentage of people who report x and the rate of y). Other research questions call for qualitative data, such as the kinds of concerns leaders have and what kind of events people enjoy.

The next few pages provide information on data methods and samples of research methods that might be useful to help ***understand the situation*** before designing an SBCC effort, including:

- key informant interviews
- observation or context immersion
- public forum
- focus group discussions
- mapping
- population surveys

GRAPHIC: Where Formative Research Fits into SBCC

As this graphic illustrates, formative research is distinct from baseline research. Baseline research is addressed in Step 2.

SOURCE: Adapted from: Health Communication Partnership, CCP at JHU (2003) the P-Process; McKee et al (2000) the ACADA Model; Parker, Dalrymple, and Durden (1998) the Integrated Strategy Wheel; Roberts et al (1995) the Tool Box for Building Health Communication Capacity; and National Cancer Institute (1989) Health Communication Program Cycle.

Data Methods

Quantitative methods generally rely on standardized approaches to collect and analyze numerical data. Almost any assessment question can be investigated using quantitative methods because most phenomena can be measured numerically. For example, quantitative methods may be used to find out how many women have come to a clinic for an HIV test in the past month or how many phone calls a hotline received over the past week. Quantitative methods tell us who, what, when, where, and how much, as well as how often something is taking place. To understand the "why," qualitative methods are typically needed.

Qualitative methods generally involve asking semi-structured or open-ended questions whose answers produce in-depth, descriptive information. Qualitative results help guide understanding, rather than being used to generalize about an entire population. For example, qualitative data indicate why something might be taking place or the underlying issues with which individuals and communities are dealing. Quantitative methods allow us to identify who is doing what, while qualitative methods allow us to dig deeper and understand why those people are doing what they do.

Data collection method	Method type	Information gathered	Comments
Secondary data analysis	Qualitative or quantitative	The scope and severity of specific health, social, cultural, and economic issues supporting or blocking social and behavior change; individuals' knowledge, attitudes, perceived skills, and behaviors; social networks, socio-cultural norms, collective-efficacy, and community dynamics	• Contact researchers to see if secondary analysis is possible. • Work to include the program's issues and questions into ongoing surveys. • Take what is already done and build from it. (For example, use an old services-mapping study and shorten the research time to conduct an updated mapping.)
Key informant interviews	Primarily qualitative	Deep and rich views into behaviors, reasoning, and lives of people and policies that support or obstruct change; public opinions; socio-cultural norms and values; identification of existing players; suggestions for segmenting the population	• Develop an interview guide that will help obtain all the information needed from informants. • Test the guide and train interviewers to allow and encourage open-ended and free-flowing dialogue. • Identify informants by relying on existing committees or organizations in the community.
Public forum	Qualitative	Public opinion about the health or development issue (how important it is, how much of a problem it is believed to be, and causes of concerns); public perspective on the response of NGOs and the Ministry of Health to the issue; public opinion on current communication activities; generally accepted community norms and values	• Develop a discussion guide and prepare all logistics. • Focus on issues that are general in scope. • Be aware that many underlying causes may not come out in a public forum; they may be rarely spoken about in public and embarrassing to some participants.

Data collection method	Method type	Information gathered	Comments
Focus group discussions	Qualitative	Good for general (social, cultural, and economic) community issues and norms and general opinions on the health or development issue and underlying causes; perceptions of the quality of communication programs serving community members and their social networks; leadership dynamics and patterns; overall community strengths and weaknesses	• Use a tested field guide (if one exists) with open-ended questions or engage an experienced qualitative researcher to help design the guide. • Ensure that groups are homogeneous—same sex, age, etc. • Keep the group size between 6 and 10 participants. • Hold at least two groups per demographic criteria as one may not work out. • Record the discussions, then transcribe for analysis. • Use a trained facilitator and trained note-taker.
Mapping	Quantitative, with some measure of quality of services	Information about service locations, target populations, number of people reached per month, geographic coverage, types of communication services offered; quantity and quality of communication materials on hand, the number of staff members dedicated to working on communication and change strategies; staff training experiences and needs; agency opinion and perceptions on the health or development issue including its underlying causes, social norms, community dynamics; identification of community leaders and gatekeepers; perceptions of governmental policies that hinder or support possible interventions; other action groups that exist; relationships with and access to media; communication practices; current resource gaps and needs	• Look for existing mapping and update if possible. • Start with a community assessment committee for the initial list of service providers. • Talk with as many of the service providers as possible. • Gather at least the basic information on services, population served, and geographic coverage. • Work to obtain additional information on the environment, services, and barriers to change and their causes.
Population and sub-population level surveys	Quantitative	Representative population- and sub-population-level perceptions of the health or development issue; community norms and values; individual beliefs, perceptions, knowledge, and behaviors; underlying factors that may influence health or development issues; skills; social networks; community dynamics; communication patterns, access to and use of various communication channels; general public opinion on topics related to the health or development issue	• Address gaps in data with own survey. • Ensure calculations are made for necessary sample size. • Develop a sample frame. • Train interviewer staff well. • Pretest all data collection instruments. • Develop an analysis plan ahead of time. • Ensure planners have the skills for data entry and analysis.

WORKSHEET: Draft Research Plan

Before beginning formative research, it is wise to plan out all the steps and activities. This worksheet includes an outline of a research plan that you can use as a guide. A number of issues will influence the final choice of research methods, such as time, cost, the willingness and accessibility of the people who would participate in the research, and the availability of skilled staff to conduct it. This draft research plan outlines each of these issues and could help you decide how the research data might be used.

Directions: Use this worksheet to think through what the research will look like, and then start to draft the research plan.

Steps for a research plan	What are the estimated dates?	What are the costs of each step?	Who or which team member would do this work?
1. Consider forming a ***community needs assessment committee.***[1]			
2. Decide what specific information you will need to collect—what ***questions need answering***—to better understand the situation you are addressing.			
3. Decide from whom you want to collect data directly. ***Who do you need to talk to, and where are they located?***			
4. Decide on the ***research method*** that best fit the situation and available resources. Draft tools for data collection.			
5. Decide on the ***timetable for data collection*** so that the information gathered is current (or gathered in a timely manner) and relevant to the program design.			
6. Collect the data using the selected tool(s).			
7. Analyze and share findings with those who can use these data to focus and design the next step of your planning process.			

[1] This committee should be made up of key stakeholders and gatekeepers who can guide the research process. It is best if potential, intended beneficiaries are included. Committee members will help with the development of the formative assessment and assist in ensuring that the most relevant information is collected, In short, they will help guide and be a part of the formative research process throughout its duration, and will help you understand and interpret the results. Committee members will also help to ensure that your program is appropriate for their community and is accepted.

WORKSHEET: Draft Research Plan (continued)

A) Community needs assessment committee: Who might be invited to form this committee?

B) Sample of questions to be answered through the research	C) Who might be suitable informants? Where can they be interviewed?	D) Proposed research methods to best fit the situation and available resources

E) A draft timetable so that the information gathered is current (or gathered in a timely manner) and relevant to the program design		
Activity to carry out	Deadline for completion	Who is responsible?

EXAMPLE: Using the Results of Research

Here are some example highlights of results from research conducted prior to the design of an SBCC program on male circumcision for HIV prevention in X country.

1. Male circumcision at birth or adolescence is part of the *traditional beliefs and practices* of about half of the people in X country. In the last five years, two clinics in the capital started offering clinic-based circumcision for adult males. They each see about 50 men a year. No program has created a communication program specifically on the public health aspects of clinic-based circumcision. Most HIV-prevention programs include a message on circumcision in their day-to-day activities with the community and provide referrals to the clinics that offer circumcision.
2. Ninety-eight percent of men and women *know* the main ways to prevent the spread of HIV (e.g., having one uninfected, faithful partner; using condoms with all partners; reducing the number of sexual partners). Twenty-five percent are *aware* that circumcision reduces the risk of contracting HIV. Forty-five percent are *aware* that having another STI increases their risk of contracting HIV *(risk perception)*. Twenty percent *know* where they can get an HIV test.
3. Through interviews and focus groups, the research team found that members of this community have mixed *beliefs* about circumcision. Some people believe that today all men should be circumcised. At the same time, many men believe that having intact foreskin is a proof of their manhood. Among those who do believe in circumcision, some see it as a religious act *(social norm)* that has nothing to do with health, while others think of it as the "modern" thing to do. Many community leaders stated that the circumcision ritual is sacred and should not be tampered with *(social norm).* Some men said that they are afraid of pain, infections, and negative consequences from circumcision, including reduced sexual pleasure. Some women told researchers that they prefer uncircumcised men.
4. Discussions with the traditional leaders made it clear that some traditional circumcision at adolescence leaves a good bit of the foreskin and is not full circumcision. This led researchers to wonder whether or not this form of circumcision will provide protection. Approximately 50 percent of all males are circumcised. Thirty-five percent of all males used a condom the last time they had sex. Twenty-five percent of all males stated that they had more than one concurrent sexual partner.

Reflection Questions

What insights does the information gathered provide into:

- ✧ the problem or issue?
- ✧ the people affected and those influencing them?
- ✧ the context of the problem or issue and cross-cutting factors that affect current and potential behaviors: information, motivation, ability to act, norms, community organization, services and products, and the enabling environment

In Step 2, research findings are used to segment and prioritize the SBCC program's audiences, craft communication objectives, and decide on a strategic approach, positioning, channel mix, and more.

Module 1, Session 6: Partners, Allies, and Gatekeepers

At this point, a lot has been done to understand the situation being faced, and it's time to map out a plan to find out what is still unknown. It is also time to consider all individuals or groups who might support or hinder efforts to fully address the issue addressed by the project, along with all those whose perspectives or cooperation will be important—partners, allies, and gatekeepers.

Partners are those who collaborate with the project and provide hands-on support. For example, the National AIDS Hotline might be a good partner for an HIV-prevention effort for young people. It could provide materials and training for project staff, and its phone number could be included in all project materials.

Allies are those whose own efforts support the project's work. For example, an international organization researching HIV risk on university campuses and working toward better campus-wide *policies* would be an ally in your efforts.

Gatekeepers are individuals or groups who either open or close the gate to effective work. For example, the Ministry of Religious Affairs could hinder work or could clear the path toward progress.

Distinctions between these groups are less important than the idea that there are people who can either block or facilitate the change being sought.

Gatekeepers are critical to the success of projects. They can be involved and turned into supporters by:
- asking for their input into the analysis
- hearing their concerns and ambitions
- offering them a summary of the analysis and its findings
- finding ways for the SBCC effort to be beneficial to them in some way

By ensuring that appropriate partners, allies, and gatekeepers on board, practitioners can:
- work with them to *advocate* for the cause or the program
- build a *network or coalition* of supporters for the cause or program
- *mobilize resources* for the cause or program

ALBANIA EXAMPLE: Matrix of Partners, Allies, and Gatekeepers

Please refer to the Introduction (Module 0, session 1, page 3 and session 4, page 16) for information on C-Change's family planning program in Albania.

Potential Partners, Allies, and Gatekeepers	Notes
Partners • Pepsi Cola/Shark • Bayer Schering • Nesmark • OES Distrimed • Professor of journalism; trainer at the Albania Institute of Media; obstetrician/gynecologist	**Long-term** • Professionals provided training for journalists, pharmacists, and C-Change peer educators **Short-term** (support for single, outdoor events for peer educators) • Pepsi Cola/Shark provided refreshments; Bayer Schering provided materials and products (cost share); Nesmark provided an informational display and condoms (cost share); OES Distrimed provided condoms
Allies • Technical advisory group (TAG): Representatives from the Ministry of Health, Institute of Public Health, USAID, UNFPA, and UNICEF; media and health professionals; faculty and students from the University of Tirana	• TAG members provided technical input and direction for the mass media campaign and other interventions. In many countries, these institutions may be natural, full-scale operational partners.
Gatekeepers • Local pharmacists' association • Mayors of towns where program worked	• Local pharmacists' association could provide support and become allies, or it could make it difficult for members to attend the training. • City mayors could become allies and providing support or they could block public health events.

WORKSHEET: Matrix of Partners, Allies, and Gatekeepers

Directions: On this sheet, note key individuals or groups who could influence the SBCC program's success. Partners actively support (or might support) the work and collaborate; allies are like-minded groups or individuals who support the work; and gatekeepers are organizations or individuals who could either provide support or interfere with the program's work.

Potential Partners, Allies, and Gatekeepers	Notes
Partners	
Allies	
Gatekeepers	

Module 1, Session 7: Summary of Analysis

A ***problem statement*** is a succinct summary of what was discovered during Step 1 of C-Planning. Such a statement helps programmers see clearly what is happening so they can begin to focus attention where it will make a difference. A good problem statement is just one sentence, with several paragraphs for elaboration.

When writing a problem statement, it helps to use the headings below.

- What is happening?
- Where and to whom?
- With what effect?
- Who and what is influencing the situation and with what effect?
- And as a result of what causes?

The problem statement should be backed up by data. It is advisable for the program team, partners, and allies to debate and agree on the problem statement and cite evidence that supports it. As the statement is drafted, some unanswered research questions might be identified. It is important to continue to note what else would be helpful to know about the situation in order to build the strategy on data, rather than on assumptions.

Once the problem statement is drafted, consider what kinds of changes the problem calls for.

- Where might be the possible *tipping points* for change?
- What will improve the situation? Consider *information, motivation, ability to act, and norms*.
- What are the desired changes in the environment? Consider *political will, resource allocation, policy change, institutional development, national consensus, and coalition building.*
- What are the desired changes in the social scene? Consider *social movements, community leadership, network participation, ownership, access to services.*
- What are the desired changes in individual behaviors? Consider *knowledge, attitudes, beliefs, skills, self-efficacy, perceived social norms.*

Change doesn't happen solely by working on individual behaviors. Consider this example of the change at multiple levels that might be required in response to a problem:

- Students on a college campus begin to get HIV tests because free services are publicized nearby, admired students speak out about the value of getting the test, counseling around the test is of high quality, and a telephone hotline allows callers to get anonymous advice about getting tested.

ALBANIA EXAMPLE: Summary of Analysis and SBCC Problem Statement

1. **What's happening?** (from problem tree)	Withdrawal is being used as a family planning (FP) method
2. **Where and to whom?** (from people analysis)	In Albania, young men and women are using this method
3. **With what effect?** (from problem tree)	The method is contributing to unwanted pregnancies, abortions, and high healthcare costs
4. **Who and what is influencing the situation and with what effect?** (people analysis and problem tree)	Mass media are contributing to general *misinformation,* and pharmacists don't have *skills or the right motivation* to advise and interact with young people. As a result, young people lack the *knowledge, motivation, and skills* to switch to safer FP methods.
5. **And as a result of what causes?** (problem tree and context analysis)	Deep *gender norms* and power relations are contributing to the lack of motivation to stop using withdrawal as an FP method.

Final SBCC Problem Statement: The use of withdrawal as an FP method among young men and women in Albania is contributing to unwanted pregnancies, abortions, and high healthcare costs. The mass media contribute to general *misinformation,* and pharmacists don't have the *skills* or the right *motivation* to advise and interact with young people. As a result, young people lack the *knowledge, motivation, and skills* to switch to safer FP methods. Deep *gender norms* and power relations discourage actions to stop using withdrawal as a FP method.

Changes This Problem Calls For: The people most affected are young men and women in Albania who need to be *motivated* to use safer FP methods, while addressing gender power relations and peer pressure. People directly influencing the young men and women are pharmacists who need to *learn* how to offer them services and become a trusted source of advice on contraception. The mass media are among indirect influencers, and need to be trained to do better reporting on FP and modern contraceptives.

Theory of Change: One could argue that a tipping point for change will be the result of a combination of the following: increased individual *self-efficacy* to use and *negotiate* FP methods among couples; increased *ease of access* to methods through better training for pharmacists; and *agenda setting* by increasing the frequency and correct reporting about FP in the media, which can also provide a better *enabling environment for norm change* with regard to FP use. These concepts are based on assumptions of the Health Belief Model, Social Learning Theory, Consumerist Model for service providers, and Agenda Setting Media Theory.

WORKSHEET: Summary of Analysis

Directions: After considering all that came from the analysis so far, write a concise problem statement, noting whether it might require further research. Add a statement about the changes that need to come about for the problem to be solved. As you do this, remember to think about the tipping point for change. Guidance that will help fill-out the last section—your theory of change—is in the next session.

Using this formula helps to summarize the situation, people, and context analysis into one paragraph. (This usually takes up a couple of pages in the strategy's background section.)	
1. **What's happening?** (from problem tree)	
2. **Where and to whom?** (from people analysis)	
3. **With what effect?** (from problem tree)	
4. **Who and what is influencing the situation and with what effect?** (people analysis and problem tree)	
5. **And as a result of what causes?** (problem tree and context analysis)	
Final Problem Statement	
Changes the Problem Calls For (and the Tipping Point for Change)	
Your Theory of Change (guidance in next session)	

Module 1, Session 8: What Is the Theory of Change?

Most people have an idea of how the world and people operate, based on *personal experiences, values, and beliefs*. In a very general and simplistic way, this is also how theory formulation starts, with personal observations, analyses, and conclusions of people's life experiences. From these observations and conclusions, a model explaining why things happen can take shape.

Academics often take these models and further develop and test them to determine how well they hold up under different conditions. This is because ***a real theory or model must be replicable in a variety of settings and with many individuals or groups*** (National STD/HIV Prevention Training Centers 2005). A theory provides predictions about the causal relation between two or more phenomena.

This beginning of thinking about theory can be called the **theory of change**. It will serve as a tool to support the change that practitioners think is needed and how this change should be addressed more explicitly. A complete theory of change incorporates the perspectives of all constituents. It is important to reconsider all assumptions that shape beliefs and check them against various data sources and SBCC theories—on what will work and why, and what strategies are likely to be most effective in the short, medium, and long term (Keystone Accountability 2012).

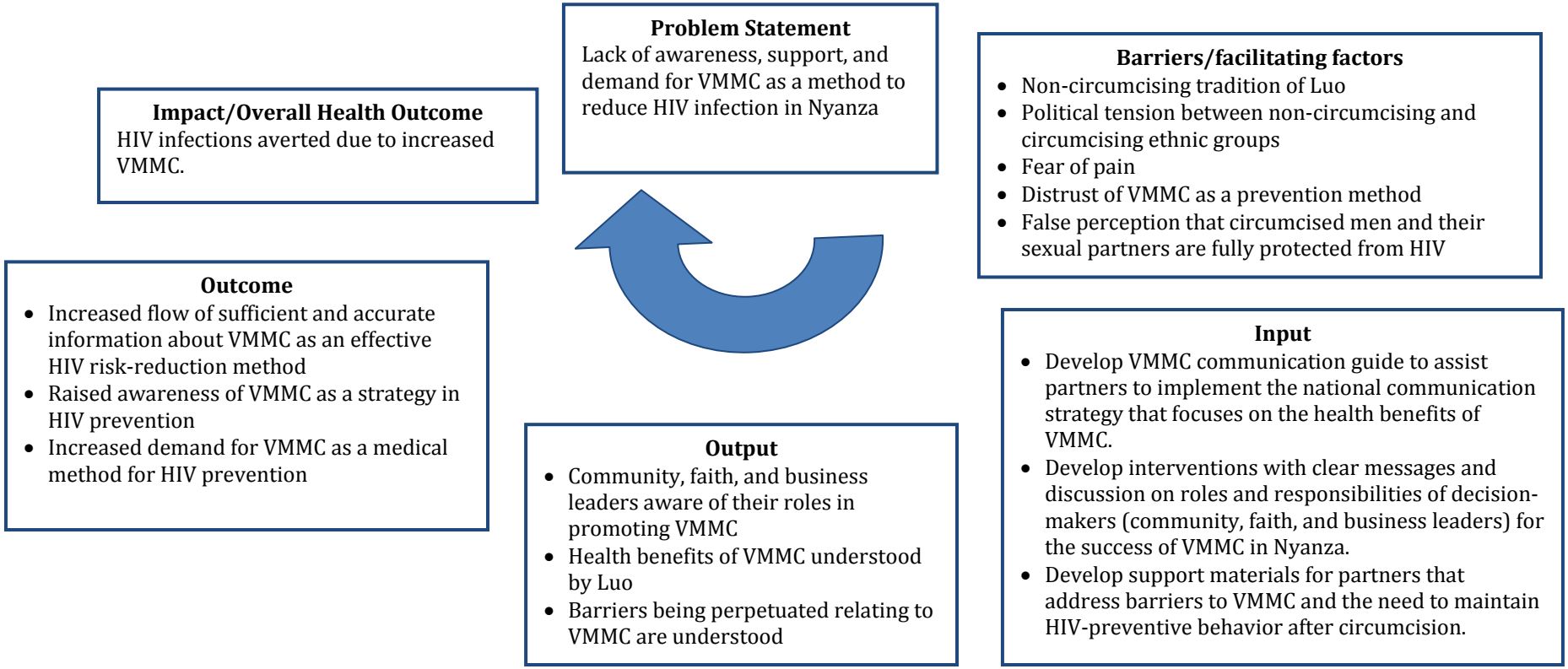
There are two stages to developing a theory of change (Walters 2007):

1. Clarify what assumptions are forming during the analysis in Step 1.
2. Seek help from SBCC theories and concepts to identify an effective *tipping point* for change (Module 0, Appendix, "The Theoretical Base of the Socio-Ecological Model," page 25).

Try to follow the example in the flowchart and worksheet on the next pages to lay out assumptions on how interventions being considered will affect identified barriers to change.

MALE CIRCUMCISION EXAMPLE: Theory of Change for C-Change's Voluntary Medical Male Circumcision Program in Nyanza Province, Kenya, 2012

1. **Name the changes needed to address the problem**. The changes needed are increased awareness, support, and demand for voluntary medical male circumcision (VMMC) as a method to reduce HIV infection in Nyanza Province.
2. **Name the key barriers to change or facilitating factors for change.** Nyanza Province has the lowest circumcision rate in Kenya, though rates vary widely by ethnic community. Among the Luo, the ethnic majority in province, the rate is 17 percent. There is tension between communities who circumcise and those who do not. In addition, some uncircumcised men fear pain associated with the procedure, and there is a growing perception that circumcised men and their sexual partners are fully protected from HIV infection.
3. **Clarify assumptions.** The VMMC communication intervention will contribute to addressing barriers to trust and barriers to accepting VMMC at the community level.



4. Name SBCC concepts to help find the tipping point for change: One could argue that the tipping point for change will be community, business, and faith leaders starting to discuss VMMC as an intervention in their community, based on information tailored for VMMC services. The leaders need to be convinced they would thereby be serving as a *catalyst* to increase *dialogue, develop collective action, and mobilize* more community members to become engaged with VMMC. These individuals are in a key position to mobilize their community members to demand VMMC services and help incorporate the procedure into broader healthy *social norms* and attitudes relating to HIV prevention and gender. These concepts are based on assumptions used in **community organization and advocacy theories**, such as *agenda setting and framing*, **Diffusion of Innovation** to see VMMC as innovation, and *coalition building* between services and community leaders.

5. Summarize: If community, business, and faith leaders are provided with information on VMMC and its benefits in preventing HIV infection, and they are convinced of its benefits, then they may become *catalysts* to advocate and shape how their communities view VMMC. Mobilization efforts with community leaders will lead to open discussion about male circumcision traditions, and will increase acceptability and support for VMMC by associating the procedure with HIV prevention and hygiene. Community leaders can shape an intervention in their communities and address relationships with service providers on VMMC.

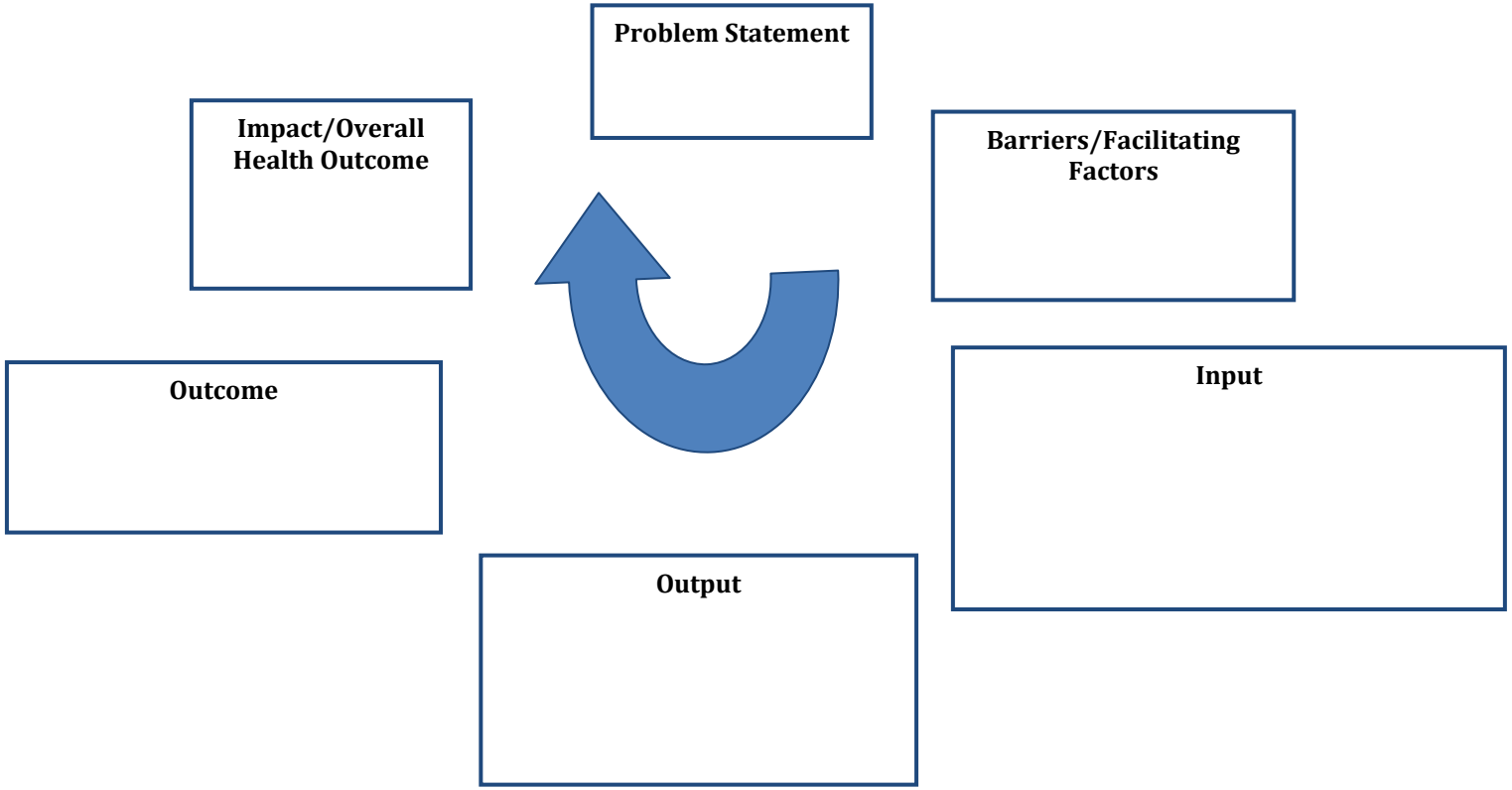
WORKSHEET: What Is Your Theory of Change?

Directions: Fill in each part of this worksheet to develop your theory of change.

1. **Name the changes needed to address the problem** (from your problem statement #1, 2, 3).

2. **Name the key barriers to or facilitating factors for the changes you identified** (from your problem statement #4, 5).

3. **Clarify assumptions by filling in the blanks:** This _____ intervention will contribute to _____ addressing the barriers of _____ through……



4. **Name SBCC concepts to help find the *tipping point* for change.** Name the SBCC concepts and theories you consulted to make sure what you are planning will work.

5. **Based on the problem statement, summarize the expected change sequence.**
(If we do X, then we should expect Y will happen).

Reflection Questions

After completing the worksheet, review your theory of change and think about the following:

- ✧ How do you know what is in the theory of change? How confident are you?
- ✧ Why are you confident that the change sequence will be as predicted?
- ✧ What data and theoretical models suggest that this might happen?
- ✧ Are there previous examples that provide evidence for the proposed change sequence?

Additional Reading

These references provide additional information for SBCC practitioners. The entire SBCC curriculum, references cited below, and additional resources are available at http://www.c-changeprogram.org/our-approach/capacity-strengthening/sbcc-modules. For more resources and opportunities to strengthen capacity in SBCC, visit C-Change's Capacity Strengthening Online Resource Center at http://www.comminit.com/c-change-orc. Graphics in the *C-Modules* can be accessed online, expanded, and shown to participants on a large poster board or through a PowerPoint presentation.

Background Reading

Topic	Item
SBCC	***Involving People, Evolving Behavior.*** Provides a model for behavior change involving information, motivation through communication, the ability to act through life skills and an enabling environment by addressing policy and legislation, service provision, education systems, cultural factors, religion, socio-political factors.
Advocacy/ Community Mobilization	***Advocacy in Action: A Toolkit to Support NGOs and CBOs Responding to HIV/AIDS.*** Helps staff of NGOs and CBOs to gain a clear understanding of what advocacy is and how it might support their work and provides practical assistance on how to undertake advocacy.
	Participatory Rural Communication Appraisal (PCRA): A Handbook. Describes the procedure for planning and conducting PRCA as the first step in the design of cost-effective and appropriate communication programs, strategies, and materials for development projects and the community level.
Gender	***Inter-Linkages Between Culture, GBV, HIV and AIDS and Women's Rights.*** Explores theories on culture and the relationship between culture and gender-based violence (GBV) and provides an analytical model to use when considering interventions related to culture, GBV, women's rights, and HIV and AIDS.
Research Skills/Tools	***Qualitative Target Audience Formative Research for Health and Development Communication: Soul City Fieldworker Training Manual 1—Qualitative Interviewing.*** Supports skills-training in qualitative interviewing and provides instruction on conducting qualitative, formative audience research.
	HIV/AIDS Rapid Assessment Guide. Provides guidance on rapid behavioral surveys and HIV-prevention tools whose data provide a spatial, quantitative, and qualitative overview of a project area, including a mapping guide; a site inventory; an ethnographic guide; a focus group guide

Curricula/Training Materials

Mainstreaming HIV, AIDS, and Gender into Culture: A Community Education Handbook. Supports and encourages discussion about how people behave and collectively cope with HIV and how culture can affect the spread of HIV. Part 2 looks at how culture, gender, and HIV are connected.

References Cited

C-Change. 2012. *Voluntary medical male circumcision (VMMC) communication in Kenya: A case study*. Washington, DC: C-Change/FHI 360.

CARE and ICRW. 2007. *Inner spaces outer faces initiative (ISOFI) toolkit: Tools for learning and action on gender and sexuality*. Washington, DC: CARE/International Center for Research on Women (ICRW). http://www.icrw.org/files/publications/ISOFI-Toolkit-Tools-for-learning-and-action-on-gender-and-sexuality.pdf.

Keystone Accountability. 2012. "Theory of change." http://www.keystoneaccountability.org/about/theoryofchange

National STD/HIV Prevention Training Centers. 2005. *Bridging theory and practice: Applying behavioral theory to STD/HIV prevention.*

Treatment Action Campaign. 2012. "About the Treatment Action Campaign." http://www.tac.org.za/community/about

World Health Organization (WHO). 2012. "Health topics: Gender." http://www.who.int/topics/gender/en/

Walters, Hettie. 2007. *Capacity development, institutional change and theory of change: What do we mean and where are the linkages. A conceptual background paper* .Support Program for Institutional & Capacity Development (SPICAD) Resource Portal. http://portals.wi.wur.nl/files/docs/successfailuredevelopment/Walters_CapacityDevelopmentConceptPaperFIN.pdf.

Credits for Graphics

C-Planning (page 3); ***Where Formative Research Fits into SBCC*** (page 21)

Health Communication Partnership. 2003. *The new P-Process: Steps in strategic communication*. Baltimore, Md.: Johns Hopkins Bloomberg School of Public Health, Center for Communication Programs, Health Communication Partnership.

McKee, Neill, Erma Manoncourt, Chin Saik Yoon, and Rachel Carnegie, eds. 2000. *Involving people, evolving behavior*. New York: UNICEF; Penang: Southbound.

Parker, Warren, Lynn Dalrymple, and Emma Durden. 1998. *Communicating beyond AIDS awareness: A manual for South Africa.* 1st ed. Aukland Park, South Africa: Beyond Awareness Consortium.

Academy for Educational Development (AED). 1995. *A tool box for building health communication capacity*. SARA Project, Social Development Division. Washington, DC: AED.

National Cancer Institute. 1989. *Making health communications work: A planner's guide*. Rockville, Md.: U.S. Department of Health and Human Services.

People Analysis (pages 10 and 11); ***Unpacking the Socio-Ecological Model*** (page 15)

McKee, Neill, Erma Manoncourt, Chin Saik Yoon, and Rachel Carnegie, eds. 2000. *Involving people, evolving behavior.* New York: UNICEF; Penang: Southbound.