

A LEARNING PACKAGE FOR SOCIAL AND BEHAVIOR CHANGE COMMUNICATION

Additional Resources

[SBCC Theory Powerpoint](#) | [Glossary of Terms](#) | [Supplemental Readings](#)

Communication for Change



**A SHORT GUIDE TO SOCIAL AND BEHAVIOR
CHANGE (SBCC) THEORY AND MODELS**

Why use theories and models?

- **Answers to key questions**
 - Why a problem exists
 - Whom to select
 - What to know before taking action
 - How to reach people with impact
 - What strategies likely to cause change

More Harm Than Good?

3

- **When we set out to improve life for others without a fundamental understanding of their point of view and quality of experience, we do more harm than good. (Lauren Reichelt, Tikkun, Winter 2011)**

Evolution of key concepts

4

Communication concepts a generation ago...

5

Expert (sender)
sending information

to non-expert (receiver)



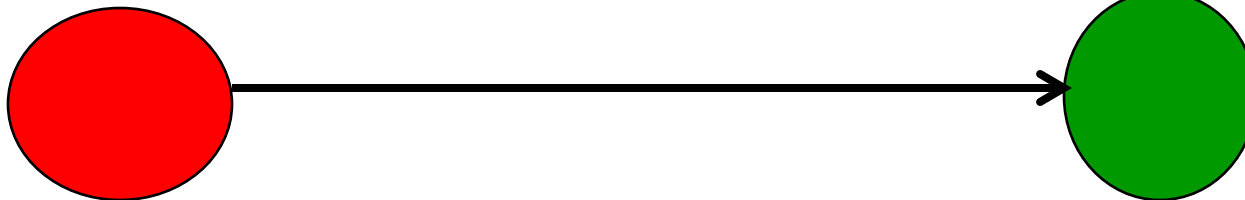
Transmission model: outdated

6

Source

Receiver

Transmission



Influence flows in one direction only

Now: Communication as dialogue

7

Communicator

Communicator

Dialogue

Influence flows in both directions

Evolution of key concepts

8

- Older approaches tried to persuade individuals to change their health behaviors
- Newer approaches try to create an enabling environment to encourage healthy behaviors
- Newer approaches consider more than just individual behaviors

Core Theories

9

**THAT HAVE FUELED THE CURRENT
THINKING**


Three levels of theory

Most theories can be sorted into three levels

Level of Change	Change Process	Targets of Change
Individual level	Psychological	Personal behaviors
Interpersonal level	Psycho-social	Social Networks
Community level	Cultural & Social	Community development

Emphasis of some core theories

11

Theory	Emphasis	More individual
Individual level		
<ol style="list-style-type: none"> 1. Health Belief Model 2. Reasoned Action – Fishbein & Ajzen 3. Stages of Change – Prochaska, DiClemente 	Planned behavior, rational decision making processes (beliefs & subjective norms)	
Fear Management – Witte	Interaction between cognition & emotion	
Interpersonal level		
Social Learning – Bandura	Social comparison, learning from role models, self efficacy	
Community level		
Theory of Gender and Power Diffusion of Innovations - Rogers	Social influence, personal networks	
Ecological Models	Behavior is a function of the person and its environment	More social

Individual level: Health Belief Model (1950s)

12

People form behaviors based on perceptions:

1. How severe is the illness?
2. How likely could I get it?
3. What do I benefit from trying to prevent it and how effective is the new behavior?
4. What keeps me from taking this action?

Application:

- Address personal risk perception and beliefs in severity of disease
- Identify key benefits and barriers to change and stimulate discussion
- Demonstrate potential positive results of change

Individual level : Reasoned Action (1960s)

13

People make decisions by:

- Weighing the advantages and disadvantages of behaviors before deciding to practice it
- People base their intentions to act on two things:
 - their attitudes (whether performing the behavior is a good thing or a bad thing)
 - their subjective norms (whether other people around you are performing it and think that you should do that too)

Application:

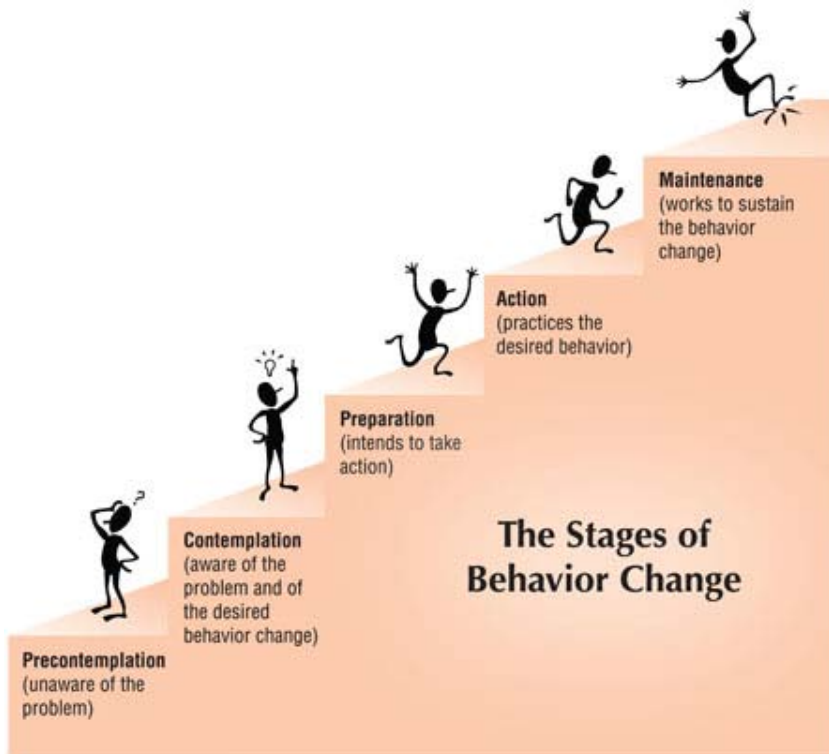
- Identify motivators and benefits for action
- Create messages that can affect attitudes
- Identify audiences that influence the group your are trying to reach

Individual level: Stages of Change (1980s)

14

People making decisions by stage

Application



Sources: Grimley 1997 (75) and Prochaska 1992 (148)

- Where is your audience with respect to the desired action?
- What information or messages do they need at that stage?
- Stage will dictate intervention
 - Pre-contemplative: generate interest
 - Preparation: develop skills
 - Action: form support groups
 - Maintenance: share stories with others

Individual level: Fear Management Theory

15

People make decisions based on

- The Threat (fear)
 - Is the threat serious or severe?
 - Can it happen to me?
- The Efficacy (response)
 - Does the response work?
 - Can I do the response (self-efficacy)?
 - What blocks me from responding (barriers)?



Application:

- Find out about perceptions of fear and efficacy; based on that:
 - Increase perceived seriousness of the illness
 - Increase risk perception
 - Increase knowledge of solutions
 - Model response behaviors
 - Show how others have overcome barriers

Interpersonal level: Principles of Social Learning (1970s)

16

People learn and decide how to act by:

- Observing the actions of others
- Observing the apparent consequences of those actions
- Checking those consequences for their own lives
- Trying out those actions themselves

Application:

- Identify key role models in the community
- Provide opportunities for them to model or talk about their behaviors
- Showcase role models and their actions through radio dramas, personal testimonials, community discussions

Key concept: Self-efficacy

17

- *A person's belief in their ability to achieve a desired outcome*
- Self-efficacy is *perceived* regardless of one's actual ability.
- If a person sees someone else performing a behavior but doubt their own ability to copy it, its not likely that the new behavior will be adopted.

Summary of individual BCC theories

18

- List of eight conditions represented in all theories:
- One or more of these conditions must be true for a person to perform a given behavior: The person
 1. Has formed a strong positive intention to act
 2. Has no environmental constraints for the behavior to occur
 3. Has needed skills to perform the behavior
 4. Believes the advantages/benefits outweigh disadvantages of performing the behavior
 5. Perceives more social pressure to perform than not to perform the behavior
 6. Perceives that behavior is consistent with self-image and personal standards
 7. Reacts emotionally more positively than negatively to performing the behavior
 8. Believes that they can execute the behavior (self-efficacy)

However,

19

- Psychological and psychosocial theories were very useful early in the HIV epidemic to identify individual transmission behaviors.
- But
- ...nearly all the individually based theories were developed in the West with little focus on the role of gender...”

Community level: Theory of Gender and Power (1995)

20

People make decisions based on:

- Wider social and environmental issues surrounding women such as
 - Distribution of power and authority
 - Gender specific norms outside of and within relationships

Application:

- Assess impact of structural gender differences and social norms on interpersonal sexual relationships
- Investigate how a woman's commitment to a relationship and lack of power can influence her risk reduction choices

Community level: Diffusion of Innovations (1960s)

21

Innovations are spread through:

- Social networks over time
- The speed at which an innovation spreads depends on
 - What people think about the innovations and the people using it
 - How well the social network works

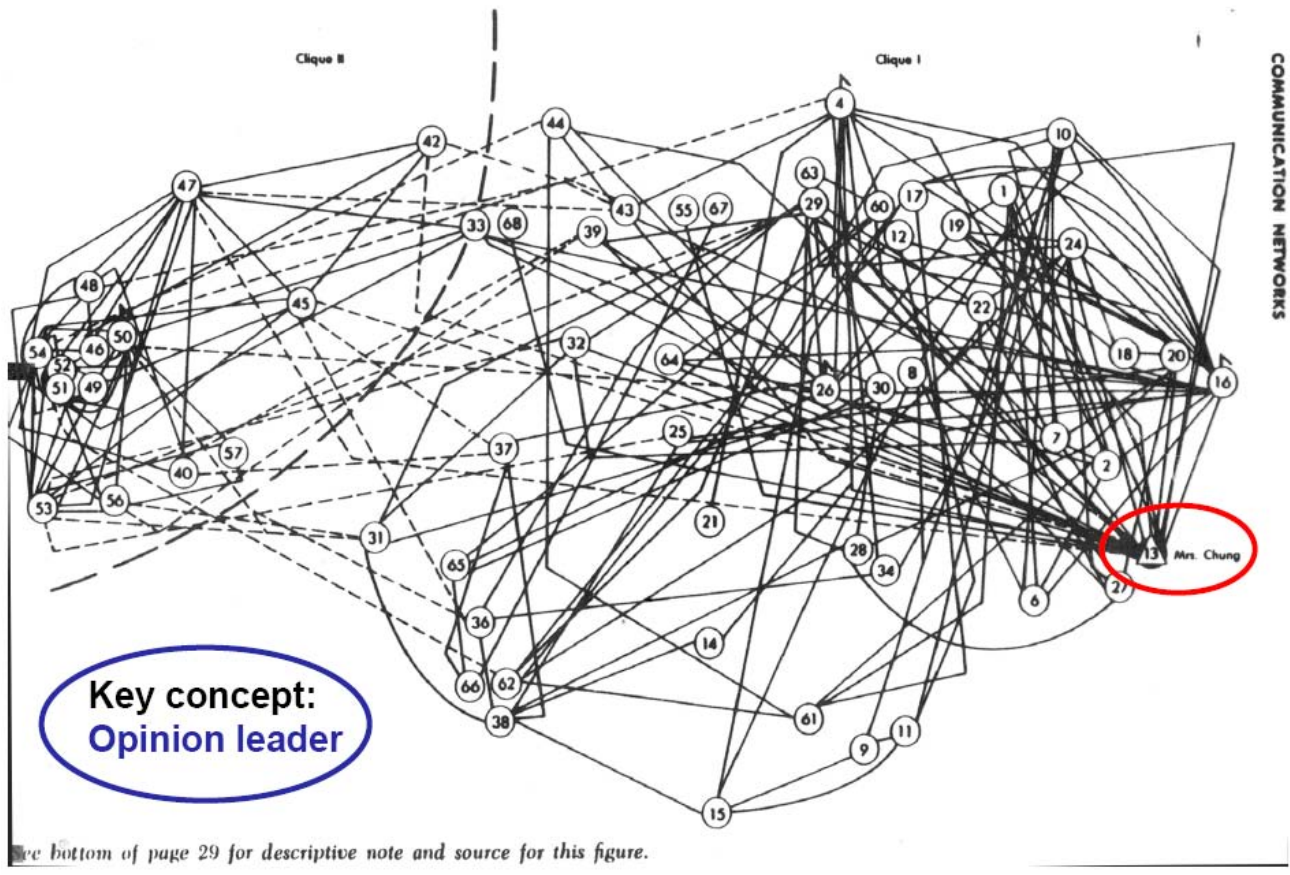
Application:

- Identify how audience thinks of the innovation
- Identify opinion leader in the network
- Identify messages that address concerns about the innovation
- Demonstrate what happens to others when they try the innovation

Social Network

22

Figure 1-2. Sociogram of the Communication Network for the Diffusion of Family Planning for 69 Women in Oryu Li.



A shift in thinking

23

**SOCIAL AND BEHAVIOR CHANGE
COMMUNICATION**

Shift in thinking

24

- Over the years, there has been a shift in thinking about behavior change communication:
 - Simply giving correct information – while important – does not change behavior by itself
 - Only addressing individual behaviors is often not enough either



Key facts about human behavior

25

1. People interpret and make meaning of information based on their own context
2. Culture, norms, and networks influence people's behavior;
3. People can't always control the issues that create their behavior; and,
4. People are not always rational in deciding what is best for their health and well-being.



SBCC has 3 characteristics:

26

- 1. SBCC is an interactive, researched and planned process**
- 2. SBCC requires a socio-ecological model for analysis to find the tipping point for change**
- 3. SBCC operates through three main strategies, namely**
 - a) advocacy,**
 - b) social mobilization, and**
 - c) behavior change communication**

Steps:

1. Understanding the Context through Situation & Communication Analysis
2. Focusing & Designing the Communication Strategy
3. Creating Interventions & Materials for Change
4. Implementing & Monitoring Change Processes
5. Evaluation & Replanning for Outcome and Sustainability

Characteristic 1. SBCC is a Process**C- Planning**

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

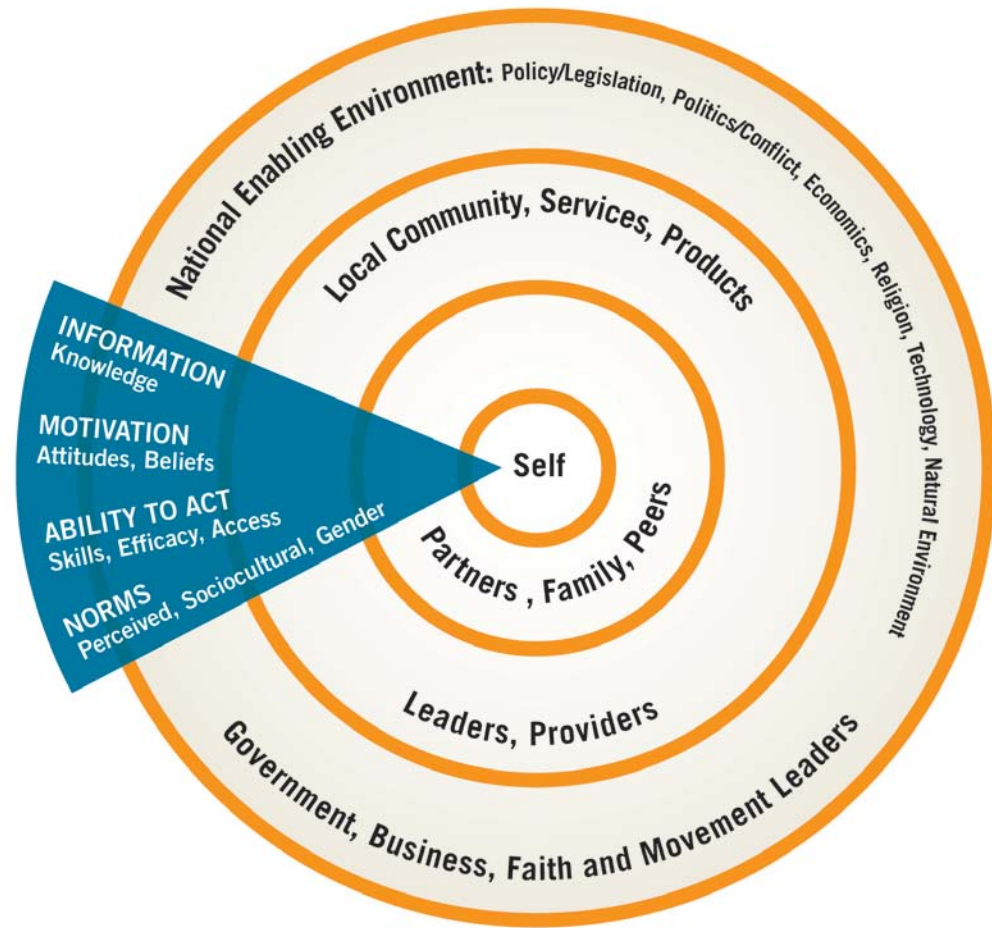
Levels of Analysis: Where is the tipping point for change?

- **Self:** Who is directly affected?
- **Partners, Family, Peers:** Who is directly influencing “self”?
- **Local Community, Services, Products & Leaders and Providers:** Who or what is directly influencing “self” at the local level?
- **National Enabling Environment & Leaders:** Who or what is indirectly affecting “self” at the national level?

Crosscutting Factors:

- **Information, Motivation, Ability to Act, and Norms:** How are these factors addressed across all levels?

Characteristic 2: SBCC Requires a Socio-Ecological Model



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

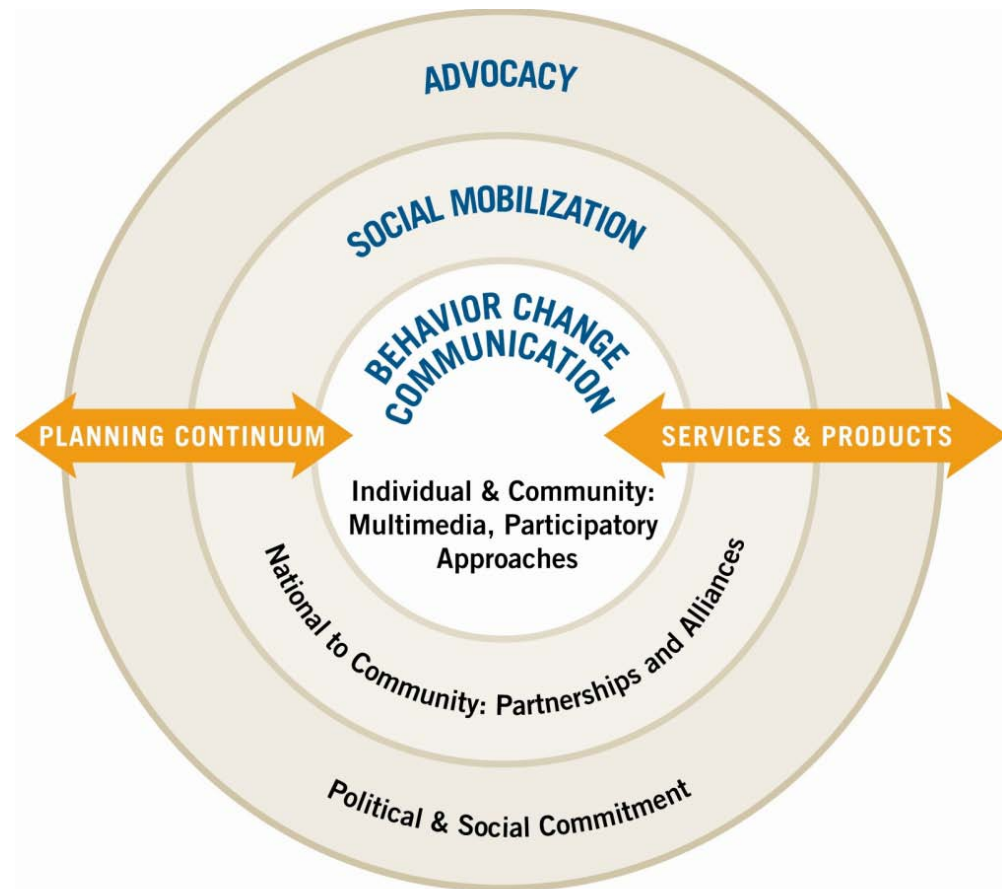
Analysis determines the mix of strategies:

Advocacy to raise resources & political/ social leadership commitment for change goals

Social Mobilization for wider participation, collective action and ownership, including community mobilization

Behavior Change Communication for changes in knowledge, attitudes and practices of specific audiences

Characteristic 3: SBCC Operates Through Three Key Strategies



SOURCE: Adapted from McKee, N. Social Mobilization and Social Marketing in Developing Communities (1992)

An ecological SBCC approach needs a broader theory base

30

For Advocacy and Mobilization, e.g.

- Agenda Setting and Framing
- Social Movement and Resource Mobilization Theory
- Social Network and Social Support Theory
- Empowerment Theory
- Integrated Model of Communication for Social Change

For BCC, e.g.

- Behavioral Economics
- Shaming Theory
- Social Convention Theory
- Culture Centered Approach
- Audience Perception/Attribution Theory
- Protection Motivation Theory

To find out how to apply these theories and approaches, go to *C-Modules: Introductory Module on page 27*

Effectiveness of communication

31

Effect of communication on behavior

32

Stover & Bollinger (2004)

- Analyzed types of HIV/AIDS interventions to estimate number of infections averted (USAID target: 7 million averted)
- Cost per person reached in 14 Emergency Fund countries

Mass media interventions

- 3rd highest impact
- 2nd highest cost-effectiveness

INTERVENTION CATEGORY	ESTIMATED INFECTIONS AVERTED	MEDIAN COST PER PERSON REACHED (\$)
Condom distribution	261,798	0.15
VCT	102,572	50.00
Mass Media	66,770	0.42
Blood Safety	35,147	5.20
PMTCT	27,877	414
Low Risk Populations	24,800	4.26
Medium Risk Populations	23,137	3.00
Youth Outreach	21,546	4.00
High Risk Populations: CSWs	11,351	101.00
STI Services	6,046	25
Youth In-School	1,908	6.00
Safe Injections	95	0.93

Evidence for SBCC as high impact practice for FP: a review of 49 articles, 1980-2009¹



- Strong association of **use** of contraceptives to communication program **exposure**
- Both **direct** and **indirect** exposure contributes to increased use of modern contraceptives
- Exposure to **multi-media** has a greater impact: increase in odds ratio from 1.6 to 10.2 by dose of exposure
- Mass media programs are found to be **cost effective**: cost per new adopter ranges from USD 1.57 to USD 17.72.

¹ Johns Hopkins Center for Communication Programs. SUMMARY REPORT: reviewing existing evidence on the contribution of communication interventions to increasing family planning use, January 2010.

Factors contributing to effectiveness

34

- Design based on locally defined needs
- Collaborate with local partners
- Involve local outreach workers
- Local funding
- Leadership of local decision makers
- Multiple channels of communication
- Entertainment-education formats
- Messages emphasized positive benefits vs. negative consequences of behavior

Conclusion

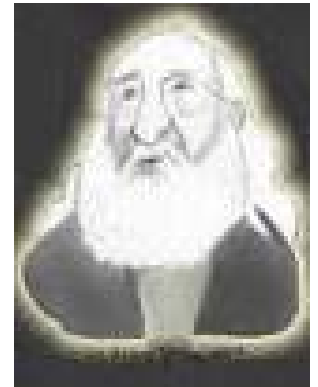
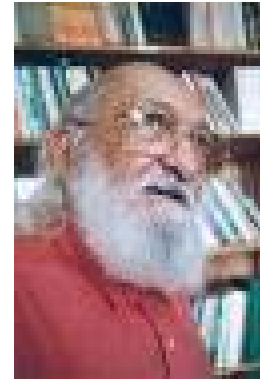
35

1. Theories are tools for creative thinking, not absolute truth or formulas for success
2. Use theories to check your **assumptions**
3. No one theory will explain every behavioral setting
4. The ecological SBCC model combines various theories
5. Creative and tailored use of models and theories increases the success of interventions

Famous last words

36

“Those who authentically commit themselves to the people must re-examine themselves constantly.”



“...they almost always bring with them the marks of their origin: Their prejudices and their deformations, which include a lack of confidence in the people’s ability to think, to want and to know.”

Paolo Freire, *Pedagogy of the Oppressed*, 1970

Glossary of Termsⁱ

A

Ability to act: a crosscutting factor. People need the ability to act in particular circumstances that pose a threat. Look at the actual skills and efficacy of the actors.

Access: ability of an individual or group to use a service e.g. use of health care services.

Activity: a specific event or action.

Advocacy: individual or collective action directed at influencing or changing policies and practices.

Allies: institutions, associations, spokespeople who can serve as a resource, usually on a short-term basis. Their support can be financial, technical, human or material.

Assets-based approach: an approach to community development that seeks to draw on the community's own strengths and resources for addressing concerns.

At risk group: a group of people sharing characteristics that put them at risk for and make them more likely to become infected than the general population.

Attitudes: personal dispositions towards a particular subject or situation; how we generally feel about a situation.

Audience segmentation: process of selecting an audience and learning everything about the audience including demographics, knowledge, attitudes, behavior, lifestyle, etc.

B

Barrier: a difficulty or obstacle that people face that can stop them performing desired behaviors to the problem you've identified.

Behavior change communication (BCC): evidence-based, consultative effort to address individual knowledge, attitudes, behaviors, and social norms in a strategic manner. BCC operates through various intervention types, namely mass media, interpersonal and community based.

Behavioral skills: the physical and psychosocial ability to behave in a particular way, e.g. negotiating use of condoms in sexual encounters.

Biomedical interventions: interventions in which the administration and use of medicines are key features.

C

C-Planning: Characteristic 1 of C-Change's SBCC Framework. It is a five-step interactive and researched process that includes understanding the situation, focusing and designing, creating, implementing and monitoring, and evaluating and replanning. All the steps of C-Planning draw on previous ones and contribute to subsequent ones.

Campaign: goal-oriented, recognizable attempt to inform, persuade or motivate change within the intended audiences; linked series of activities with mutually supportive messages.

Capacity strengthening: the process of increasing people's skills and knowledge in a particular area that enable them to build and use their own strength to solve problems. Capacity strengthening suggests that programs build on existing resources while capacity building suggests limited local capacity that needs to be built from scratch.

Catalytic interventions: interventions that are seen as important triggers in changing the course of the epidemic.

Channel: three categories of communication channels are interpersonal, community, and mass media. Interpersonal channels include one-on-one communication such as hotlines and counseling. Community channels reach a group of people within a distinct geographic area or reach a group that shares common interests or characteristics. Community-based media, community-based activities, and community mobilization are all examples of community channels. Mass media channels, which can reach large audiences quickly, can include television, radio, newspapers, magazines, outdoor/transit advertising, direct mail and social media.

Channel mix: the use of at least two or more different media in one communication campaign with the goal to increase intensity, reach, and frequency of its content to reach intended audiences. The three channels are interpersonal, community based, and mass media.

Cohort: a group of people sharing a common characteristic, e.g. females born in 1985, males who have never had sex, etc.

Communication objective: name SMART ways to address barriers to achieve desired change in policies, social norms, or behaviors. They are audience-specific and contribute to program objectives (see program objective definition).

Communication strategy: a comprehensive statement that guides and links decisions on intended audiences, communication objectives, channels and materials based on analysis and integrated by a strategic approach.

Community empowerment: process by which communities are enabled to assume leadership and exercise control over the processes and resources for their own transformation.

Community outreach: an organized series of activities within a specified area such as a town or village with the aim to extend interventions to the population in the area.

Community participation: process through which communities participate in determining their condition without necessarily controlling the process.

Community: a group united around a shared characteristic or concern or a group of people located in the same area.

Concept testing: a type of formative evaluation that involves systematically gathering intended audience reactions to creative concepts and “big ideas” that capture the essence of what you want to communicate to your intended audience before finalizing concepts and formats for pre-testing.

Contemplation: used in the stages of change theory to describe the period prior to adoption of a new behavior when one is thinking but not yet acting.

Creative Brief: is a short (one- or two-page) tool to guide the development of materials and activities.

Cross-cutting factors: are represented in the triangle of influence in the socio-ecological model. These factors are put into four large categories: information, motivation, ability to act, and norms which SBCC interventions may be able to modify to generate change.

D

Determinant: factor that cause changes e.g.; in behavior.

E

Ecological: in this context means the relationships between individuals and their environments.

Environment: the physical, emotional, or social contexts that shape individual attitudes and behaviors.

Epidemic: significantly high incidence of disease occurrence in a population.

Evaluation: a process that tries to determine as systematically and objectively as possible the worth or significance of an intervention. In this course, we focus on evaluating the outcomes of your SBCC efforts.

F

Focus group discussion: in-depth discussion in which a small group of people, usually 8 to 10, talk about a topic of common interest to all the participants. These group discussions take place under the guidance of a facilitator and are used to collect research data or test materials.

Formative research: research conducted during the planning process that allows program planners to obtain insight into, e.g.; the knowledge, attitudes, and practices of the situation. This research helps to form, plan and develop communication programs and determine audiences and strategies.

G

Gatekeepers: powerful individuals or groups that influence the environment that can inhibit or promote change (open or close the “gate”). They can be brought in as partners, or “neutralized” so as not to inhibit progress.

Gender analysis: methodologies for assessing the relative power of males and females in a given community.

Gender inequality: conditions under which men and women are systematically provided different access to resources for self determination such that one accrues unearned advantages over the other.

Gender roles: behaviors expected of males and females on the basis of their sex, not their abilities.

Gender: roles in societies that are considered appropriate and expected for men and women.

Generalized epidemic: HIV is firmly established such that sexual networking in the general population is sufficient to sustain the epidemic independent of sub-populations at higher risk of infection.

Goal: General statement that describes the result hoped for of a program (e.g., reduction of HIV incidence). Goals are achieved over the long term and through the combined efforts of multiple programs.

Group norm: established attitudes, patterns of thought and behaviors within a particular group.

I

Impact: long-term effects (e.g., changes in health status). This can be through special studies with wide district, regional, or national coverage.

Incidence: the number of new cases of infection within a specified period of time.

Indicator: clue, sign, and marker that show how close we are to our path and how much things are changing. The clue “indicate” possible changes in the situation that may lead to improved health status.

Informal communication: communication networks that fall outside of established systems for conveying information, e.g. information communicated over drinks at the bar or by the communal pipe stand.

Information: a crosscutting factors. People need information that is timely, accessible, and relevant. When looking at information consider the level of knowledge held by that person or group, e.g., about modern contraceptives and their side effects.

Information education communication (IEC): a communication strategy for influencing behavior which emphasizes information and education.

Input: resources going into conducting and carrying out the project or program. These could include staff, finance, materials, and time.

Institutional bias: official policy or established procedures that discriminate e.g. applications for loans are accepted from married males but not married females without the spouse's consent.

Interpersonal communication: face to face exchange of e.g.; information, education, motivation, or counseling.

Intervention: a set of complementary program activities designed to achieve program goals.

Inventory review: a methodical search for existing materials and activities developed by other programs, It can help put resources to good use by complementing or adapting rather than recreating what is already out there.

L

Learning: process of mastering or internalizing values, knowledge, skills through socialization, formal instruction or experience.

Levels of analysis: are the rings of the socio-ecological model and represent both domains of influence as well as people representing them at each level.

M

Maintenance: having to do with the ability of an individual to continue with a newly adopted behavior.

Media advocacy: the strategic use of mass media to advance social or political policy initiative.

Message: a brief, value-based statement aimed at an audience that captures a concept. Messages must be personally appealing and discuss only one/two key points. The information in the message should be new, clear, accurate, and complete, culturally appropriate, and include specific suggestions of what people can do.

Monitoring: a process of tracking or measuring what is happening. In this course we focus on monitoring two aspects of your SBCC activities: process and quality.

Motivation: a crosscutting factors. People require motivation often represented by attitudes and beliefs about the issues they are trying to change.

N

Norms: reflect the values of the group and specify those actions that are expected of the individual by its surrounding society as expressed in perceived norms, socio-cultural, and gender norms have considerable influence.

O

Objective: specific, operationalized statement detailing the desired accomplishments (includes communication and program objectives). A properly stated objective is action-oriented, starts with the word “to,” and is followed by an action verb. Objectives address questions of “what”, “when,” and “how much”, but not “why” or “how.” An objective is stated in terms of results to be achieved, not processes or activities to be performed.

Outcome: short-term or intermediate result and change in your population/community that are obtained by program through the execution of activities.

Output: immediate result obtained by the program through the execution of activities (e.g., number of commodities distributed, number of staff trained, number of people reached, or number of people served). Good process monitoring of outputs from activities (if mutually supportive) can lead to program outcomes and hopefully have impact!

P

Participation: playing an active and meaningful role in decisions that affect one’s interest.

Partners: any group, formal or informal, with whom you might work long term to make your effort a success overall.

Perceived barrier: belief or perception that there are negative consequences associated with a contemplated change.

Perceived benefit: the belief that there are benefits or positive outcomes associated with changing a current action or situation.

Perceived risk: belief or perception that one is likely to fall victim to a particular illness if prevailing conditions remain unchanged. This also referred to as risk perception.

Perceived vulnerability: recognition that current situation places one at risk of infection.

Popular education: education that employs simple, learner-centered methods and is aimed at broadening people's understanding of factors which affect their lives.

Positioning (in the context of strategic design): presenting an issue, service, or product in such a way that it stands out from others, is appealing, and is persuasive. Positioning creates a distinctive and attractive image which may be turned into a logo.

Positioning statement: describes how a proposed changed will be seen in the minds of the audience. It is not a catchy slogan, but rather provides direction for message design.

Pretesting: a type of formative evaluation that involves systematically gathering intended audience reactions to messages and materials before the messages and materials are produced in final form.

Prevalence: the proportion of persons in a population who have a particular disease or condition.

Problem statement: succinct summary of what is discovered during the situation analysis that helps programmers clearly see what is happening so that they can focus attention where it will make a difference.

Process: set of activities in which program resources are used to achieve the results expected from the program (e.g., number of workshops or number of training sessions).

Program objective: the specific outcome that you expect your entire program to achieve. It is broader than a communication objective, but must also specify an outcome.

Q

Qualitative method: help build an in-depth picture among a relatively small sample of people on a specific issue. They reveal in more detail how people perceive their own situation and problems, why and what their priorities are. Questions are asked in an open-ended way and the findings are usually

analyzed as data is collected. Information gathered should not be described in numerical terms, and generalization about the intended audience cannot be made. It is a useful tool for exploring reactions and uncovering additional ideas, issues, or concerns..

Quantitative method: things are either measured or counted, or questions are asked according to a defined questionnaire so that the answers can be coded and analyzed numerically by asking a large number of people identical (and predominantly close ended) questions. If the respondents are a representative random sample, quantitative data can be used to draw conclusions about the intended audience as whole. Quantitative research is useful for measuring the extent to which knowledge, attitudes, or behaviors are prevalent in an intended audience. .

R

Reinforcement: information, actions or 'rewards' which encourage adoption or continuation of a particular behavior.

Risk factor: conditions associated with increased likelihood of a particular disease or condition, e.g. individual behaviors, lifestyle, environmental exposure or hereditary characteristics.

Risk: increased probability of being affected.

Role model: someone who is respected and revered such that one patterns ones behavior from their example.

S

Segmenting: dividing and organizing an audience into smaller groups who have similar communication-related needs, preferences, and characteristics.

Self-efficacy: the belief and confidence in one's ability to do something successfully.

Sequencing: the order in which activities are implemented.

Sex: biological and physiological characteristics that define what men's and women's body physically are able to do.

Situation analysis: a systematic review of social, cultural, political and behavioral data aimed to identify internal and external determinants of a situation, such as immediate and underlying cause and effects.

SMART (objectives): specific, measurable, attainable, realistic, time-bound

Social behavior change communication (SBCC): looks at the role communication has in bringing about social change including policy, norm and individual behavior change by finding an effective tipping point for change.

Social behavior change communication (SBCC) framework: lays out the three characteristics of SBCC that the C-Modules and C-Change use. It requires an interactive, researched, and planned process; C-Planning; a socio-ecological model for analysis to find the tipping point for change; and operates through three key strategies --advocacy, social mobilization, and behavior change communication.

Social change intervention: activities directed at changing conditions within the social environment.

Socio-ecological model for change: Characteristic 2 of C-Change's SBCC framework. It views individual behavior as a product of multiple overlapping individual, social, and environmental influences. This model helps to combine individual change with the aim to influence the social context in which the individual operates.

Social learning: learning that comes about as a result of socialization and observation of social norms –usually passive and unconscious.

Social marketing: application of commercial marketing techniques for consumerism to the promotion of health behaviors.

Social mobilization: process of partnership building among inter-sectoral institutions, groups, networks, and communities to determine and raise demand for a certain issue. Coalition building can happen at national, regional or community level. It uses community mobilization as well as interpersonal communication to create a critical mass and strengthen self-reliance and sustainability of achievements.

Social norms: dominant beliefs and standards about what is normal and acceptable is a society.

Social skills: the ability to successfully negotiate acceptance of one's behaviors by one's peer group or society at large.

Social support: stated and unstated approval of ones behavior by the society or peer groups in which one operates.

Stakeholder: a person or group whose interests are affected by the outcome of an intervention.

Stereotype: an assumption about an entire group based on limited exposure to that group.

Stigma: the dishonoring, shaming, disgracing and discriminating against an individual on the basis of a single characteristic, e.g. homelessness, HIV infection, commercial sex work.

Strategic approach: the way you decide to package or frame what you are doing into a single recognizable program or campaign. The strategic approach is one of the most important elements in a communication strategy because it drives the program-it tells you how the communication objectives work together to create change or is a platform holding together your different channels and activities.

Strategic gender needs: legal and social conditions needed to create equality between women and men.

Strategy outline: a document that contains a summary of analysis, communication strategy, implementation plan, and monitoring plan.

Strategy: a coordinated and comprehensive set of activities aimed at achieving an objective.

Susceptibility: individual, group and general social *predisposition* to infection. This concept may be applied at any level, from an entire society or country to a household. Thus, individuals, nations, and societies are more or less susceptible to infection, and the speed and extent of the spread of HIV will be determined by the susceptibility.

Synergy: the added benefit you get from activities or materials which enhance each other.

T

Three key strategies: characteristic 3 of the SBCC framework which includes an appropriate mix of the following strategies to address change at all levels of the Socio-Ecological Model. These key strategies are mutually reinforcing: advocacy, social mobilization and behavior change communication.

Tipping point: can be a naturally occurring event or a strong determinant for change, such as political will that can provide the final energy to “tip over” a situation to change.

Tools: any instrument (e.g. worksheet, checklist, or graphic) that assists or guides practitioners in the understanding and application of concepts in their programmatic work.

Trend: a pattern in frequencies of disease incidents or prevalence over time, within or across various subgroups.

V

Values: deeply held feelings/beliefs that shape our choices and behaviors.

Vulnerability: those features within a society/community that make it more or less likely that its members will be disproportionately impacted by an adverse condition –like HIV and AIDS; vulnerability analysis focuses on political, social, cultural and economic factors influencing health behavior.

ⁱ Adapted from:

- International HIV/AIDS Alliance/International Council of AIDS Service Organizations. Without Date. *Advocacy in action: A toolkit to support NGOs and CBOs responding to HIV/AIDS*. Brighton: Progression.
- O'Sullivan, Gael, Joan Yonkler, Win Morgan, and Alice Payne Merritt. 2003. *A field guide to designing a health communication strategy*. Baltimore: Johns Hopkins Bloomberg School of Public Health/Center for Communications Programs.
- National Cancer Institute. 2001. *Making health communication programs work. A planner's guide*. Bethesda: National Institutes of Health.
- Becker, Antje. 1998. *Community health communication: Guidelines through the maze of IEC methods*. Germany: GTZ

Supplemental Readings

References in Facilitator Preparation

Caroselli, Marlene. 1998. *Great openers, closers, and energizers*. New York: McGraw Hill.

Organized into three sections (openers, closers, and energizers), this book offers 100 ideas that can spark your own creative juices on how to design a short activity to open, close or energize your group.

International HIV/AIDS Alliance. 2002. *100 ways to energise groups: Games to use in workshops, meetings and the community*. Brighton: Progression.

Games to Use in Workshops, Meetings and the Community is one in a series of resources that the Alliance is developing to encourage participation in practice. It is a compilation of energisers, icebreakers, and games that can be used by anyone working with groups of people, whether in a workshop, meeting or community setting.

<http://www.aidsmap.com/en/docs/pdf/Energisers2002%28English%29.pdf>

Kaner, Sam, Lenny Lind, Catherine Toldi, Sarah Fisk, and Duane Berger. 2007. *Facilitator's guide to participatory decision-making*. 2nd ed. San Francisco: Jossey-Bass.

This handbook provides tools to facilitate workshops in a participatory manner. It provides insights into group dynamics and group work.

McKee, Neil, Maruja Solas, and Hermann Tillmann. 1998. *Games and exercises: A manual for facilitators and trainers involved in participatory group events*. New York: UNICEF.

A book full of games and exercises grouped around areas, such as team building, conflict management, gender analysis, creativity or evaluation.

<http://www.unssc.org/web/images/downloads/Games%20&%20Exercises%20VIPP%20UNICEF.pdf>

Salas, Maria, Hermann Tillmann, Neill McKee, and Nuzhat Shahzadi. 2007. *VIPP: Visualisation on participatory programmes: How to facilitate and visualise participatory group processes*. Dhaka, Bangladesh: UNICEF.

This is the only text of its kind, containing all you need to know about the VIPP process, with very helpful guidelines that are generalizable to various aspects of learning-centered facilitation.

Information available at <http://www.southbound.com.my/vipp>

Schwarz, Roger. 2002. *The skilled facilitator*. Revised ed. San Fransisco: Jossey-Bass.

A comprehensive resource to build facilitation skills for workshops, meetings, organizational situations, and more.

Vella, Jane. 2002. *Learning to listen, learning to teach: The power of dialogue in educating adults*. Revised ed. San Francisco: Jossey-Bass.

This is the quintessential text on Dialogue Education. Reading more like a novel than a text, it offers practical, universally applicable approaches to adult learning. Vella draws on her own life experiences as an adult educator to reveal basic principles that transcend cultural differences.

Readings in Module 0 – Introduction

King, Rachel. 1999. *Sexual behavioural change for HIV: Where have theories taken us*. Geneva: UNAIDS.

Provides a brief overview of theoretical models of behavioral change, a review of key approaches used to stem sexual transmission of HIV, a summary of successful interventions targeting specific populations at risk, and a discussion of remaining challenges.

http://www.who.int/hiv/strategic/surveillance/en/unaid99_27.pdf

Rimer, Barbara and Karen Glanz. 2005. *Theory at a glance. A guide for health promotion practice*. 2nd ed. Washington, DC: National Cancer Institute.

Provides information and examples of influential theories of health-related behaviors, the processes of shaping behaviors, and the effects of community and environmental factors on behavior.

<http://www.nci.nih.gov/PDF/481f5d53-63df-41bc-bfaf-5aa48ee1da4d/TAAG3.pdf>

Policy Project. 2003. *Moments in time: HIV/AIDS advocacy series*. Washington, DC: USAID.

This manual highlights some advocacy moments of many of the HIV/AIDS global advocacy efforts from the perspective of those involved. The manual is intended to be flexible and used as a companion to other trainings.

<http://www.policyproject.com/stories/>

CARE. 2007. *Inner spaces outer faces initiative (ISOFI) toolkit: Tools for learning and action on gender and sexuality*. Washington, DC: CARE/ICRW

This toolkit is based off of the experiences of CARE staff under the ISOFI project. It is meant to guide staff and organizations in development and health fields to understand gender and sexuality and its relationship to reproductive health.

<http://www.careacademy.org/health/isofi/Welcome/Welcome%20to%20ISOFI.pdf>

O'Sullivan, Gael, Joan Yonkler, Win Morgan, and Alice Payne Merritt. 2003. *A field guide to designing a health communication strategy*. Baltimore: Johns Hopkins Bloomberg School of Public Health/Center for Communications Programs.

Provides practical guidance to those who are in a position to design, implement, or support a strategic health communication effort with an emphasis on developing a comprehensive, long-term approach to health communication that responds appropriately to audience needs.

<http://www.jhuccp.org/pubs/fg/02/index.shtml>

National AIDS Coordinating Agency and African Comprehensive HIV/AIDS Partnership. 2005. *Behaviour change interventions and communications. A learner-driven training programme piloted in Botswana*. Botswana: ACHAP.

A 10-module course includes assignments, readings, and worksheets on a full range of BCIC subtopics. Participants work through issues such as HIV and AIDS and National Response, research tools, communication strategies, and monitoring plans. Includes assignments on gender, including explanations of key concepts in gender education, gender analysis, and gender equity promotion.

Additional Readings for Module 0 - Introduction

Chen, Peter. 2006. *Planning BCC interventions: A practical handbook*. Bangkok: UNFPA CST Bangkok.

A practical handbook in response to the needs of UNFPA to help their colleagues and partners to plan and implement effective BCC strategies in support of RH, ARH, and HIV and AIDS prevention.

<http://67.59.173.161/cst4/docs/bkbcchandbook.pdf>

International HIV/AIDS Alliance. 2001. *A facilitator's guide to participatory workshops with NGO's/CBOs responding to HIV/AIDS*. Brighton: Progression.

To support people who facilitate participatory workshops with NGOs and CBOs responding to HIV and AIDS in developing countries. It is based on the practical experiences of the International HIV/AIDS Alliance (aka, the Alliance).

http://www.aidsalliance.org/includes/Publication/fge1101_Facilitators_guide_eng.pdf

Linkages Project. 2004. *Behavior change communication for improved infant feeding: Training of trainers for negotiating sustainable behavior change*. Washington, DC: Academy for Educational Development.

The purpose of this course is to train community health workers in behavior change communication (BCC) skills to improve infant feeding, and to train trainers of community health workers to deliver training on behavior change communication related to infant feeding.

http://www.globalhealthcommunication.org/tool_docs/22/bcc_and_if.pdf

Medical Care Development International/The Academy for Educational Development. 2008. *HIV/AIDS capacity building and technical assistance field Training for behavior change communications*. Washington, DC: Academy for Educational Development.

This manual is designed for use by behavior change communications trainers in Lesotho to deliver a revised BCC strategy. It is designed for a 3-day training with a 2-day refresher course after 1 month to prepare trainees (e.g., health care professionals, community activists, and government officials) to develop BCC interventions at the community level.

ADDITIONAL RESOURCES

O'Sullivan, Gael, Joan Yonkler, Win Morgan, and Alice Payne Merritt. 2003. *A field guide to designing a health communication strategy*. Baltimore: Johns Hopkins Bloomberg School of Public Health/Center for Communications Programs.

The purpose of this strategic communication field guide is to provide practical guidance to those who are in a position to design, implement, or support a strategic health communication effort. The emphasis of the guide is on developing a comprehensive, long-term approach to health communication that responds appropriately to audience needs.

<http://www.jhuccp.org/pubs/fg/02/index.shtml>

Roberts, Ann, Reynaldo Pareja, Will Shaw, Barbara Boyd, Elizabeth Booth, and Jose Ignacio Mat. 1995. *A toolbox for building health communications capacity*. Washington, DC: Academy for Educational Development/USAID

This comprehensive toolkit is structured so that people can read and use it without a facilitator, but it can also serve as a guide to a facilitated learning process.

<http://www.globalhealthcommunication.org/tools/29>

The Global HIV Prevention Working Group. 2008. *Behavior change and HIV prevention: (Re)considerations for the 21st century*. n.p: The Global HIV Prevention Working Group.

This report is based on a comprehensive review of hundreds of studies of behavior change for HIV prevention. It finds that the evidence base for behavioral HIV prevention is robust, with multiple studies documenting the effectiveness of interventions in numerous settings, among diverse populations, and throughout the course of the epidemic.

http://www.globalhivprevention.org/pdfs/PWG_behavior%20report_FINAL.pdf

Readings in Module 1 – Understanding the Context

McKee, Neill, Erma Manoncourt, Chin Saik Yoon, and Rachel Carnegie. 2000. *Involving people: Evolving behavior*. Penang: Southbound/UNICEF.

Why do people behave as they do? This book provides theories and frameworks for creating an enabling environment, including policy and legislation, service provision, education systems, cultural factors, religion, socio-political factors, and behavior and beyond—an evaluation perspective.

International HIV/AIDS Alliance/International Council of AIDS Service Organizations. Without Date. *Advocacy in action: A toolkit to support NGOs and CBOs responding to HIV/AIDS*. Brighton: Progression.

This toolkit aims to assist NGOs/CBOs to gain a clear understanding of what advocacy is and how it might support their work, and provides practical assistance to undertake advocacy.

http://www.aidsalliance.org/includes/Publication/adv0602_Advocacy_toolkit_eng.pdf

Anyaegbunam, Chike, Paolo Mefalopulos, and Titus Moetsabi. 2004. *Participatory rural communication appraisal: A handbook*. Rome: FAO.

This handbook describes the procedures for planning and conducting PRCA as the first step in the design of cost-effective and appropriate communication programmes, strategies, and materials for development projects.

<ftp://ftp.fao.org/docrep/fao/008/y5793e/y5793e00.pdf>

Mamimine, Patrick, Sara Page, and Lois Chingandu. 2008. *Inter-linkages between culture, GBV, HIV and AIDS and women's rights*. Harare, Zimbabwe: SAfAIDS/Oxfam International.

This training manual explores theories on culture and its relationship with gender-based violence. This training manual explores these ideas and provides an analytical model to use when considering interventions related to culture, GBV, women's rights, and HIV and AIDS.

http://www.safaids.net/files/GBV_manual.pdf

Soul City Institute for Health and Development Communications. 2003. *Qualitative target audience formative research for health and development communication: Soul city fieldworker training manual 1 – Qualitative interviewing*. Johannesburg: Soul City Institute for Health and Development Communications.

Developed to support skills training in qualitative interviewing and provides instruction for conducting qualitative formative audience research.

Document available by writing to Soul City Institute for Health and Development Communications. P.O. Box 1290. Houghton 2041. Johannesburg, South Africa.

Wilson, David. 2001. *HIV/AIDS rapid assessment guide*. Arlington: Project Support Group/Family Health International.

Consists of five prevention tools: a mapping guide, a site inventory, an ethnographic guide, a focus group guide, and rapid behavioral surveys, which can be used to collect data that provide a spatial, quantitative, and qualitative overview of a project area

<http://www.fhi.org/en/HIVAIDS/pub/guide/RapidAssessmentGuide/index.htm>

Wallace-Karenga, Katrina, Lois Chingandu, Sara Page, and Rouzeh Eghtessadi, eds. 2009. *Mainstreaming HIV, AIDS and gender into culture: A community education handbook*. Harare, Zimbabwe: SFAIDS.

This resource is meant to support and encourage discussion about how people behave together and cope with HIV. Its purpose is to bring understanding of how culture can affect the spread of HIV. Part 2 of the handbook looks specifically at how culture, gender, and HIV are connected.

http://www.safaids.net/files/Mainstreaming_HIVgender_intoculture_handbook_Part_1.pdf (Part 1)

http://www.safaids.net/files/Mainstreaming_HIVgender_intoculture_handbook_Part_2.pdf (Part 2)

Additional Readings for Module 1 – Understanding the Situation

Rimer, Barbara and Karen Glanz. 2005. *Theory at a glance. A guide for health promotion practice*. 2nd ed. Washington, DC: National Cancer Institute.

Provides information and examples of influential theories of health-related behaviors, the processes of shaping behaviors, and the effects of community and environmental factors on behavior.

<http://www.nci.nih.gov/PDF/481f5d53-63df-41bc-bfaf-5aa48ee1da4d/TAAG3.pdf>

Readings in Module 2 – Focusing & Designing

Salem, Ruwaida, Jenny Bernstein, and Tara Sullivan. 2008. *Tools for behavior change communication. INFO Reports 16: 1-8.* This publication is a companion piece to “Communication for Better Health. Series J, No. 56.”

This publication has a series of tools to assist with planning and developing a BCC component in family planning programs.

<http://info.k4health.org/inforeports/BCCTools/BCCTools.pdf>

O’Sullivan, Gael, Joan Yonkler, Win Morgan, and Alice Payne Merritt. 2003. *A field guide to designing a health communication strategy.* Baltimore: Johns Hopkins Bloomberg School of Public Health/Center for Communications Programs.

This guide shares a set of steps and tools to help ensure that BCC efforts are developed strategically, with participation from all stakeholders. Its primary audiences are program managers in developing countries who are responsible for designing and implementing health programs, communication specialists, policymakers, and representatives of funding agencies.

<http://www.jhuccp.org/pubs/fg/02/index.shtml> (Longer version)

Howard-Grabman, Lisa, and Gail Snetro. 2003. *How to mobilize communities for health and social change.* Baltimore: Johns Hopkins Bloomberg School of Public Health/Center for Communication Programs.

This guide is designed for use by health program directors and managers of community-based programs who are considering using communication mobilization at the individual, family, and community levels.

<http://jhuccp.org/node/1256>

Zambesi, Rose, and Juan Hernandez. 2006. *Engaging communities in youth reproductive health and HIV projects: A guide to participatory assessments.* Arlington: Family Health International.

Provides guidelines for carrying out participatory assessments with young adult community members and outlines how various tools and methods that can be applied.

<http://www.care.org/careswork/whatwedo/health/downloads/PLAguide.pdf>

Sharma, Ritu. 1997. *An introduction to advocacy: Training guide.* Washington, DC: Academy for Educational Development.

Introduces the concept of advocacy and provides a framework for developing an advocacy campaign. It is designed primarily for use in training sessions, but can also be used as a self-teaching device.

<http://www.globalhealthcommunication.org/tools/15>

Price, Leigh, Patrick Mamimine, and Lois Chingandu. 2009. *Changing the river’s flow series: Zimbabwean stories of “best practice” in mitigating the HIV crisis through a cultural and gender perspective.* n.p.: SAfAIDS/Oxfam International.

A collection of best practices from six CBOs in Zimbabwe who implemented innovative strategies and approaches in gender programming through a culture lens.

<http://www.safaids.net/files/Changing%20river%20Best%20Practice.pdf>

ADDITIONAL RESOURCES

AfriComNet/Johns Hopkins University Center for Communication Programs. 2006. *A Training of trainer's on strategic communication and HIV and AIDS: Facilitator's guide*. Kampala, Uganda: AfriComNet.

This guide is designed to assist in facilitating a five-day training on the following topics: basics of HIV and AIDS strategic communication, HIV and AIDS stigma and discrimination, research, M&E for HIV and AIDS communication programs, utilization of demographic and health surveys for health programming, applied skills in HIV communication and counseling, and community mobilization for health and development.

<http://www.africomnet.org/pub/tot/index.php>-

The CORE Group. 2005. *Designing for behavior change*. Washington, DC: CORE Group.

It is designed as six-day training to build the capacity of NGO staff to plan, implement, monitor, and evaluate effective behavior change strategies.

http://www.coregroup.org/storage/documents/Workingpapers/dbc_curriculum_final_2008.pdf

Additional Readings for Module 2 – Focusing & Designing

AIDS Control and Prevention (AIDSCAP). n.d. *How to create an effective communication project*. Arlington: Family Health International.

This handbook is designed to guide users through the development of effective behavior change communication interventions using a strategy developed by AIDSCAP.

<http://www.fhi.org/en/HIVAIDS/pub/guide/BCC+Handbooks/effectivecommunication.htm>

Weiss, William, and Pat Bolton. 2000. *Training in qualitative research methods for PVOs and NGOs (and counterparts)*. Baltimore: The Johns Hopkins University Bloomberg School of Public Health/Center for Refugee and Disaster Studies.

A set of training manuals (a trainer's guide and a participant's manual) designed to promote the systematic use of qualitative methods by PVOs and NGOs to help plan and manage community health programs.

http://www.jhsph.edu/refugee/publications_tools/publications/qualresearchtrain.html (Curriculum)

http://www.jhsph.edu/refugee/publications_tools/publications/qualresearch.html (Participant Resources)

Readings in Module 3 – Creating

National Cancer Institute. 2001. *Making health communication programs work. A planner's guide*. Bethesda: National Institutes of Health.

This guide offers a practical overview to the health communication process and delves into the following four stages: planning and strategy development, developing and pre-testing concepts, messages, and materials; implementing the program; and assessing effectiveness/making refinements.

http://www.cancer.gov/PDF/41f04dd8-495a-4444-a258-1334b1d864f7/Pink_Book.pdf

Salem, Ruwaida, Jenny Bernstein, Tara Sullivan, and Robert Lande. 2008. *Communication for better health*. Population Reports Series J, No. 56: 1-28.

This publication discusses how managers of family planning programs can build effective behavior change communication programs.

<http://www.populationreports.org/j56>

Policy Project. 1999. *Networking for policy change: An advocacy training manual*. Washington, DC: The Futures Group.

This manual was prepared to assist NGOs and other organizations considering work in advocacy to develop effective advocacy skills, especially in family planning and reproductive health.

AIDSCAP. n.d. *How to conduct effective pretests*. Arlington: Family Health International.

The goal of this handbook is to assist field-level planners and implementers in designing and conducting simple, effective pretests of BCC materials for HIV/AIDS prevention.

<http://www.fhi.org/en/HIVAIDS/pub/guide/BCC+Handbooks/effectivepretests.htm>

National Cancer Institute. 2003. *Clear & simple: Developing effective print materials for low-literate readers*. Washington, DC: National Institutes of Health.

This publication provides tools and guidance to develop print materials for low-literacy groups. It provides step-by-step guidance for the concept development, material development, and pretesting.

Additional Readings in Module 3 – Creating

Rimer, Barbara and Karen Glanz. 2005. *Theory at a glance. A guide for health promotion practice*. 2nd ed. Washington, DC: National Cancer Institute.

Provides information and examples of influential theories of health-related behaviors, the processes of shaping behaviors, and the effects of community and environmental factors on behavior.

<http://www.nci.nih.gov/PDF/481f5d53-63df-41bc-bfaf-5aa48ee1da4d/TAAG3.pdf>

Readings in Module 4 – Implementation and Monitoring

Russell, Nancy, Kristina Gryboski, Meredith Miller Vostrejs, and Angela Nash-Mercado. 2004. *Igniting change! Capacity-building tools for safe motherhood alliances*. Baltimore: JHPIEGO.

The purpose of these tools is to foster communication and collaboration among all levels of safe motherhood stakeholders. The tools emphasize strengthening group processes, building capacity for the linkages between diverse stakeholders, and helping stakeholders work as a team to advocate for safe motherhood.

<http://www.jhpiego.jhu.edu/resources/pubs/mnh/ICtools.pdf>

Y-PEER Programme. 2006. *Performance improvement: A resource for youth peer education managers*. Arlington: Family Health International.

This publication will be useful even if the organization has not yet identified severe or even moderate performance problems; successful managers recognize that there is always room for improvement. Likewise, peer educators themselves should be regularly updated in order to do their best work, as should the systems that support these peer educators.

<http://www.fhi.org/NR/rdonlyres/eegzejwh556pyosky4ofygjr5movetmchc5hggfuu0567yensje6gjbydtu5cd7iqwoex3etjnucl/Performanceenyt1.pdf>

International HIV/AIDS Alliance. *Raising funds and mobilizing resources for HIV/AIDS work*. Brighton: Progression.

This toolkit introduces an approach to planning and carrying out resource mobilization strategically and systematically to ensure that maximum returns are gained for the least effort, and that NGOs/CBOs remain true to their missions.

http://www.aidsalliance.org/graphics/NGO/documents/english/415a_Alliance_mobilising_resources.pdf

CARE. 2007. *Inner spaces outer faces initiative (ISOFI) toolkit: Tools for learning and action on gender and sexuality*. Washington, DC: CARE/ICRW

This toolkit is based off of the experiences of CARE staff under the ISOFI project. It is meant to guide staff and organizations in development and health fields to understand gender and sexuality and its relationship to reproductive health.

<http://www.careacademy.org/health/isofi/Welcome/Welcome%20to%20ISOFI.pdf>

Finn, Theresa. 2007. *A guide for monitoring and evaluating population-health-environment programs*. Chapel Hill, NC: MEASURE Evaluation/USAID.

The overall objective of this guide is to encourage program monitoring and evaluation and improve the quality of work in the population-health environment area. The guide provides a listing of the most widely used M&E indicators for population-health-environment programs.

<http://www.cpc.unc.edu/measure/tools/other-health-related-programs/me-of-phe-programs/a-guide-for-monitoring-and-evaluating-population/?searchterm=A%20Guide%20for%20Monitoring%20and%20Evaluating%20Population-Health-Environment%20Programs>

UNAIDS. 2005. *Monitoring the declaration of commitment on HIV/AIDS: Guidelines on construction of core indicators*. Geneva: USAID.

This document provides key constituents, who are actively involved in an individual country's response to HIV and AIDS, with essential information on core indicators that measure the effectiveness of the national response.

http://data.unaids.org/Publications/IRC-pub06/jc1126-coreindicatorsmanual-2005_en.pdf

IMPACT Project. 2004. *Monitoring HIV/AIDS programs: A facilitator's training guide and participant resources*. Arlington: Family Health International.

This training package is designed to build skills for conducting monitoring and evaluation (M&E) activities. Three core modules anchor the course: Introduction to M&E; Collecting, Analyzing and Using Monitoring Data; and Developing an M&E Work Plan. In addition, The course features seven program specific modules designed including one on Behavior Change Communication.

<http://www.fhi.org/en/HIVAIDS/pub/guide/meprogramguide.htm>

Additional Readings in Module 4 – Implementing and Monitoring

AIDSTAR-One. 2009. *Integrating multiple gender strategies to improve HIV and AIDS interventions: A compendium of programs in Africa*. Washington, DC: ICRW/USAID.

This publication is a compendium of global programs' efforts to integrate various gender strategies to improve HIV and AIDS interventions.

http://www.aidstar-one.com/sites/default/files/Gender_compendium_Final.pdf

IMPACT Project. 2004. *Monitoring HIV/AIDS programs: A facilitator's training guide and participant resources*. Arlington: Family Health International.

This training package is designed to build skills for conducting monitoring and evaluation (M&E) activities. The course consists of three core modules: Introduction to M&E; Collecting, Analyzing and Using Monitoring Data; and Developing an M&E Work Plan.

<http://www.fhi.org/en/HIVAIDS/pub/guide/meprogramguide.htm>

USAID. 2002. *Expanded response guide to core indicators for monitoring and reporting on HIV/AIDS programs*. Washington, DC: USAID.

An expanded monitoring and evaluation system to provide information on the national and USAID programs levels will be implemented, with first priority given to rapid scale-up and intensive focus countries.

<http://www.usaid.gov/policy/ads/200/200sbk.pdf>

Winch, Peter, Jennifer Wagman, Rebecca Malouin, and Garrett Mehl. 2000. *Qualitative research for improved health programs: A guide to manuals for qualitative and participatory research on child health, nutrition, and reproductive health*. Baltimore: Johns Hopkins University Bloomberg School of Public Health.

This guide is designed for program managers, researchers, funders of health programs, and others who are considering using qualitative research methods to help them design more effective health programs and/or evaluate the strengths and weaknesses of existing programs.

http://globalhealthcommunication.org/tool_docs/67/qualitative_research_for_improved_health_programs_-_a_guide_.pdf

Readings in Module 5 – Research, Monitoring and Evaluation

IMPACT Project. 2004. *Monitoring HIV/AIDS programs: A facilitator's training guide and participant resources*. Arlington: Family Health International.

This training package is designed to build skills for conducting monitoring and evaluation (M&E) activities. Three core modules anchor the course: Introduction to M&E; Collecting, Analyzing, and Using Monitoring Data; and Developing an M&E Work Plan. In addition, the course features seven program-specific modules, including one on Behavior Change Communication.

<http://www.fhi.org/en/HIVAIDS/pub/guide/meprogramguide.htm>

Chapman, Jennifer, and Amboka Wameyo. 2001. *Monitoring and evaluating advocacy: A scoping study*. Johannesburg: ActionAid.

This Scoping Study sets out to document the various frameworks and approaches that international agencies are using to assess the value of their advocacy work. The report draws on a large body of literature as well as, where possible, first-hand interviews and discussions. The report does not attempt to evaluate the various frameworks. It sets out to draw together a body of knowledge without passing judgment on the merits or demerits of various approaches.

http://www.g-rap.org/docs/monitoring_and_evaluation/Chapman-Wameyo%202001%20M&E%20on%20Advocacy.pdf

Horizons Project. 2008. *Horizons operations research on HIV/AIDS toolkit*. Population Council. <http://www.popcouncil.org/horizons/ORToolkit/index.htm>

In this online toolkit, you will find the tools and information you need to design a successful HIV-related operations research or study, from developing the research protocol to analyzing and reporting on results.

Ullin, Pricilla, Elizabeth Robinson, and Elizabeth Tolley. 2002. *Qualitative Methods: A field guide for applied research in sexual and reproductive health*. San Francisco: Jossey-Bass.

A practical, "hands-on" guide for use by social scientists, public health specialists and research teams interested in using qualitative methods to study sexual and reproductive health. It covers theory, research design and methodology, data collection, data analysis, writing, and research dissemination.

http://www.fhi.org/en/RH/Pubs/booksReports/Qual_Methods.htm

Pulerwitz, Julie, and Gary Barker. 2008. Measuring attitudes toward gender norms among young men in Brazil: Development and psychometric evaluation of the GEM scale, *Men and Masculinities* 10(3): 322-338.

This article describes the development and psychometric evaluation of a 24-item scale to measure attitudes toward gender norms among young men: the Gender-Equitable Men (GEM) Scale. Scale items on gender norms related to sexual and reproductive health, sexual relations, violence, domestic work, and homophobia are designed.

Weiss, William, and Pat Bolton. 2000. *Training in qualitative research methods for PVOs and NGOs (and counterparts)*. Baltimore: The Johns Hopkins University Bloomberg School of Public Health/Center for Refugee and Disaster Studies.

A set of training manuals (a trainer's guide and participant's manual) designed to promote the systematic use of qualitative methods by PVOs and NGOs to help plan and manage community health programs.

http://www.jhsph.edu/refugee/publications_tools/publications/qualresearchtrain.html (Curriculum)

http://www.jhsph.edu/refugee/publications_tools/publications/qualresearch.html (Participant Resources)

Additional Readings in Module 5 – Evaluating and Replanning

MEASURE Evaluation. 2007. *Data quality assurance tool for program level indicators*. Chapel Hill, NC: MEASURE Evaluation/USAID.

To outline the essential parameters of data quality, to show how data quality fits within the President's Emergency Plan for AIDS Relief (Emergency Plan) system of results reporting, and to provide an overview of the Data Quality Assurance Tool for Program-Level Indicators.

<http://www.cpc.unc.edu/measure/publications/pdf/ms-07-19.pdf>

Carter McNamara. 1997. *Basic guide to program evaluation*. Minneapolis: Authenticity Consulting, LLC.

This document provides guidance toward planning and implementing an evaluation process for both for-profit and nonprofit programs. There are many kinds of evaluations that can be applied to programs, for example: goals-based, process-based, outcome-based, etc.

http://www.mapnp.org/library/evaluatn/fnl_eval.htm

Rehle, Thomas, Tobi Saidel, Stephen Mills, and Robert Magnani, eds. 2001. *Evaluating programs for HIV/AIDS prevention and care in developing countries: A handbook for program managers and decision makers*. Arlington: Family Health International.

This handbook is dedicated to the premise that evaluation must be a critical part of the initial phases of planning effective HIV and AIDS prevention and care programs. Readers of this handbook will find that the authors have set the stage and provided the tools for a comprehensive and strategic approach to evaluation.

<http://www.fhi.org/NR/rdonlyres/ez7svgsmatlnljiupck35ipxkbfwqr43tmidspsesufm2ptudeudeiithei2ufzwbfcsebjilt4ca/31776textR1enhv.pdf>

Fink, Arlene. 2005. *Evaluation fundamentals: Insights into the outcomes, effectiveness, and quality of health programs*. Thousand Oaks, California: Sage Publications.

The book contains an added emphasis on outcomes, effectiveness, and quality of evaluations. Among the topics the book covers is how to justify evaluation questions and set standards of effectiveness, design studies, and conduct ethical research. The book contains numerous examples of evaluation methods as well as evaluation reports.

<http://www.sagepub.com/booksProdDesc.nav?prodId=Book226492&currTree=Courses&lev>

ADDITIONAL RESOURCES

Finn, Theresa. 2007. *A guide for monitoring and evaluating population-health-environment programs*. Chapel Hill, NC: MEASURE Evaluation/USAID.

The overall objective of this guide is to encourage program monitoring and evaluation and to improve the quality of work in the population-health-environment area. To this end, the guide provides a comprehensive listing of the most widely used M&E indicators for population-health-environment programs in developing countries.

<http://www.cpc.unc.edu/measure/tools/other-health-related-programs/me-of-phe-programs/a-guide-for-monitoring-and-evaluating-population/?searchterm=A%20Guide%20for%20Monitoring%20and%20Evaluating%20Population-Health-Environment%20Programs>

McNamara, Carter. 1997. *Basic guide to outcomes-based evaluation for nonprofit organizations with very limited resources*. Minneapolis: Authenticity Consulting, LLC.

This document provides guidance toward basic planning and implementation of an outcomes-based evaluation process (also called outcomes evaluation) in a nonprofit organization. This document provides basic guidance, particularly to small nonprofits with very limited resources.

<http://www.managementhelp.org/evaluatn/outcomes.htm>

Centers for Disease Control and Prevention. 1999. Framework for program evaluation in public health. *Morbidity and Mortality Weekly Report* 48(RR-11): 1-58.

The framework guides public health professionals in their use of program evaluation. It is a practical, nonprescriptive tool designed to summarize and organize essential elements of program evaluation.

<http://www.cdc.gov/mmwr/PDF/rr/rr4811.pdf>

OERL. *Online evaluation resource library (OERL)*. National Science Foundation. <http://oerl.sri.com>

OERL's resources include instruments, plans, and reports (the tabs across the top of this page) from evaluations that have proven to be sound and representative of current evaluation practices. These resources are organized into project categories, represented by the tabs at left.

Soul City Institute for Health and Development Communications. 2003. *Qualitative target audience formative research for health and development communication: Soul city fieldworker training manual 2 – Qualitative analysis and reporting*. Johannesburg: Soul City Institute for Health and Development Communications.

Soul City Institute for Health and Development Communications.

Developed to support skills training in qualitative interviewing and provides instruction for conducting qualitative formative audience research.

Document available by writing to Soul City Institute for Health and Development Communications. P.O. Box 1290. Houghton 2041. Johannesburg, South Africa.

ADDITIONAL RESOURCES

Wong-Rieger, Durhane, and Lindee David. 1993. *A hands-on guide to planning and evaluation: How to plan and evaluate programs in community based organizations*. Ottawa: Canadian Hemophilia Society.

A comprehensive guide to planning and evaluating education and prevention programs for community-based AIDS groups. The purpose of the book is to demystify structured planning and evaluation processes. It provides a step-by-step guide to planning and evaluation with sample work sheets and models.

USAID Center for Development Information and Evaluation. 1996. Using rapid appraisal methods. *Performance Monitoring and Evaluation Tips* 5: 1-4.

What are these methods? What are their strengths and weaknesses? When are they appropriate?

http://gametlibrary.worldbank.org/FILES/223_M&E%20tips%20Using%20rapid%20appraisal%20methods.pdf

USAID Center for Development Information and Evaluation. 1996. Conducting key informant interviews. *Performance Monitoring and Evaluation Tips* 2: 1-4.

Rapid appraisal techniques offer systematic ways of getting such information quickly and at low cost. This *Tips* advises how to conduct one such method— key informant interviews.

http://www.usaid.gov/pubs/usaid_eval/pdf_docs/pnabs541.pdf

USAID Center for Development Information and Evaluation. 1996. Conducting focus group interviews. *Performance Monitoring and Evaluation Tips* 10: 1-4.

http://www.usaid.gov/pubs/usaid_eval/pdf_docs/pnaby233.pdf

USAID Center for Development Information and Evaluation. 1996. Using direct observation techniques. *Performance Monitoring and Evaluation Tips* 4: 1-4.

<http://aetcnec.ucsf.edu/evaluation/UseDirectObservationTechniques.pdf>

Bertrand, Jane, and Gabriela Escudero. 2002. Compendium of indicators for reproductive health program evaluation. *MEASURE Evaluation Manual Series* 6:1-2.

The general objective of this *Compendium* is to encourage program evaluation and to improve the quality of work in this area. To this end, the *Compendium* provides a comprehensive listing of the most widely used indicators for evaluating reproductive health programs in developing countries.

<http://www.cpc.unc.edu/measure/tools/maternal-and-child-health/maternal-and-child-health/indicators-for-evaluating-rh-programs/compendium-of-indicators-for-reproductive-programs/?searchterm=Compendium%20of%20Indicators%20for%20Reproductive%20Health%20Program%20Evaluation>

Bertrand, Jane, Robert Magnani, and Naomi Rutenberg. 1994. *Handbook of indicators for family planning program evaluation*. Chapel Hill, NC: MEASURE Evaluation/Carolina Population Center.

This handbook provides a comprehensive listing of the most widely used indicators for evaluating family planning programs in developing countries. The indicators are organized according to the conceptual framework developed under the EVALUATION project.

<http://www.cpc.unc.edu/measure/tools/maternal-and-child-health/family-planning/indicators-for-family-planning-programs/handbook-of-indicators-for-family-planning-program/?searchterm=Handbook%20of%20indicators%20for%20family%20planning%20program%20evaluation>

Bertrand, Jane, and Amy Tsui. 1995. *Indicators for reproductive health program evaluation: Introduction*. Chapel Hill, NC: Carolina Population Center.

This document serves as an introduction to and rationale for the Reproductive Health Indicators Working Group (RHIWG), which convened to develop indicators for monitoring and evaluating reproductive health programs. RHIWG members formed subcommittees, each of which developed a series of indicators for one of the following areas: safe pregnancy, HIV and other STDs, women's nutrition, breastfeeding, and adolescent reproductive health services.

<http://www.cpc.unc.edu/measure/publications/pdf/ms-95-02.pdf>

Dallabetta, Gina, and Susan Hassig, eds. 1995. *Indicators for reproductive health program evaluation: Final report of the subcommittee on STD/HIV*. Chapel Hill, NC: MEASURE Evaluation/Carolina Population Center.

This report presents the most appropriate evaluation indicators defined to date for use in programs integrating reproductive health services and sexually transmitted disease (STD)/HIV prevention efforts. The target population for these programs is assumed to be the general population of men and women of reproductive age.

<http://www.cpc.unc.edu/measure/publications/pdf/ms-95-02b.pdf>

Koblinsky, Marge, Katie McLaurin, Pauline Russell-Brown, and Pamina Gorbach. 1995. *Indicators for reproductive health program evaluation: final report of the subcommittee on safe pregnancy*. Chapel Hill, NC: MEASURE Evaluation/Carolina Population Center.

<http://www.cpc.unc.edu/measure/publications/pdf/ms-95-02a.pdf>

Stewart, Lindsay, and Erin Eckert, eds. 1995. *Indicators for reproductive health program evaluation: Final report of the subcommittee on adolescent reproductive health services*. . Chapel Hill, NC: MEASURE Evaluation/Carolina Population Center.

<http://www.cpc.unc.edu/measure/publications/pdf/ms-95-02e.pdf>

O'Gara, Chloe, Martha Newsome, and Claire Viadro, eds. 1995. *Indicators for reproductive health program evaluation: Final report of the subcommittee on breastfeeding*. Chapel Hill, NC: MEASURE Evaluation/Carolina Population Center.

<http://www.cpc.unc.edu/measure/publications/pdf/ms-95-02d.pdf>

ADDITIONAL RESOURCES

Galloway, Rae, and Allison Cohn, eds. 1995. *Indicators for reproductive health program evaluation: final report of the subcommittee on women's nutrition*. Chapel Hill, NC: MEASURE Evaluation/Carolina Population Center.

<http://www.cpc.unc.edu/measure/publications/pdf/ms-95-02c.pdf>

Horizons Project. 2006. *AIDSQuest: The HIV/AIDS survey library*. Population Council.

AIDSQuest is a resource for researchers and others developing HIV and AIDS-related data collection tools. Horizons has collected surveys and scales from a number of international and local organizations and from the published literature

<http://www.popcouncil.org/horizons/ORToolkit/AIDSQuest/index.html>

Creative Research Systems. *Survey Design*, (707) 765-1001; Skype: surveysystem; info@surveysystem.com

The Survey System is the most complete survey software package available for all types of questionnaires and research projects from web, phone, PDA, or paper questionnaires. This exceptional survey software package is ideal for mixed-mode surveys, which combine two or more of those methods.

<http://www.surveysystem.com/sdesign.htm>

Taylor-Powell, Ellen. 1998. *Questionnaire design: Asking questions with a purpose*. Madison: University of Wisconsin-Cooperative Extension.

<http://learningstore.uwex.edu/Questionnaire-Design-Asking-Questions-with-a-Purpose-P1028C0.aspx>

Creative Research Systems, *Statistical Significance*, (707) 765-1001 Skype: surveysystem ; info@surveysystem.com,

This article is presented in two parts. The first part simplifies the concept of statistical significance as much as possible; so that nontechnical readers can use the concept to help make decisions based on their data. The second part provides more technical readers with a fuller discussion of the exact meaning of statistical significance numbers.

<http://www.surveysystem.com/signif.htm>

International HIV/AIDS Alliance. 2001. *Documenting and communicating HIV/AIDS work: a toolkit to support NGOs/CBOs*. Brighton: Progression.

The toolkit is designed to be used by organizations and trainers who support NGOs/CBOs. It can be used flexibly, with one or a group of NGOs/CBOs during training workshops or during technical support visits.

http://pdf.usaid.gov/pdf_docs/PNACS578.pdf

LaFond, Anne, Eckhard Kleinau, Lonna Shafritz, Suzanne Prysor-Jones, et al. 2003. *Using data to improve service delivery: A self-evaluation approach*. Washington, DC: Support for Analysis and Research in Africa (SARA) Project/Academy for Educational Development.

This guide will help frontline health workers use the data collected at health facilities to solve common problems in service delivery and improve their response to community needs. It is intended for doctors, nurses, and midwives in community based health centers.

http://www.globalhealthcommunication.org/tool_docs/65/using_data_to_improve_service_delivery_-_a_self-evaluation_a.pdf

World Health Organization. 2006. *Turning research into practice—Suggested actions from case-studies of sexual and reproductive health research*. Geneva: World Health Organization.

This document is the outcome of two meetings. The first meeting reviewed case-studies and other evidence related to research utilization from the standpoint of researchers and donors, while the second meeting reviewed additional materials from the standpoint of policy-makers and sexual and reproductive health program managers.

<http://www.who.int/reproductivehealth/publications/general/9241594837/en/index.html>

Segone, Marco, ed. 2008. *Bridging the gap: The role of monitoring and evaluation in evidence-based policy making*. Geneva: UNICEF.

This publication offers a number of strong contributions from senior officers in institutions dealing with evidence-based policy making. It tries to bring together the vision and lessons learned from different stakeholders on the strategic role of monitoring and evaluation in evidence-based policy making.

<http://www.who.int/pmnch/topics/mdgs/bridgingap/en/index.html>

Aubel, Judi. 1999. *Participatory program evaluation manual: Involving program stakeholders in the evaluation process*. 2nd ed. Calverton, MD: Catholic Relief Services/ORC Macro.

This manual is intended as a tool for PVO staff, their NGOs, and government partners to use in evaluating development projects and programs. There are many ways to go about evaluating a project or program. The choice of the most appropriate approach largely depends on the goal and objectives of the evaluation, as well as on the availability of human and material resources for the activity.

http://www.crdi.ca/uploads/user-S/10504133390Participatory_Program_Evaluation_Manual.pdf

DeMarco, Renee. 2005. *Conducting a participatory situation analysis of orphans and vulnerable children affected by HIV/AIDS: Guidelines and tools*. Arlington: Family Health International.

The six-chapter, 210-page guide offers sample consent forms, baseline surveys and interview guides, which can be adapted for local use. It was funded by the U.S. President's Emergency Plan for AIDS Relief through the U.S. Agency for International Development.

<http://www.fhi.org/en/HIVAIDS/pub/guide/ovcguide.htm>

Bertrand, Jane, Robert Magnani, and Naomi Rutenberg, eds. 1996. *Evaluating family planning programs with adaptations for reproductive health*. Chapel Hill, NC: MEASURE Evaluation/Carolina Population Center Population Center.

This manual provides guidelines relevant to developing an evaluation plan for a national family planning program, where the prime emphasis is on contraceptive services. It is noted that evaluation is the application of a social science research procedure to judge and improve the ways in which social policies are forged and programs are conducted. The manual is divided into eight main chapters, in which each chapter addresses a section of the prototype evaluation plan.

<http://www.cpc.unc.edu/measure/tools/family-planning/evaluating-family-planning-programs>

ADDITIONAL RESOURCES

Sullivan, Tara, Molly Strachan, and Barbara Timmons. 2007. *Guide to monitoring and evaluating health information products and services*. Baltimore: Johns Hopkins University Bloomberg School of Public Health/Center for Communication Programs.

The Guide offers guidance and 29 indicators to measure how information products and services contribute to improving health programs. Together, the elements in the Guide can help health professionals to better evaluate the contribution of their knowledge management work to crucial health outcomes.

<http://www.infoforhealth.org/hipnet/MEGuide/MEGUIDE2007.pdf>

The Centers for Disease Control and Prevention. 2008. *The handbook for evaluating HIV education*. Atlanta: Centers for Disease Control and Prevention.

Nine booklets are included in the *Handbook for Evaluating HIV Education*. These booklets address evaluation of HIV policy, HIV curricula, HIV staff development programs, and HIV-related student outcomes. They can be used to help assess the quality of HIV education programs at state and local levels.

http://www.cdc.gov/HealthyYouth/publications/hiv_handbook/index.htm

Burroughs, Catherine, and Fred Wood. 2000. *Measuring the difference: Guide to planning and evaluating health information outreach*. Seattle: National Libraries of Medicine.

Health information outreach programs are based on the commonly held assumption that access to information results in improved delivery of health care. The overall goals of outreach are to affect the capacity of the individual, organization, or community to effectively utilize health information resources and to address problems and barriers to accessing them.

<http://nmlm.gov/evaluation/guide/frontmatter.pdf> (front matter)

Gage, Anastasia, Disha Ali, and Chiho Suzuki. 2005. *A Guide for monitoring and evaluating child health programs*. Chapel Hill, NC: MEASURE Evaluation/Carolina Population Center.

Large-scale international efforts are being made to improve the health of infants and young children in several areas: the Millennium Development Goals, Roll Back Malaria, the Global Alliance for Vaccines and Immunization, and others. This guide intends to help these efforts succeed by providing information about effectively monitoring and evaluation.

[http://www.cpc.unc.edu/measure/tools/maternal-and-child-health/maternal-and-child-health/me-child-health-programs/a-guide-for-monitoring-and-evaluating-child-health/?searchterm="A%20Guide%20for%20Monitoring%20and%20Evaluating%20Child%20Health%20Programs](http://www.cpc.unc.edu/measure/tools/maternal-and-child-health/maternal-and-child-health/me-child-health-programs/a-guide-for-monitoring-and-evaluating-child-health/?searchterm=)

Adamchak, Susan, Katherine Bond, Laurel MacLaren, Robert Magnani, and et al. 2000. *A guide to monitoring and evaluating adolescent reproductive health programs*. FOCUS Tool Series #5. Arlington: Family Health International.

This Guide is designed for program managers who monitor and evaluate adolescent reproductive health programs.

<http://www.fhi.org/en/Youth/YouthNet/Publications/FOCUS/ToolsGuides/index.htm>

ADDITIONAL RESOURCES

Schenk, Katie, and Jan Williamson. 2005. *Ethical approaches to gathering information from children and adolescents in international settings: Guidelines and resources*. Washington, DC: Population Council.

This publication aims to provide practical guidance to help program managers and researchers understand and uphold ethical standards when planning and implementing information gathering activities among children and adolescents. It promotes discussion of ethical issues when working with children and adolescents among people of different backgrounds and training to gather information for different purposes.

<http://www.popcouncil.org/pdfs/horizons/childrenethics.pdf>
