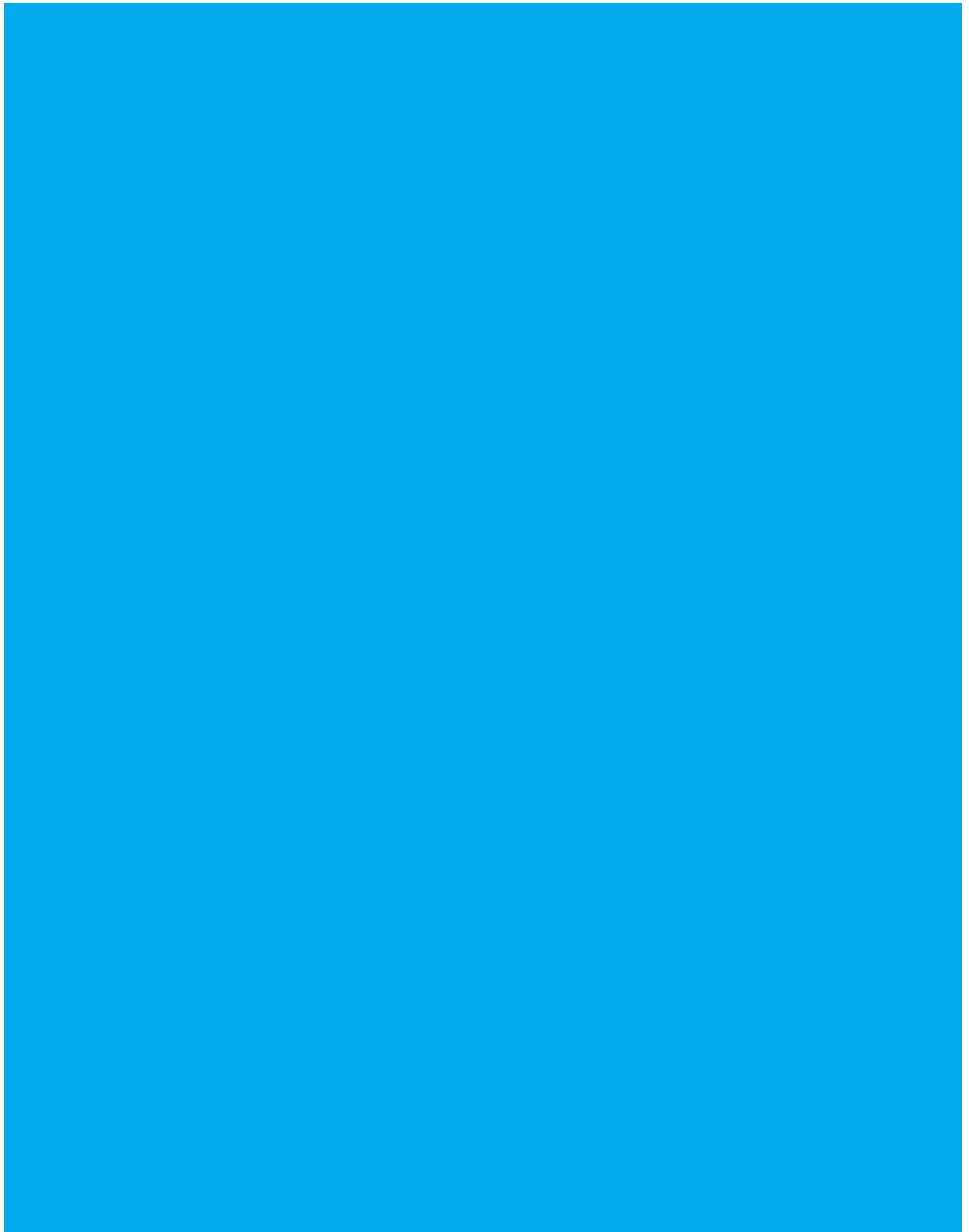
PART THREE

# TOOLS



# HOW TO DEVELOP SMART BEHAVIOURAL OBJECTIVES / RESULTS

Be smart. Always define SMART behavioural objectives or, in the context of the results-based management approach - SMART behavioural results - that are specific to a problem (like reducing diarrhoea outbreaks in a community). Avoid citing generic behaviour results like "to raise awareness" or "to improve knowledge". These are useful only if they lead to behavioural results. The rapid changes that are characteristic in emergencies make your planning and results-setting imperative. It is therefore a MUST for you to define behavioural results in specific terms before you develop your strategy and begin to implement.[3]

Avoid the tendency to proceed with your communication strategy without the benefit of evidence-based planning. The inexperienced would go ahead and say "Let's print a poster to address people's lack of knowledge". Also avoid this mode of thinking: "Let's use the same strategy for polio eradication for our hand-washing campaign". Both approaches are doomed to failure and are not sustainable. Achieving behavioural impact, maintaining the intended behaviour and influencing others to follow suit in a sustained manner - require research and consultation with the participant actors within their own environment. This entails far more than simply printing a poster.[4]

# How to do it

**1. Answer the following questions to help you develop behaviour objectives/results.** To do so, you and your team need to work with the affected community.

- Whose behaviour needs to change to bring about a given desired health or social outcome in the emergency (mothers'; primary caregivers'; fathers'; neighbours'; volunteers'; health workers'; religious leaders', teachers'; politicians')?
- What are the current behaviours? Why are people currently doing it all the time; doing it sometimes, or not doing it at all? What factors account for the difference?
- If they are not doing it now, why not? Are they practising a similar desired behaviour? How can you best influence and support that behaviour? What are the barriers to change?
- What factors - social, cultural, economic, environmental, psychological, physiological, etc. - and who, what, where are the most influential channels that can motivate changing or maintaining the behaviour?
- What skills and resources are needed for the affected groups to practice the desired behaviours?

2. **Conduct a rapid communication assessment using a combination (triangulation) of techniques.** The rapid assessment will give you the answers to the above questions and will help you define your SMART behavioural results. To do this, you can conduct exploratory or transect walks and participant or non-participant observations. You can also engage in discussions with key informants and opinion leaders such as religious and secular heads, community opinion leaders – usually the elders and local leaders - service providers, relief workers and others. You can further gain insights into people's social habits, attitudes, risk behaviours and underlying vulnerabilities of families and communities through community mapping, network analysis, focus group discussions (men, women and children) and other participatory learning approaches or PLA tools. While they participate in these activities, they too gain collective insights about themselves and their own communities. You can perform these rapid assessment techniques easily and quickly in an emergency setting.

3**. Analyse, prioritise, and finalise the statement of behavioural results** after you have collected the information you need. Do so with representatives from the affected groups. Remember to keep the list short – too many behavioural expectations are as bad as none at all. Target a few behaviours, if possible not more than three behaviours that are feasible for the intended participant actors to practice.

# What is a SMART behaviour objective/result?

Behavioural results are best stated in terms of the **intended behaviour change or the maintenance of an existing desired behaviour.** A behavioural result usually has at least three features, which makes it a **SMART result**:

- Clear identification of the participant group.
- Detailed description of the promoted behaviour (appropriate and realistic); and how many times the behaviour should take place.
- The measurable result you hope to observe over a specific time period.



## Examples of SMART behavioural objectives and results:

**Behaviour Objective:**
*Within two weeks from the start of the emergency, to increase from 30 percent to 60 percent the number of caregivers who wash hands with soap or ash and water before preparing food, after going to the toilet and after washing the baby.*

Behaviour Result:
*Within six weeks from the start of an emergency, the number of Community Nutrition Promoters who provide friendly and accurate answers to questions at every nutrition education session would have increased from 30 percent to 60 percent.*

# Footnotes

1. SMART is an abbreviation for Specific, Measurable, Achievable, Relevant, Time-bound. See Chapter 2 for more information.
2. *Adapted from Parks, W., et al.,* Planning Social Mobilization and Communication for Dengue Fever Prevention and Control*, WHO, Geneva, 2004, p. 35.*
3. *Adapted from Oxfam UK,* Guidelines for Public Health Promotion in Emergencies, *Oxfam, London, 2001, p. 34.*
4. Adapted from Parks, et al., op.cit., pp. 35-36.
5. *Graeff, J., Programme Communication Advisor, UNICEF, Bangladesh* Final Report on Behavioural Monitoring Workshop*, UNICEF, Dhaka, 2005.*

# HOW TO DEVELOP INDICATORS BASED ON BEHAVIOURAL RESULTS[1]

How do you know if your efforts in communicating to change behaviour and social mobilisation are actually making a difference in emergency situations?

This is an important question that highlights the value of well-planned monitoring and evaluation (M&E). Unfortunately, M&E is often an afterthought in emergency management planning. This trend tends to reduce the quality and cost-effectiveness of actual and future responses. Likewise, tracking and assessing communication activities during an emergency are often weak, which makes it difficult to report on results.

This tool shows you how to plan the monitoring and evaluation of behaviour change communication and social mobilisation in emergency situations. We look at participatory methods on how to develop indicators based on behavioural results in a participatory way. We consider some simple data collection methods that can be used to monitor and evaluate communication and mobilisation activities.

Let's begin by clarifying the basic terms:

## What is an M&E system?

Monitoring provides insight into how well a response or planned set of activities is being implemented. It is part of the evaluation process. Evaluation is a continuous process, done periodically, i.e., at each stage of the programming cycle. It offers a comprehensive review of whether an emergency response is achieving its short-term results and longer-term goals. Continual and careful monitoring of relevant indicators and processes generates information for evaluation and, more importantly, for corrections that may be needed as an emergency response unfolds.

An M&E system refers to a textual, graphical and/or numerical data system used to measure, manage and communicate desired performance levels and emergency response achievements. M&E systems are often based on a combination of evaluation types (see Table 1 below).

| Type of evaluation | Broad purpose | Main questions answered |
| --- | --- | --- |
| Baseline Analysis/ Formative Evaluation Research | Determines concept and design | Where are we now?<br>Is an intervention needed?<br>Who needs the intervention?<br>How should the intervention be carried out? |
| Monitoring/Process Evaluation | Monitors inputs and outputs; assesses service quality | How are we doing?<br>To what extent are planned activities actually realised?<br>How well are the services provided? |
| Outcome/Effectiveness Evaluation | Assesses outcome and impact | How did we do?<br>What outcomes are observed?<br>What do the outcomes mean?<br>Did the response make a difference? |
| Future Plans/Cost-Effectiveness Analysis | Value-for-resources committed including sustainability issues | What are our next steps and needed resources?<br>Should response priorities be changed or expanded?<br>To what extent should resources be reallocated? |

## What is an indicator?

An indicator is information on a particular circumstance that is measurable in some form. Indicators are approximations of complex processes, events and trends. They can measure the tangible (e.g., service uptake), the intangible (e.g., community empowerment), and the unanticipated (e.g., results that were not planned). An indicator gives an idea of the magnitude and direction of change over time. But it cannot tell us everything we might want to know.

Indicators need not be perfect - only sufficiently relevant and accurate enough so that those interpreting the information can do so.

Indicators should be easily interpreted. It is very important, therefore, to carefully define any indicators and ensure that the way they are defined "travels accurately" back and forth between languages and cultures (including organisational cultures).

Indicators can also be "progress markers". It is clear that behaviour change communication and social mobilisation in emergency responses must demonstrate impact. Stakeholders - whether members of affected communities, programme managers, donors or policy makers - need immediate data that show the contribution your communication initiative has made. Because behaviour and social change often take time to happen, we sometimes need signpost indicators or progress markers - measures that do not necessarily tell us that the ultimate outcome or impact has been reached, but signals that we are on the right track. In communication programmes, for example, "intent to change" has been used as predictor of actual change.

## Types of indicators

Indicators may be pictorial. For example, drawings and photographs that show the situation immediately after an emergency that are then compared with drawings and photographs produced some time after the emergency (e.g., 6 weeks, 3 months, etc.) can promote greater discussion and lead to a better understanding amongst both literate and non-literate stakeholders. We will look at examples of pictorial methods that can generate information for indicators in Table ** below.

Indicators may be in the form of stories. Qualitative approaches to monitoring and evaluation usually include the collection of "stories from the field". These stories often provide meaning to quantitative information or capture real "voices". A monitoring technique known as the Most Significant Change (MSC) has been developed that allows for the systematic collection and interpretation of stories. Please refer to Tool 3 for the MSC Technique.

## How many indicators do we need?

In choosing indicators, it is important for you to *limit the number to a set of critical indicators*. A multitude of indicators will create problems when you attempt to interpret results. The challenge then lies in defining what is a *critical* indicator, while at the same time making each indicator comprehensible, measurable, comparable (to ascertain trends) and affordable.

Spending the time working out (and trialing) the few, critical measurements needed to tell your programme's essential story will undoubtedly save you the time (and frustration) later. Applying the Rapid Appraisal principle of **optimal ignorance** helps here. "Optimal ignorance" refers to *the importance of knowing what facts are not worth knowing*, thus enabling the cost-effective, timely collection and analysis of information.[1] Applying this principle avoids collection of irrelevant data but its application requires courage!

## How to develop indicators

Each chapter in this Toolkit offers examples of possible indicators. Remember, these examples are intended to foster debate and negotiation about what should be measured amongst those planning and implementing emergency responses. You may end up with a range of locally created indicators that are supplemented by these examples.

Here we consider how todevelop indicators based on your programme's intended behavioural results. The emphasis is on completing the bulk of this work before a disaster occurs - in other words, these steps should ideally be taken during disaster preparedness planning. We recognise, however, that much depends on the nature, scale and extent of a particular emergency. For this reason, we offer simple monitoring tools and indicators in the main chapters of this Toolkit that can be used to get a basic M&E system up and running during an emergency. The indicators and data collection methods presented below are likely to be more useful when time allows or when preparedness planning is conducted in a comprehensive manner.

Indicator development is best viewed as part of an M&E process. We can summarise the core steps or stages for this process as follows:

1. Assemble an M&E core team.
2. Clarify the question: who wants to know what and why?
3. Identify indicators that will provide the information needed.
4. Choose and adapt data collection methods.
5. Synthesise, verify data, and analyse contribution.
6. Use M&E results to re-develop future communication/social mobilisation activities.

With each step, we offer questions that you can discuss with relevant stakeholders. Between selected steps, we offer a checklist for you to complete before proceeding to the next step.

## Step 1. Assemble an M&E core team

Who should, and wants to be involved in the monitoring and evaluation of a behaviour change communication effort in emergency responses? How should participants be identified and selected? What should participants' backgrounds and interests be? What constraints will they bring to the task (workload considerations, educational limitations, motivation)? What type of skills, knowledge, changes in behaviour and attitudes are required to effectively conduct M&E?

Minimal requirements for core team members are:

- Personal commitment to an interactive process and the principles of participatory monitoring and evaluation.
- Ability to work as a team.
- Competency in a wide variety of research techniques and methodologies, with emphasis on participatory methodologies.
- Group facilitation skills, understanding of group process, dealing with tensions and conflict, equalising participation, running participatory activities, summarising, and being an active listener.
- Ability to communicate with different stakeholders, such as members of affected communities, government representatives, and representatives of international donor and UN agencies.

Additional questions to ask at this step include: How is the training of participants in M&E to be accomplished? To what extent do cultural and linguistic differences impact training effectiveness? Can evaluators and other professionals assume the role of trainer or facilitator with relative ease? How does one listen for the voices that have not been heard yet? How can cultural, language, or racial barriers be addressed?

## Step 2: Clarify the question: who wants to know what and why

Gather stakeholders together and pose the question: "Who wants to know what and why?" Responses to this question will help develop the behavioural results - statements of intent that begin with words such as: "To assess…" or "To measure…" or "To monitor…" or "To evaluate…"

Ensure that many stakeholders are involved in this planning step as possible. Different groups of stakeholders will have different interests, values, and information requirements. Excluding stakeholder groups from planning how the communication and social mobilisation will be monitored and evaluated may disenfranchise these groups.

Behavioural results should be derived and linked to what your team is aiming to achieve in relation to the promotion of hygiene, breastfeeding, immunization and vitamin A, safe motherhood, and child protection in emergency situations.

To help you discuss what people need to know and why, you could ask stakeholder groups the following questions:

- From your point of view, what difference will the communication strategy make? In what way will communication influence individual and group behaviour? How will we know?
- Will the communication strategy strengthen individual and affected community communication capacity, decision-making and action? If so, how will we know?
- Do you think the strategy takes into account obstacles to behaviour and social change? If so, how? If not, what could be done to consider these obstacles? How will we know when these obstacles have been overcome?
- In your opinion, will the proposed communication strategy enable previously powerless individuals and communities to take control of the means and content of communication, to achieve their own behaviour and social change goals? If so, how will we know?

## *Quick checklist before you proceed to Step 3

| | | |
|---|---|---|
| Have you assessed the link between project overall results, behavioural results and strategies? | ☐ Yes | ☐ No |
| Have you included individuals and organisations that will be affected by the emergency response in your monitoring activities? | ☐ Yes | ☐ No |
| Are participants involved in the monitoring trustworthy and competent? | ☐ Yes | ☐ No |
| Have they made an informed decision about where, when and how they want to be involved? | ☐ Yes | ☐ No |
| Have steps been taken to assure that all stakeholders and the population served will be respected, and their values honoured during the monitoring and evaluation? | ☐ Yes | ☐ No |
| Have conflicts of interest been discussed to ensure that the results or findings will not be compromised? | ☐ Yes | ☐ No |
| Have you described the purpose of your monitoring and evaluation in detail? | ☐ Yes | ☐ No |
| Is there a written or at least verbal understanding among stakeholders about the purpose of the monitoring and evaluation activities? | ☐ Yes | ☐ No |

## Step 3: Identify indicators that will provide the information needed

Identifying indicators is one of the most challenging tasks when setting up an M&E system. More so than any other step, identifying and agreeing on what indicators to use highlights the different information needs and expectations that the different stakeholders have of the monitoring work.

Identification of indicators is best started after a dialogue on the affected community's concerns, goals, issues and obstacles, and the vision of the change they seek. The indicator-specific discussion begins by asking stakeholders to reflect on their M&E results (what they want to know and why) and consider the information they are already collecting; and what methods of information exchange or reporting they are using that may be appropriate. One question you should ask stakeholders is: what behavioural information is needed early on, continuously or frequently to make sure this communication initiative is on track and achieving its results?

Several M&E processes and indicators set for measuring communication and social mobilisation have been created and offered in Tool 3 as useful guides

## Step 4: Choose and adapt data collection methods.

M&E systems may use visual (maps, calendars, problem ranking, wealth-ranking, photonovella, pocket charts, story with a gap) and dramatic forms (story telling, songs, dances, sculptures, role plays) of data collection together with more standard methods such as interviewing, observation, focus group discussions, workshops, community meetings, questionnaires, and document analysis. A few of these methods are described in Table 2.

**Table 2: Examples of M&E data collection methods**

| TECHNIQUE | BRIEF DESCRIPTION |
|---|---|
| **Mapping** | Establishes connections and local insights into what is "useful" and "significant" in order to understand community perceptions of the local environment, natural and human resources, problems and resources for dealing with them. There are several different types of maps including: spatial maps; social maps (depicting social relationships); temporal maps (showing changes over time); aerial maps (aerial photographs or standard geographic maps); and organisational maps (venn diagrams depicting institutional arrangements or networks). |

| | |
|---|---|
| **Seasonal calendars** | Ways of illustrating seasonal changes in subjects of interest - i.e. harvests, labour availability, fever, seasonal transmission of HIV and communication resources. Months, religious events, seasons and other local climatic events, for example, are used to illustrate time periods. Issues of interest are then discussed (sometimes using stones, sticks, or marks on paper in relation to these periods). Discussions usually highlight periods of maximum stress, constraints (no time or resources available), or the best time when new initiatives could be undertaken. |
| **Problem ranking/ sorting** | Cards with words or pictures are sorted into piles or ranked according to local criteria in order to understand how participants rank problems (e.g., communication obstacles) in terms of frequency, severity, and so on. Ranking provides a systematic analysis of local terms, perceptions or evaluations of local issues. Disadvantage is that ranking can force participants to structure their knowledge in artificial ways unless the ranking criteria are themselves developed through a participatory process. This exercise can be used in pre- and post-intervention evaluations to measure change in particular rankings. |
| **Well-being and wealth-ranking** | Uses perceptions of local inhabitants to rank households, families or agencies within a social network or village/neighbourhood according to wealth, well-being or social contacts. For example, names of household heads are written on cards. These cards are then sorted into piles by at least three M&E participants (ideally interviewed separately) according to criteria that they describe to the M&E team member. The resulting classifications are often at odds to conventional socio-economic surveys, revealing locally important well-being or wealth criteria that can be used to measure more subtle and usually important social changes than can be measured in quantitative methods. |

| | |
|---|---|
| **Photo-novella** | Local people themselves produce visual images through the use of video or instamatic camera. The images then serve as a catalyst to depict, reflect on and discuss social conditions affecting their lives and future possibilities. |
| **Pocket charts** | Helps people to assess and analyse their situation in a new way using pictures and a "voting" process based on a simple grid-sheet with rows of pockets, pictures, and markers (clothes pegs, pebbles, etc.). Can be used in group or individual (confidential) situations. Dialogue members place their "vote" (pebble) in a pocket underneath or corresponding to picture they agree with or prefer. |
| **Story with a gap** | Engages people to define and classify goals, and to make sustainable plans by working on "before and after" scenarios. A variety of pictures depicting present problems and future possibilities are presented. Dialogue members consider possible reasons for differences in the contrasting pictures, create stories to explain the "gap" between pictures, and identify community solutions to local problems. Can be used in one-to-one interviews but best in group situations. |
| **In-depth individual interview** | A semi-structured interview using a flexible interview guide consisting mainly of open-ended questions (questions that cannot be answered with a "yes" or "no" or any other single word or number). The aim is to collect detailed information on the individual's beliefs and attitudes related to a particular topic. |
| **Key informant interview** | A "key informant" is someone who has extensive experience and knowledge on a topic of interest to the evaluation. Often key informants are community or organisation leaders. The interviewer must develop a relationship of confidence with the individual so that his/her experience and insights will be shared. |

| | |
|---|---|
| **Group interview** | There are several different types of group interview such as consensus panels (local experts debate to reach a consensus on a series of issues), structured group interview (participants are asked the same questions as individuals), focus group discussions (a facilitator guides 10-15 participants through a series of issues, with the group interacting with each other rather than just with the facilitator - reaching consensus is not the main aim), community meetings (formal discussions organised by the local group or agency at which the M&E team or facilitator ask questions and/or make observations), spontaneous group discussions (everyday meetings e.g., a sports event, at which groups of people gather around to chat and in which the M&E team or facilitator participates). |
| **Observation** | While an activity is ongoing, an observer records what he/she sees either using a checklist or by taking descriptive notes. The observation can include information on: the setting (the actors, context, and surroundings); the actions and behaviour of the actors; and what people say - including direct quotations. |
| **Analysis of secondary data** | Reports and other written documents that provide information on the activities planned and carried out. |

When choosing the methods needed to collect information for each indicator, core M&E team members should facilitate discussion with stakeholders on:

- The indicator and the kind of data required.
- The technical difficulty and adaptability of the method to a particular level of expertise.
- Cultural appropriateness of the method - will it make people feel comfortable learning, communicating, and interacting?
- Facilitation of learning - does the method facilitate learning?
- Barriers to participation - e.g., levels of literacy, command of language used, social class, physical challenge, age, and time constraints.

YYou will also have to make decisions on the number and location of data collection sites, the sampling processes involved (random or deliberate), the

characteristics and sample size of people to be interviewed or invited to meetings, the selection of people or events to be observed, and the scheduling of data collection (e.g., the date and time for site visits, meetings, interviews).

Now in the following table (make a copy for each behavioural result):

- List the indicators you have decided to develop or use to monitor progress against each result.
- For each indicator, determine what method or methods will be used to collect information to inform the indicator/s.
- Work out what samples your behavioural indicators will require.
- Then give thought to who will collect the information (e.g., who will conduct the interviews, observations, focus groups, participatory methods, questionnaires).

## Quick checklist before you proceed to Step 5

| | | |
|---|---|---|
| Have you assessed the link between the behavioural results, indicators, methods, and samples? | ☐ Yes | ☐ No |
| Have you checked whether measuring the indicators is feasible in terms of how much information is required, how many methods, how much time, how many data collectors are needed, and their skill levels? | ☐ Yes | ☐ No |
| Will the methods and tools you have chosen require development, pre-testing and training of data collectors? If "Yes", make a note in the space below. | ☐ Yes | ☐ No |
| Have you made sure that information will be collected using more than one method (triangulation)? | ☐ Yes | ☐ No |
| Have you determined the samples that you will require? | ☐ Yes | ☐ No |
| Have you identified who will be needed to collect the information? | ☐ Yes | ☐ No |

Note here if any tool development, pre-testing or data collector training will be required for one or several of your measurement methods:

| BEHAVIOURAL RESULT 1 | BEHAVIOURAL INDICATOR/S | MEASUREMENT METHOD/S | SAMPLES | WHO WILL COLLECT INFORMATION AND WHEN |
| --- | --- | --- | --- | --- |
| | | | | |

## Step 5: Collect, synthesise, verify data, and analyse contribution

Data collection to monitor and evaluate communication in emergency responses is usually drawn out over a number of weeks or months. It is highly desirable that data synthesis and analysis occur **as** the data are collected. In other words, there should not be a distinct period of "data collection" followed by a distinct period of "data analysis" – analysis usually leads to new questions requiring further data collection, and so on.

"Data saturation" is often used as a sign that data collection can be reduced in intensity. **Data saturation** can be defined as the point at which no **new** answers to questions are being recorded and no **new** insights are being generated from the data analysis, which suggest the need for further periods of data collection for the time-being. It is important also to have regular reviews or reflections on the methods. Methods and questions may need to be adapted or modified on occasions.

Step 5 also involves processing and analysing data. Core M&E team members should organise meetings with relevant stakeholders and facilitate critical reflection on problems and successes, understanding the impacts of their efforts, and acting on what they have learned. Will there be a need for computer-based analysis? Is there a need for further training/reading for your team on qualitative and/or quantitative analysis? *What becomes critical is how stakeholders actually use information in making decisions and identifying future action.*

How will you ensure participants can provide feedback (verification) on the information that is collected? Analysis of data should include **data validation** among stakeholders. Data should be presented back to participants for verification and collective analysis. Ways to ensure that feedback and validation occurs can include workshops and meetings, distribution of reports (with follow-up interviews), transcripts of interviews returned to interviewees, and so on.

We asked at the beginning of this tool how do you know if behaviour change communication and social mobilisation are actually making a difference in emergency situations?

How much of the success (or failure) in an emergency response can we associate with communication for behaviour change and social mobilisation? Was the contribution worth the investment? *Perhaps without communication and social mobilisation, the observed changes would have occurred anyway, or would have occurred at a lower level or at a slower pace.*

To *definitively prove* behaviour change communication and social mobilisation is making a contribution, we would need "controlled comparisons" (intervention versus non-intervention) to estimate what happens with communication is in place, versus what would happen without it. But such evaluation designs have ethical and resource implications, especially for emergency response situations.

So the question remains: in the absence of a complex evaluation study, how do we measure contribution?

The first key is to recognise the *limits of measurement*. Definitively determining the extent to which communication contributes to any particular behavioural or social change is usually not possible (even with a meticulously designed evaluation). At best, we should be *satisfied with a reasonable estimate of the magnitude of impact*. Let's focus less on decimal points and more on what Rapid Appraisal practitioners describe as **appropriate imprecision** – not measuring more accurately than is necessary for practical purposes.[1] It is perhaps more useful to measure trends and directions of change, rather than absolute numbers.

When M&E resources are scarce, our second interest should be in *increasing understanding and knowledge rather than worrying about scientific certainty*. We should embrace uncertainty because we will never eliminate it.[2] If you must know with a high degree of certainty what communication's contribution is then you will need a carefully designed evaluation study (and probably a lot of money).

The third key is to acknowledge that *there is a problem of linking outputs directly to outcomes*. Many factors are at play beyond specific communication and mobilisation activities. We need to be realistic about the outcomes we are trying to influence and acknowledge many potential influences are beyond the control of strategic communication.[3]

Any reasonable attempt to measure the contribution of communication in an emergency response would accomplish at least three things during the planning stage:

(1) Intelligently map intended behavioural outcomes related to hygiene, breastfeeding, immunization, vitamin A, safe motherhood, and child protection.
(2) Develop key indicators that either directly measure these outcomes or can serve as proxies or progress markers towards these outcomes.
(3) Recognise or list those factors communication has no control over.

Collecting information from this point on might therefore show:

- Outcomes appeared at an appropriate time after your efforts began.
- Outcomes faded when your efforts stopped.
- Only outcomes appeared that you should have affected.
- Outcomes appeared only where or when communication activities were implemented.
- The biggest outcomes appeared where or when you did the most.

The analytical job is then to explore and discuss (and hopefully discount) plausible alternatives that might explain these relationships between effort/time/place and associated outcomes. Identifying what these alternative explanations might be is usually straight-forward. The core M&E team's job is to provide further evidence that discounts these alternatives. If there is little evidence that counters other plausible explanations, then you can possibly conclude that you cannot be sure what the contribution of communication has been. This unfortunate conclusion, however, is not usually arrived at if you have gathered additional, relevant evidence. For example, your communication might have been based on a previously proven theory and/or field experiences elsewhere, in which case, the associations between the communication and outcomes are supported by other examples. Other supporting evidence may be found, not from specific indicators, but from programme reports, meeting minutes, national surveys, or stories from the field.

## Step 6: Use M&E results to re-develop future communication/ social mobilisation activities

How is the data being used and for whose benefit? This step serves as an important means of disseminating findings and learning from others' experiences. Core M&E team members should seek agreement with stakeholders (through meetings) on how findings should be used, and by whom. Several versions of M&E reports may be required, each tailored to different requirements and capacities of different stakeholders. Possible areas of future work should be discussed for follow-up. At this key moment, core M&E team members should also clarify with stakeholders if the M&E system needs to be sustained, and if so, how. The M&E system may need to be adjusted accordingly.

# Resource bank

## Further reading

### Participatory M&E

1. Aubel, J., Participatory Program Evaluation Manual: Involving program stakeholders in the evaluation process, Catholic Relief Services, Dakar, 1999.

2. Estrella, M., with Blauert, J., Campilan, D., Gaventa, J. et al., Learning from Change: Issues and experiences in participatory monitoring and evaluation, Intermediate Technology Publications Ltd., London.

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4. Parks, W. with Grey-Felder, D., Hunt, J. and Byrne, A., Who Measures Change? An Introduction to Participatory Monitoring and Evaluation of Communication for Social Change. Communication for Social Change Consortium, South Orange, 2005. http://www.communicationforsocialchange.org.

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### Data collection methods for M&E

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7. Gosling, L., Toolkits: A practical guide to monitoring, evaluation and impact assessment, New Edition, Save the Children Fund UK, London, 2003.

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9. Patton, M.Q., Participatory Learning and Action (PLA) Notes and Rapid Rural Appraisal (RRA) Notes: Qualitative evaluation and research methods, Second Edition, Sage Publications, Newbury Park,1990.

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14. World Bank, Monitoring & Evaluation: Some tools, methods & approaches, World Bank, Washington, D.C., 2002.



## Web sites

Communication for Social Change Consortium
http://www.communicationforsocialchange.org

## Footnotes:

1 *Source: Parks, W.*
2 *Rehle, T., Saidel, T., Mills, S. and Magnani, R., Evaluating Programs for HIV/AIDS Prevention and Care in Developing Countries: A handbook for program managers and design makers, Family Health International, Arlington, p. 11.*
3 *Hamilton, C., Kumar Rai, R., Shestra, R.B. et al (2000) 'Exploring Visions: Self-monitoring and evaluation processes within the Nepal-UK Community Forestry Project.' In Estrella, M. with Blauert, J., Campilan, D., Gaventa, J. et al (eds) Learning from Change: Issues and experiences in participatory monitoring and evaluation. London: Intermediate Technology Publications Ltd. Pp.15-31. (P.29).*
4 *Davies, R. and Dart, J. (2005) The Most Significant Change 'MSC' Technique: A Guide to Its Use. http://www.mande.co.uk/docs/MSCGuide.pdf.*
5 *Scrimshaw, N.S and Gleason, G.R. Eds. (1992) Rapid Assessment Procedures: Qualitative Methodologies for Planning and Evaluation of Health Related Programmes. Boston, MA: International Foundation for Developing Countries.*
6 *Aubel (1999) describes 7 phases and 20 steps for participatory evaluation. See Aubel, J. (1999) Participatory Program Evaluation Manual: Involving Program Stakeholders in the Evaluation Process. Dakar: Catholic Relief Services.*

7 *Guijt, I. (2000) 'Methodological Issues in Participatory Monitoring and Evaluation.' In Estrella, M. with Blauert, J., Campilan, D., Gaventa, J. et al (eds) Learning from Change: Issues and experiences in participatory monitoring and evaluation. London: Intermediate Technology Publications Ltd. Pp.201-216 (p.204).*

8 *Scrimshaw, N.S and Gleason, G.R. Eds. (1992) Rapid Assessment Procedures: Qualitative Methodologies for Planning and Evaluation of Health Related Programmes. Boston, MA: International Foundation for Developing Countries.*

9 *Mayne, J. (1999) Addressing Attribution through Contribution Analysis: Using Performance Measures Sensibly. Office of the Auditor General, Canada.*

10 *Information on Outcome Mapping is drawn from: Earl, S., Carden, F. and Smutylo, T. (not dated) Brochure on Outcome Mapping: The Challenges of Assessing Development Impacts. http://web.idrc.ca/en/ev-26979-201-1-DO_TOPIC.html*

# MOST SIGNIFICANT CHANGE TECHNIQUE

The **most significant change** (MSC) technique is gaining increasing popularity. [1]
In MSC:

- All stakeholders in a program are involved in deciding the changes to be recorded.
- The same questions are asked of everyone.
- Resulting stories are rigorously and regularly collected.
- Stories are then analysed, discussed and filtered (voting), verified, and documented

There are three essential phases to MSC:

A Determine the sorts of change to monitor.
B Collect stories, review, select, and feedback.
C Compile 'selected' stories, analyse, verify and monitor the process.

Phase A and B are often inter-connected.

The MSC technique begins with participants/stakeholders affected by an emergency being asked a simple question in the context of an emergency response program:

"*Looking back over the last few weeks, in your opinion, what do you think was the most significant change that took place in the lives of people involved in…*[name of response project/program]?"

To collect a few more details for the story, follow-up questions can be asked such as:

- What happened, who was involved, where did it happen, when did it happen?
- Why is the change the most significant out of all the changes that took place in the [time period]?
- What difference did it make already, or will it make in the future for you, for your community?

Stories can be collected from diaries, interviews, group discussions, and community meetings. Groups of stakeholders then meet to discuss and vote for the most significant stories out of those collected. An effective MSC system ensures feedback to storytellers of their selected stories. Some stories can be used to generate press coverage.

MSC is a valuable way of "dignifying the anecdote" – creating a legitimate space for storytelling and giving these stories validity. MSC has already been applied in developed and less developed economies, in participatory rural development projects, agricultural extension projects, educational settings, and mainstream human services delivery.

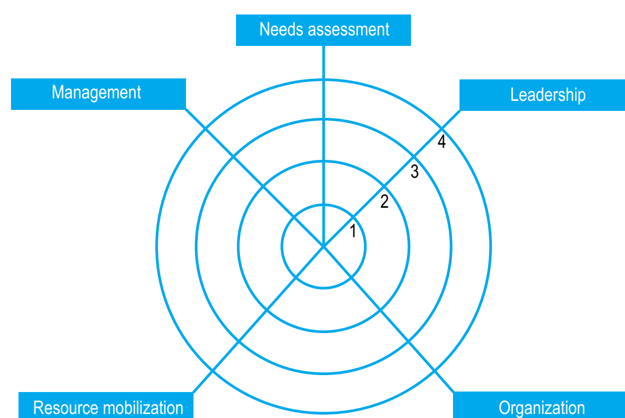
## Measuring community participation[2]

A framework originally proposed by Susan Rifkin and colleagues for measuring community participation in health programs, may be suitable for adaptation to measuring community participation in emergency responses. This framework has been used in Nepal, Cameroon, Indonesia, Sweden, the Philippines, Fiji, Papua New Guinea, and the United Republic of Tanzania.[3]

| Indicator | Questions |
|---|---|
| **Needs assessment** | 1) How are needs identified?<br>2) Does identification relate only to health service needs?<br>3) Is the affected community involved in needs identification and assessment?<br>4) Does the assessment strengthen the role of a broad range of affected community members? |
| **Leadership** | 1) Which groups does the leadership represent and how does it do so?<br>2) Is the leadership paternalistic and/or dictatorial, limiting the prospects of wider participation for various groups in the affected community?<br>3) How does the leadership respond to the needs of poor and marginalised people?<br>4) Do most decisions by the leadership result in improvements for the majority of the people, for elites only, or for the poor only? |

| | |
|---|---|
| **Organization Resource mobilization Management** | 1) Are new organisations being created to meet defined needs, or are the existing ones being used?<br>2) Are the organisations flexible and able to respond to change, or are they rigid, fearing a change in control?<br>emergency responses, and do changes benefit professionals or affected community members?<br>3) What changes have taken place in the organisations since the introduction of emergency responses, and do changes benefit professionals or affected community members? |
| **Resource mobilization** | 1) What is the affected community contributing, and what percentage is this of the total response costs?<br>2) Are resources from the affected community being allocated for the support of parts of the response that would otherwise be covered by government allocations?<br>3) Whose interests are served by the mobilisation and allocation of resources? |
| **Management** | 1) Are decisions solely in the hands of professionals, or are they made jointly with affected community members?<br>2) Are the decision-making structures changing in favour of certain groups, and if so, which groups?<br>3) Are management structures expanding to broaden decision-making groups?<br>4) Is it possible to integrate non-health needs? |

A ranking for each indicator has to be elaborated to determine the scores assigned to describe each of the five categories. The findings also rely on visualisations to help make various dimensions of the assessment clearer.




## Health Communication [4]

1) Is the affected community involved in planning, management and control of the communication for emergency response at the community level?
2) Were the felt needs of the community determined at the outset of the response planning and was notice taken of them in planning the behavioural objectives?
3) Have local forms of social organisation (e.g., farmer's cooperatives, clubs, churches, political organisations, trade unions, etc.) been involved in the decision-making process and to what extent?
4) Is there a mechanism for dialogue between health system personnel and community leadership?
5) Is there a mechanism for community representatives to be involved in decision-making at higher levels and is this effective?
6) Is there any evidence of the external agents changing their plans as a result of criticism from the community?
7) Are deprived groups, such as poor, landless, unemployed, and women, adequately represented in the decision-making process?
8) Are local resources used, such as labour, buildings, money?
9) Was the community involved in evaluating the project and in drafting the final report?

## Social connectedness [5]

1) As a result of the response, is the affected community better able to deal with other problems?
2) Are the communication and mobilisation activities building effective collaborative networks between affected communities, other communities, and organisations?
3) Are the communication and mobilisation activities contributing to the affected community's capacity to deal with issues it faces?
4) Is the affected community being rendered more able to meet its needs or solve current health problems?
5) Are organisations and worksites in affected communities demonstrating increased activity in service delivery and emergency response more generally?
6) Is 'social connectedness' or an increase in 'social connectedness' or networking among community organisations being created as a consequence of the response?

## Measuring communication for social change [6]

- Are meeting times and spaces creating opportunities for poor and marginalised people to speak, be heard and contribute to making decisions?
- In relation to the issues of concern (hygiene, breastfeeding, immunization, vitamin A, safe motherhood, child protection), what increase or other positive changes have there been in:
    - Family discussion?
    - Discussion among friends?
    - Discussion in community gatherings?
    - Problem-solving dialogue?
    - New ways of sharing relevant information?
    - Coverage and discussion in news media?
    - Focus and discussion in entertainment media?
    - Debate and dialogue in the political process?
- Are more people from all affected community groups involved in dialogue about these issues?
- To what extent do participants listen, evaluate information before they use it, challenge rumour and articulate their voice in private and public? Have there been improvements in these areas?
- Who is creating and telling the stories around the issues? Is that changing?
- What are the cultural norms those stories reveal? Are they changing?
- Are new connections between different groups being established within the community, either through face-to-face encounters or using technology?
- Are members of the affected community making their views known to those who hold official power? How? Is this changing?
- Are affected community members connecting with outside allies, communities and groups who support of their efforts?

# Footnotes

1 Davies, R. and Dart, J., The Most Significant Change 'MSC' Technique: A guide to its use, http://www.mande.co.uk/docs/MSCGuide.pdf, 2005.

2 Adapted from Rifkin, S.B., Muller, F. and Bichmann, W. 'Primary Health Care: On measuring participation'. Social Science and Medicine, 26 (9), 1988, pp.931-940.

3 Bichman, W., Rifkin, S., and Shrestha, M. 'Towards the Measurement of Community Participation'. World Health Forum, No. 10, 1989, pp.467-472; Laleman, G., and Annys, S., 'Understanding Community Participation: A health programme in the Philippines', Health Policy and Planning (4)3, 1989, pp.251-256; De Koning, K., Bichman, W., 'Listening to Communities and Health Workers: A participatory training process to improve communication skills of health workers in Cameroon', Learning for Health, No. 3, 1993, pp.3-7; Nakamura, Y., and Siregar, M., 'Qualitative Assessment of Community Participation in Health Promotion Activities, ' World Health Forum, 17, 1996, pp.415-417; Bjärås, G., Haglund, B., and Rifkin, S., 'A New Approach to Community Participation Assessment', Health Promotion International, (6)3, 1991, pp.199-206; Schmidt, D., and Rifkin, S., 'Measuring Participation: First use as a managerial tool for district health planner based on a case study in Tanzania', International Journal of Health Planning and Management, No. 11, 1996, pp.345-358; Parks, W.J., and Hill, P., Kadavu Subdivision Rural Health Project Post-Project Evaluation Report, AusAID, Canberra, 1997; Parks, W., 'Community Participation in Health Program Design: Experiences from Papua New Guinea', Health Services Support Program, Health Promotion Working Paper Series, Brisbane, JTA International,2000.

4 Adapted from Hubley, J., Communicating Health: An action guide to health education and health promotion, MacMillan,London, 1993.

5 Adapted from: Hawe, P., 'Capturing the Meaning of 'Community' in Community Intervention Evaluation: Some contributions from community psychology', Health Promotion International, (9)3, 1994,pp.199-210.

6 Adapted from Hunt, J. ,Notes on Communication for Social Change, in process.

# GENDER CHECKLIST[1]

This checklist can help you clarify instances where men and women's activities overlap with each other and which ones are gender specific. It should also give you ways to ensure that women's views and inputs are represented in your communication initiative.

1. In consultation with local organisations, community leaders, women's representatives, service providers and other relevant individuals who are knowledgeable on gender and disasters, categorise:
   - The specific issues that relate to women.
   - Those that relate to boys and those that relate to girls.
   - Those that relate to the affected community as a whole (issues shared by men and women).
2. Identify locally appropriate, effective mechanisms to gather information and inputs from affected women. Integrate these into the planning, implementation and monitoring process.
3. Pay attention to the concerns of vulnerable groups within the category of women and girls (including the landless, widows, disabled, minority ethnic and religious groups, and others).
4. Ensure that women and girls are not seen as 'helpless victims' by paying attention to the skills and capacities they demonstrate in livelihood and disaster management processes.
5. Have separate discussions with organisations that focus on women's concerns so that the capabilities and strengths of such organisations can be enhanced through their engagement in the communication initiative.

6. Organise consultations with village-level and community organisations that work on issues, and initiate discussions for the appointment of both women and men into leadership positions.
7. Organise and mobilise special women's groups or societies in the affected communities where it is culturally prohibited for men and women to work together.
8. Create and ensure that communication materials have clear graphics and messages, and that other means of communication are available to women to address the concern that women are often culturally restrained in public discussions. Ensure that women and girls are involved in designing graphics and messages.
9. Ensure that emergency communication initiatives include measures that address the gender-based concerns specific to the locality and programmatic issues at hand.
10. Emphasise the importance of sharing and involving both women and men to achieve more focused action on sustained behaviour change and social mobilisation within the affected community.
11. Ensure that women are given space and opportunities within the planning, implementing, monitoring and reporting process to apply their skills and capabilities in your communication initiative.
12. Ensure that there are gender-sensitised women working in the communication effort to interact with affected women.

# Footnotes

1 Source: Adapted from Ariyabandu, M., and Wickramasinghe, M., *Gender Dimensions in Disaster Management: A guide for South Asia,* ITDG South Asia Publication, Colombo, 2003.

# HOW TO CONDUCT A KEY INFORMANT INTERVIEW

The key informant interview is a standard anthropological method that is widely used in health related and other social development inquiry. This is one method used in rapid assessment for gathering information from the affected community. The term "key informant" refers to anyone who can provide detailed information and opinion based on his or her knowledge of a particular issue. Key informant interviews seek qualitative information that can be narrated and cross checked with quantitative data, a method called "triangulation".

## Step 1: Choose the interviewer

The interviewer has to remain neutral and must refrain from asking biased or leading questions during the interview. An effective interviewer understands the topic and does not impose judgments.

Choose an interviewer who:[1]

- Listens carefully.
- Is friendly and can easily establish rapport.
- Knows and understands the local customs, behaviours and beliefs.
- Can inspire confidence and trust.

## Step 2: Identify suitable key informants

Choose suitable key informants according to the purpose of the interview. A key informant can be any person who has a good understanding of the issue you want to explore. The informant can be a community member, teacher, religious or secular leader, indigenous healer, traditional birth attendant, local service provider, children and young people or others from the affected community. Interviews can take place formally or informally – preferably in a setting familiar to the informant.

## Step 3: Conduct the interview[2]

- Based on what you already know about the issue, develop an interview guide beforehand to ensure that all areas of interest are covered. Use open-ended questions as much as possible.
- Hold the interview in a place that can put the respondent at ease.
- Establish contact first by introducing yourself.
- Thank the participant for making his or her time available.
- Describe the objectives of the interview.
- Go through the interview guide questions, (recording the proceedings with a tape recorder only if this exercise is conducted during the emergency preparedness or recovery phases of your communication initiative), together with your notes.
- If time allows tape recorder use, be sure to ask permission tape the interview.
- After each interview, transcribe the results of your discussion, using the guide questions in recording the responses. Remember to write as legibly as possible to facilitate this step.
- For each interviewee, note down your own observations about the process and content of the interview.

### Do not forget to:

- Assure the respondent of confidentiality.
- Avoid judgmental tones so as not to influence responses.
- Show empathy with the respondent and interest in understanding his/her views.
- Let the respondent do most of the talking.
- Be an active, attentive listener.
- Pace yourself according to the time you have allotted for the interview.

## Step 4: Crosscheck information[3]

In the initial response of an emergency each informant may give you new information. But later on, informants usually confirm or clarify the data that you already have. Be sure to confirm that your notes reflect more than one background or viewpoint. If not, your conclusions may end up one-sided or biased.

## Step 5: Use the data

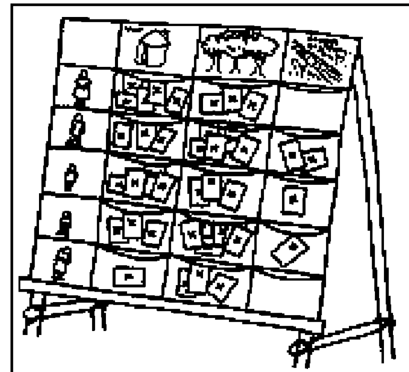
Information from key informant interviews helps you to further probe the needs, wants and priorities of an affected community during a rapid communication assessment exercise. You can use this qualitative information to complement the findings from the initial assessments undertaken in an emergency situation. It can also guide you in developing and adjusting your communication initiative.

## Footnotes

1 Whitman, C., et al., *Rapid Assessment and Action Planning Process,* Health and Human Development Programs, a Division of Education Development Center, Inc. (EDC), The World Health Organization Coordinating Center to Promote Health through Schools and Communities, p. 7.
2 Whitman, C., et al., op.cit., p.7.
3 Adapted from *Needs Assessment Techniques Using Key Informant Interviews*, University of Illinois, Extension Service-Office of Program Planning and Assessment, Chicago, p. 3.

# HOW TO USE A POCKET OR VOTING CHART

The use of pocket charts is a participatory method that can help you examine an affected community's practices more closely, and to monitor progress. You can lead this exercise in various ways. – a cloth pocket chart can be made from cotton by a local tailor. People can vote using tins or pots, or you place drawings or photographs showing selected behaviours on the pocket chart. Once you have chosen the type of chart to use, ask each participant to vote accordingly and as privately as possible. If privacy is not ensured, participants may change their vote to please others. After the votes are cast, collate them and discuss the results with the group.[1]



## A step-by-step guide to using the pocket or voting chart[2]

**Step 1:** Ask a participant who is familiar with the pocket chart to facilitate this activity.

**Step 2:** Set up the pocket chart with a behaviour that is measured and explain what it is and how it is used. Place a vote yourself to show how to use the pocket chart. Make sure you remove your vote and explain that it was a just a demonstration.

**Step 3:** Position the chart so that people can vote in private. Then invite people to approach the chart one at a time to place their votes.

**Step 4:** Once everyone has had a chance to vote, ask a participant to count the votes and display the results. Make sure that the counting is in full view of everyone.

**Step 5:** Facilitate the group discussion on:

- What the pocket chart has shown.
- The reasons why people voted the way they did.
- Whether this result shows improvement (if this is used as a monitoring exercise), or need for improvement.

**Step 6:** Once the comparison has been made, ask the group to discuss:

- What behavioural changes have been successful?
- What behavioural changes have been problematic?

**Step 7:** Ask the group to record (in drawings or words) the problems and sort them into three categories:

- Problems the participants do not fully understand.
- Problems the affected community can deal with by itself.
- Problems the affected community cannot solve by itself.

**Step 8:** Stick the three groups of problems on a wall and ask the participants to decide:

- For the problems not understood, how they will get more information, when they will do this, and whose responsibility it will be.
- For the problems the affected community can deal with, what actions they will take.
- For the problems the affected community cannot solve alone, how they will get outside help to overcome these problems.

**Step 9:** Use information from the pocket or voting exercise to assess the knowledge of the affected community, feed into the initial baseline data report, adjust your programme to meet the evolving needs of the affected community and to verify indicators.

# Sample charts:
## Water use

| | River/stream | Pond | Handpump | Unprotected well | Standpost | Protected spring | Unprotected spring |
|---|---|---|---|---|---|---|---|
| Drinking | | | | | | | |
| Cooking | | | | | | | |
| Washing | | | | | | | |
| Washing utensils | | | | | | | |
| Washing clothes | | | | | | | |
| Making beer | | | | | | | |

*It may be useful to have two voting rounds or two different voting slips for the wet and dry season, or for pre-and-post displacement.

## Public health practices

| Using bednet | Covering drinking water | Hand washing after using toilet | Hand washing after cleaning baby | Hand washing before eating and feeding baby | Disposing of children's faeces in latrine |
|---|---|---|---|---|---|
| Sometimes | | | | | |
| Always | | | | | |
| Never | | | | | |

| Purpose | Most widely used source of water | | Reasons |
|---|---|---|---|
| | 1st | 2nd | |
| Drinking | | | |
| Cooking | | | |
| Washing | | | |
| Washing utensils | | | |
| Making beer | | | |

## Defaecation practices

| | Latrine | Fields | Compound | River |
|---|---|---|---|---|
| Women/girls | | | | |
| Men/boys | | | | |
| Girl Children < 8yrs | | | | |
| Boy Children < 8yrs | | | | |
| Old Women | | | | |
| Old Men | | | | |
| Babies' faeces | | | | |

# Footnotes

1 Adapted from Oxfam UK, *Guidelines for Public Health Promotion in Emergencies*, Oxfam, London, 2000, pp. 79 – 80. Sample charts adapted from Oxfam.

2 Adapted from Sawyer, R., et al., 'Part II Step-by-step activities' as cited in *PHAST Step-by-Step Guide: A participatory approach for the control of diarrhoeal disease*, WHO, Geneva, 1998, pp. 90-91.

# HOW TO DO A RANKING EXERCISE

A ranking exercise is a simple, participatory and rapid method for establishing what the affected community considers its primary problems and needs. In contrast to simple voting procedures, ranking can help you identify different priorities and the associated facilities and activities needed within a camp of an affected community.

### Step 1: Know the exercise

Do the preference ranking in six basic steps:[1]

- Identify participants.
- Draw the matrix.
- Rank the items against each other.
- Document each result in the matrix.
- Count the scores.
- Facilitate a discussion and identify the main actions needed.

### Step 2: Diversify your participant group

If participants in this ranking exercise represent various groups affected by the emergency - primary caregivers, community leaders, health workers, vulnerable groups such as children, young people, widows, displaced people and so on - you will be able to establish the different priorities, associated actions, facilities and services needed.

### Step 3: Facilitate the process

The facilitator helps guide the group in identifying and weighing its priorities as well as identifying and weighing the associated facilities, services and activities needed; however, the ideas should primarily come from the participants.

### The facilitator should:[2]

- Introduce the purpose of the exercise and how it will be used.
- Give either a practical example from a previous ranking exercise – or better – run through it once with one of the participants, where he/she acts as interviewer and the participant acts as interviewee.
- Divide the participants into sub-groups of three persons.
- Instruct each sub-group to select one interviewer, one informant who answers the questions and one recorder who writes the reasons that the informant gave for the preferences. The sub-group exercise works best when to explain and complete each step before the next step is started.
- The sub-groups then present their results and observations to the whole group

| Priority Needs | Rank | Associated facilities/activities | Rank |
|---|---|---|---|
| Preventing Diarrhoea | 4 | Communal latrines<br>Family latrines<br>Hand washing | 1<br>3<br>2 |
| Clean Environment | 2 | Solid waste pits<br>Cleaning materials | 2<br>1 |
| Preventing Malaria | 3 | Wastewater disposal<br>Bed nets | 2<br>1 |
| Traditional Funerals | 1 | Morgue<br>Burial ground<br>Coffins<br>Concrete Grave markers | 4<br>1<br>2<br>3 |
| Family Facilities | 5 | Family latrines<br>Family solid waste pits<br>Cleaning materials<br>Tools | 4<br>3<br>1<br>2 |

The following table shows an sample ranking exercise for sanitation related needs and priorities. The first priority is ranked as 1, the second 2, and so on:[3]

**Step 4: Interpret the results**

Priorities may differ greatly and the exercise may produce surprising results. An important advantage is that participants can see how the main needs or problems of a person or a group can be determined. In addition, the affected individuals can learn how to compare the priorities of different groups within the affected community against another. In the above exercise, the group was much more concerned with funeral rites than with diarrhoea.

**Step 5: Use the data**

For a hygiene promotion programme, you can use ranking to help the affected community prioritise the most significant problems, understand the links between seasonal changes and incidence of disease, understand water sources and use, and sanitation practices. Overall, you can use information gained from ranking exercises as inputs to planning and assessment and for subsequent monitoring and evaluation of your BCC programme.[4] Remember that priorities and actions differ depending on the impact and stage of the emergency.

## Footnotes

1 Berg, C. et al., *Introduction of a Participatory and Integrated Development Process (PIDEP) in Kalomo District, Zambia, Vol., 2, Manual for trainers and users of PIDEP,* 1997.

2 Adapted from Berg, C., et al., op.cit.

3 Harvey, P., et al., *Emergency Sanitation: Assessment and programme design,* London, 2003, p. 184.

4 Adapted from Oxfam UK, *Guidelines for Public Health Promotion in Emergencies,* Oxfam, London, 2001, p. 22.

# HOW TO FACILITATE PARTICIPATORY EXERCISES

The most important thing to remember about being a facilitator is that you are not a teacher. Your role is to help or "facilitate".[1] In planning your communication, recognise that command and control, and participatory processes go hand-in-hand. Human rights demand participatory processes in which all stakeholders buy in and contribute to solutions. Participatory processes are valuable in all stages of a emergency programme cycle – from rapid assessment to monitoring and evaluation - but such processes need to be integrated and balanced with command and control procedures during rapidly changing events that require quick decision-making and action.

With that in mind, when leading focus group discussions, doing a ranking or pocket chart exercise, a KAP survey or using any rapid assessment or monitoring and evaluation tool, your role is to help affected individuals and community groups to:

- Identify issues of importance to them.
- Express their problems.
- Analyse their problems.
- Identify possible solutions.
- Select appropriate options.
- Develop a plan to implement the solutions to which they identify and agree.
- Evaluate the outcome of the plan.

## So you must not:

- Give information: instead, allow the group to find out information for themselves (although, it may be that in the initial days after a disaster, people will be seeking/needing information).
- Tell the group what they should do. Let them discuss and agree on what they should do and how they would like to do it.
- Make assumptions about what the right response should be to an activity.

Using participatory methods does not reduce the role of the facilitator in an emergency response situation, but rather redefines it. What you can do is encourage and facilitate community involvement; and create an environment in which the participants can discover information for themselves. In so doing, participants will build the confidence and self-esteem necessary to analyse problems and work out solutions.

As a facilitator, you are not a leader who directs the group to where you think it should go. Instead, you help the group to better understand its own situation and to enable them to make informed decisions on how to improve that situation.

## Keep these important points in mind:

### All participants are equal

The activities in this guide have been developed so that the participation of each group member is considered equally important. The participants must view you as an equal. So you should not present yourself as an authority figure. Information should flow from you to the group and vice versa. By sharing and receiving information, you and the group will remain equal. For this type of information exchange, good listening skills are essential.

### There is no one right answer

This means that there can be many correct answers or results. Decisions made by the group reflect what is right for the group and what the group is prepared to take responsibility for.

### Create the right atmosphere

If your aim is to reach agreement on priorities for activities, or a plan for improving hygiene behaviours and sanitation, participants must be able to work well together. This is why participatory sessions often begin with a fun activity, something to break the ice and make people laugh. You need to make people feel at ease

throughout the planning process. Most cultures have traditional games and songs that can create the right atmosphere and build group spirit.

## Coping with dominant personalities

From time to time the group process may not be able to proceed because one individual wants to control the group's thinking. If this happens, find out whether the dominant individual is a designated leader, or simply a competitive or aggressive person with little or no significant support or influence in the group. Competitive or aggressive persons can either be taken aside and convinced of the importance of the group process, or given separate tasks to keep them busy and allow the group to carry on. If the persons concerned are community leaders, approach them formally or privately – early in the planning phase – explain the process, and try to gain their support. Hopefully, you will convince them that allowing community members to fully and equally participate will result in the personal growth of and better conditions for each participant.

## General guidance for all activities:

1. Have all the materials for each activity ready before starting.
2. Make sure the materials are large enough to be seen by all participants.
3. Try to limit the size of your group to no more than 40 persons.
4. Make sure that people can talk to one another easily. Use a circle where possible.
5. Begin each new session with a warm-up activity such as a game or song. Provide refreshments where possible.
6. Go through each activity one step at a time and follow the instructions in the guide.
7. When giving the group its task, use the exact words provided for this purpose.
8. Encourage and welcome the input that individuals make. Remember, there are no wrong answers.
9. Facilitate the group, do not direct it.
10. Try to encourage the active participation of each participant. Be careful not to find fault or make critical comments when you respond to people.
11. Take into account the participants' literacy level and work out ways in which they can keep record of what is discussed and agreed.
12. Have the group keep the materials and records in a safe place.
13. At the end of each activity, ask the group members to evaluate the activity on the basis of what they have learned, what they liked and what they did not like.
14. At the end of each session, congratulate the group members on their efforts and explain briefly what will be covered at the next session.

15. At the beginning of each new meeting of the group, ask the group to review what it has done so far and the decisions it has taken.

# Footnotes

1 Adapted from Sawyer, R., et al., 'Part I 'Introduction to the PHAST Step-by-step Guide' as cited in *PHAST Step-by-Step Guide: a participatory approach for the control of diarrhoeal disease*, WHO, Geneva, 1998, p. 88.

# MONITORING CHART

A monitoring chart can be used to see if the set goals for your communication initiative have been met.[1]

**Step 1: Have the group look at the monitoring chart to review the goals set during the initial**
emergency response. Then ask them to compare these goals with what has been achieved since making the chart. The group might want to make a record of the differences between what was planned and what has been achieved. Encourage participants to make a comparison in any way it wants – using pens, paper, drawings, words, etc.

**Step 2: Once the comparison has been made, ask the group to discuss:**
- Successes.
- Problems.

**Step 3: Ask the group to record (in drawings or words) the problems and sort them into three categories:**
- Problems the affected community can deal with by itself.
- Problems the participants do not fully understand.
- Problems the affected community cannot solve by itself.

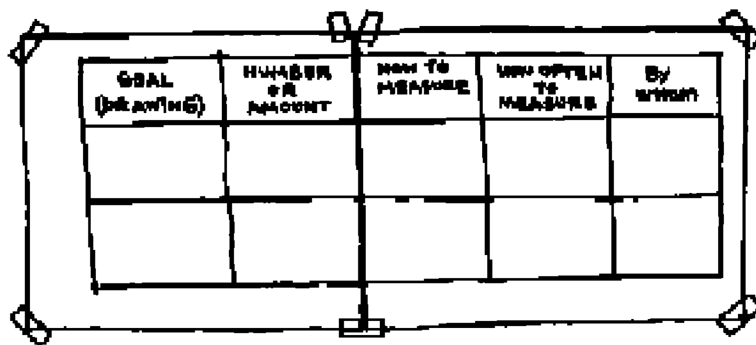
**Step 4: Stick the three groups of problems on a wall and ask the participants to decide:**
- **For the problems the affected community can deal with**, what actions they will take.
- **For the problems not understood**, how they will get more information, when they will do this, and whose responsibility it will be.
- **For the problems the affected community cannot solve alone**, how they will get outside help to overcome these problems.

**Step 5: Discuss possible (or adjustments to existing) communication methods that can help the affected community overcome its problems. Find out whether existing communication channels are reaching the target populations in the affected community.**

**Step 6: Finish with a discussion on what was learned, liked/disliked about the activity. Investigate**

**Step 7:** Adjust messages, communication channels and behavioural objectives according to the information received.

## Sample monitoring chart




## Footnotes

1 Source: Adapted from Sawyer, R., et al., 'Part II Step-by-Step Activities' as cited in *PHAST Step-by-Step Guide: A participatory approach for the control of diarrhoeal disease*, WHO, Geneva, 1998, p. 88.

# STRUCTURED OBSERVATION CHECKLIST FOR COMMUNICATION SKILLS[1]

- **Collect a group of stakeholders to work on developing this checklist:** This will depend on the programmatic issue but stakeholders can include trainers, relief workers or anyone who is a representative of the people whose behaviour is being observed. Whoever is chosen needs to be acquainted with the event to be measured. A research agency might also be involved.
- **Observe event to be measured**: This can be done in various ways such as a health worker leading a group meeting or a peer educator doing an individual interpersonal communication session. Usually, this is done with a role play. Prepare the person/people doing the role play to demonstrate a "perfect" example of the communication session to be observed.
- **Identify key behaviours or skills observed** in the event. Record them on VIPP cards or flip chart.
- **Through discussion** (and perhaps repeated demonstration of the event) **reduce the number of behaviours/skills to a few items** for the observation check list. While there is no correct number of items for a check list, you will need to strike a balance between capturing the essence of a good communication session, by having a measurement tool that can be correctly (90 percent accuracy by 100 percent of the observers) and easily used. Somewhere from five to eight items can be handled by a trained observer who is scoring a 5-minute event.
- **Operationalise each item selected for the list**. Operationalising means making the item easy for multiple observers to check correctly. For example, the health worker (HW) shouldn't read the text of the flipchart. The HW must look at the participants at least half the time while he/she is using or discussing the flipchart.
- **Train observers to reach 90 percent agreement** for each item. Use repeated role plays of the event to score and discuss why each observer did or did not check the item. If 90 percent agreement cannot be reached, then re-define the item; clarify exactly what behaviours constitute a "yes". This can be done by looking at the group once, three times, half the time. Or calling on one, two or three participants who have not been talking, etc.

- **After field testing, discuss whether getting a perfect score on the check list** does, indeed, **capture an adequate, acceptable communication session**. If it does not, consider replacing items with others or adding to the exercise. Remember, the more items on the check list, the more difficult it will be to use correctly.

*This is a check list to record observed communication skills only. To record the context of the communication session (time of day, physical conditions, language used, characteristics of the field worker), use another sheet that can be filled out before or after the actual observation.*

Sample Checklist for Community Nutrition Promoter's Communication Skills during a Nutrition Advice Session

Community Nutrition Promoter ________

Date of Session __________

## Community Nutrition Promoter:

| | | |
|---|---|---|
| Greets all participants | Y | N |
| When speaking moves head to make eye contact with participants | Y | N |
| Uses open-ended questions to check for understanding | Y | N |
| When using material, keeps it visible to all participants | Y | N |
| When using material, asks questions on content of material | Y | N |
| Summarises the actions of mothers at end of session | Y | N |

**OBSERVER COMMENTS:**

## Footnotes

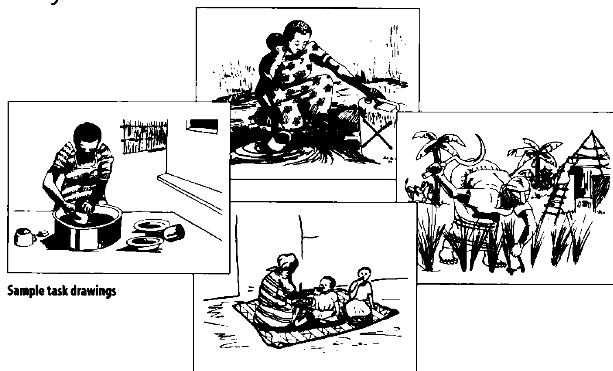
1 Source: Graeff, J., *Final Report on Behavioural Monitoring Workshop*, UNICEF Dhaka, 2005.

# TASKS OF MEN AND WOMEN IN THE COMMUNITY

This exercise can be done to increase knowledge and understanding of which household and community tasks are done by affected women, and which are done by affected men. It can also help identify whether any change in task allocation would be desirable and possible.[1]

## What to do

1. If there has been a break between this activity and a previous one, start with a group discussion to review what was learned or decided at the previous meeting.
2. Ask the participants to form groups from five to eight people.
3. Using the following words, ask the group to carry out the activity:
   *"Each group will be given a drawing of a man, a woman and a man and woman (a couple) together, and a set of drawings showing different tasks. Discuss in your group who would normally do this task. When you agree, put the task drawing underneath the drawing of the man, woman or couple based on what you decide. The drawing of the man and woman together means that both sexes perform the task"*



Sample task drawings

4 Let the groups work on their own and discuss their findings. They can draw and add other tasks. You should provide them with blank paper for this purpose.
5 Once the activity has been completed, ask each group to present its selection to the rest of the participants, explain its choice and answer any questions.
6 Facilitate a group discussion on:
   - Who does what tasks.
   - The workloads of men and women.
   - How differences in workloads might affect task allocation for overcoming the new problems in the community because of the disaster.
   - The advantages and disadvantages of changing tasks done by men and women.
   - The potential for changing the tasks done by men or women.
   - Ask the group to identify roles which could be changed or modified in order to improve sanitation and hygiene, and record these conclusions for use in monitoring later on.
7 Facilitate a discussion with the group on what it has learned during this activity, what it liked and disliked about this activity.

## Special Note:

During this activity men sometimes complain that drawings of their usual tasks have not been included in the set. This is because the set focuses mostly on tasks related to domestic and community hygiene and sanitation, and in most societies these tasks fall to women. If this happens, ask the men to make drawings of tasks they perform, and add them to the activity. The group may decide that three drawings (man, woman, and both together) are not enough and choose to add drawings of boys and girls. This is fine, but the analysis should focus on gender not age.

## Footnotes

1 Adapted from Sawyer, R., et al., 'Part II Step-by-step activities' as cited in *PHAST Step-by-Step Guide: A participatory approach for the control of diarrhoeal disease*, WHO, Geneva, 1998, pp. 33-35.

# A 12- POINT COMMUNICATION MONITORING CHECKLIST

1. Was an assessment done to identify:
   a. The information gaps among your audience (i.e. health workers, caregivers, volunteers or other critical groups)?
   b. The information-seeking and sharing patterns of the affected communities (communication network analysis)?
   c. The main barriers for affected families and communities to practice the intended behaviour (e.g. caretakers taking their children to immunization services, safe hygiene practices)?

2. Did you develop a communication plan that is linked to the service and supply components of the emergency response?

3. Does the plan clearly state the behavioural objectives you seek to influence?

4. Did you prepare an implementation plan?

5. Does it include opportunities for community participation in areas such as material preparation, message design and dissemination?

6. Did you establish a monitoring system to keep track of your efforts and gather feedback?

7. Did you determine the budget?

8. Are messages and materials gender, age and culturally sensitive and appropriate?

9. Did you choose the most appropriate a mix of the most effective communication channels – interpersonal and mediated?

10. Did you invite and receive feedback from the various audience(s) of the affected community on your suggested messages and materials (pre-testing)?

11. Do you know if the material and the messages in it reached the people they were meant to reach (e.g. affected population, health workers, volunteers, etc.)?

12 Do you have a system to share and manage the information with humanitarian organisations, UN sister agencies, government bodies, professional organisations and other concerned partners?

# TOOLS TO MONITOR THE MILESTONES

Chapters 4 through 8 each contains a section on *Monitoring milestones*. The section should help you establish simple monitoring and evaluation systems. Importantly, the inclusion of such a section in each chapter emphasises the need for early planning of how communication programmes will be monitored and evaluated. In other words, M&E must be developed during the communication planning stage, if not during the pre-planning or "groundwork" stage. Development of indicators, of course, will depend on specific behavioural results to be achieved, but the indicators presented in each section are useful guides.

## Chapter 4 – Hygiene Promotion

Each indicator provided in the monitoring milestone sections needs to be measurable. Some indicators (identified below), may not be measured easily – so we have provided some measurement tools that can help you measure the suggested indicators.

| Indicators for hygiene practice | Measurement tools |
|---|---|
| ▪ " People use the toilets available and children's faeces are disposed of immediately and hygienically.<br>" People use toilets in the most hygienic way, both for their own health and for the health of others. | Observation<br>Self report<br>Focus group discussion |

| Indicators for hygiene practice | Measurement tools |
|---|---|
| " Household toilets are cleaned and maintained in such a way that they are used by all intended users and are hygienic and safe to use. | Household observation<br>Focus group discussion |
| ■ Parents (mothers and fathers or other primary caregivers) demonstrate knowledge of the need to dispose of children's faeces safely. | Focus group discussion<br>Ranking exercise<br>KAPS survey |
| ■ Families and individuals participate in a family latrine programme by registering with the agency, digging pits or collecting materials.<br>■ People wash their hands after defecation and handling children's faeces and before cooking and eating.<br>■ People demonstrate correct hand-washing and know when to engage in this behaviour. | Registration records<br>Observation<br>KAPS survey<br>Demonstration of correct hand-washing |

| Key indicators for design and implementation of your hygiene promotion programme | Measurement tools |
|---|---|
| ■ Key hygiene risks of public health importance are identified. | Review of key IEC materials |
| ■ Programmes include an effective mechanism for representative and participatory input from all users at all phases, including the initial design and location of facilities - | Observation of latrine design, camp adjustments<br>Focus group discussions with girls, women and disabled<br>Reports from health workers |

| Key indicators for design and implementation of your hygiene promotion programme | Measurement tools |
|---|---|
| making sure that latrines accommodate the disabled; are well-lit and designed to protect women from sexual molestation; and provide girls and women the privacy to cleanse themselves, wash out underclothes and sanitary napkins. | |
| ■ All groups within the affected community have equitable access to the resources or facilities needed to continue or achieve the hygiene practices that are promoted. | Observation of latrine design<br>Focus group discussions with girls, women and disabled<br>Reports from health workers, camp managers, latrine attendants<br>Key informant interviews<br>Gender checklist |
| ■ Hygiene promotion messages and activities address key behaviours and misconceptions and are targeted for all participant groups. Representatives from these groups participate in planning, training, implementation, monitoring and evaluation. | Pre-and-post testing of materials<br>Participation logs of FGDs, ranking exercises, pocket or voting exercises<br>Monitoring chart |
| ■ Participants take responsibility for the management and maintenance of facilities as appropriate, and all populations of the affected community contribute equitably. | Observation<br>Latrine/facility maintenance reports<br>Tasks of men and women in the community. |

# Chapter 5 - Breastfeeding

| Indicator | Possible measurement tools/sources of information |
|---|---|
| ■ Health workers, peer educators, birth attendants, midwives and other relevant service providers are trained on infant and child feeding practices, and can communicate and motivate affected women to breastfeed exclusively and safely prepare BMS and cup feed (in exceptional cases). | Register of training events<br>Structured interview<br>Structured observation checklist<br>Demonstration |
| ■ Breastfeeding women know the benefits of colostrum, the importance of/how-to breastfeed, and how-to safely prepare BMS and cup feed - and are doing it. | Structured interview<br>Structured observation checklist<br>Demonstration |
| ■ The affected community is mobilised to support breastfeeding women via, mother-to-mother support networks, "safe havens", trials of new feeding practices, activities in women's groups, etc. | Semi-structured interviews<br>Focus group discussions<br>Observation of trials<br>Observation of women's groups |
| ■ Infants under six months are exclusively breastfed, wet-nursed (where acceptable), or in exceptional cases, have access to an adequate amount of an appropriate BMS. | Mother's self-report (24 hour recall interview)<br>Demonstration of appropriate use of BMS |
| ■ Local governments, humanitarian agencies, camp management and other service providers know the international guidelines on the marketing of BMS, the appropriate use of BMS in emergencies, and are supplying it to artificially-fed infants without undermining the breastfeeding population at the camp. | Structured interview<br>BMS supply records |

## Chapter 6: Immunization and vitamin A promotion

| Input indicators | Possible measurement tools/sources of information |
|---|---|
| ■ Percentage of communication plans that map resistant or difficult groups, including "zero-dose" children, and propose strategies for reaching them | Document analysis of communication plans. |
| ■ Is there a communication component for EPI in the emergency preparedness and response plan? | Emergency response and preparedness plans<br>EPI programme |
| ■ Does the communication component to support the EPI programme in an emergency situation include a budget? | Financial documents<br>EPI programme proposal |
| ■ Number of planned outreach activities in the affected communities and camps. | Analysis of communication plan |
| ■ Number of materials produced. | Literature audit |

| Output indicators | Possible measurement tools/sources of information |
|---|---|
| ■ Percentage of emergency vaccination programme budgets used for, a) broadcast media, b) print materials, and c) strengthening of interpersonal communication skills. | Financial plans, budgets |
| ■ Percentage of planned activities to reach the hard to reach population groups actually conducted. | Programme reports, field observations, structured observation checklist |
| ■ Number of materials disseminated and visible/used in health facilities. | Observation, material audit, health worker/caregiver self-reports or interviews |

| Output indicators | Possible measurement tools/sources of information |
|---|---|
| ■ Number of health workers and mobilisers trained in immunization communication. What is the number of training sessions conducted? | Training logs<br>Programme reports, observation, meeting reports |
| ■ Number of meetings held with community and faith leaders. | Structured interview including photographs (measles symptoms) |
| ■ Percentage of health workers/ vaccinators/care-givers who know how-to recognise measles and where such a case should be reported. | |

| Outcome indicators (linked to EPI indicators) | Possible measurement tools/sources of information |
|---|---|
| ■ Percentage of health workers/ vaccinators providing key messages during immunization sessions. | Exit interviews with caregivers<br>Key informant interviews<br>Structured observation checklist<br>Field observations |
| ■ Percentage or caregivers with vaccination cards. | Vaccination records<br>Self report |
| ■ Percentage of caregivers who know where to go for vaccination and vitamin A supplementation. | Key informant interviews<br>KAP surveys<br>Self report |
| ■ Percentage of caregivers who know where to take a sick child for treatment. | Same as above. |
| ■ Percentage of households in affected communities/camps visited by community health volunteers/ mobilisers. | Field reports<br>Self report |

| Outcome indicators (linked to EPI indicators) | Possible measurement tools/sources of information |
|---|---|
| ■ Percentage of budget spent on communication activities according to the plan. | Financial documents |

| Impact indicators (EPI indicators) include: | Possible measurement tools/sources of information |
|---|---|
| ■ Percentage of children vaccinated with measles.<br>■ Percentage of children who received vitamin A supplements.<br>■ Percentage of drop-out rates.<br>■ Percentage of planned outreach sessions actually conducted. | Health centre records, programme reports, field reports |

## Chapter 7: Safe Motherhood

| Indicator | Possible measurement tools/sources of information |
|---|---|
| ■ Health workers, midwives, women's representatives, counsellors and other relevant stakeholders are trained on maternal nutrition and breastfeeding facts and communicate the importance of antenatal and postnatal care visits, clean and attended delivery, the warning signs during pregnancy and danger signs during pregnancy. | Training records; self-report of health workers, midwives, counsellors and women's representatives<br>Demonstration |
| ■ Affected women and their families know the benefits of eating healthy, taking vitamin A supplements and iron; receiving tetanus shots; clean and attended delivery; seeking antenatal and postnatal care - and are doing it. | Health centre registers<br>FGD with affected pregnant women/new moms/family members<br>Key informant interviews<br>Structured interviews |

| Indicator | Possible measurement tools/sources of information |
|---|---|
| ■ Affected women and their families know the warning signs during pregnancy; when and where to get immediate help, and are seeking medical help when complications occur. | Same as above. |
| ■ The affected community demonstrates support to pregnant women via mother-to-mother support networks, women's group, community-based birthing plans and referral systems, etc. | Presence of active support groups in affected community<br>Established referral systems<br>FGD/structured interviews with community members |
| ■ Local governments and humanitarian agencies have allocated the resources needed for adequate care and affordable quality services; have established the necessary transportation systems, supplied essential drugs, clean delivery kits - and have formed necessary partnerships to supply these. | Transportation systems in place<br>Work plans<br>Financial documents, approved budgets<br>Medicines/clean delivery kits available to women, health facilities |

# Chapter 8 Child Protection

| Indicator | Possible measurement tools/sources of information |
|---|---|
| Affected parents/primary caregivers know the importance of recreational/ educational activities to the psychosocial recovery of children, know where these activities are provided in the camp and are sending affected children. | Structured interview<br>Focus group discussion<br>Group mapping (of camp)<br>Observation of children attending recreational/educational facilities<br>Registers of children at above facilities |

| Indicator | Possible measurement tools/sources of information |
| --- | --- |
| Affected parents/primary caregivers know not to leave their children unattended, and are aware of the unsafe areas for children in the camps. | Structured interview<br>Focus group discussion<br>Group mapping (of camp)<br>Observation of unsafe areas |
| Parents/primary caregivers know how-to prevent child separation in the camp, during migration or evacuation and are doing it. | Structured interview<br>Focus group discussion<br>Story with a gap (pictures illustrating before and after potential child separation) - "Story with a gap" is explained below<br>Registry of reported child separation |
| Camp officials know the importance of lighting latrines, providing adequate camp security and designating safe spaces for women and children and are making the necessary adjustments. | Meeting reports<br>Interviews with camp officials<br>Observation of camp adjustments |
| The affected community knows to report strangers, (suspected) traffickers that enter the camp and are doing it. | Focus group discussion (with affected community members)<br>Registers of reported "suspected" traffickers |
| Parents/primary caregivers who have lost children know how/where to go to register, facilitate tracing. | Structured interview (with parents)<br>Register kept at "tracing centres" |
| Separated children know their rights to be involved in the decisions being made for them; know where to go to register, facilitate tracing and receive essential services | Focus group (with children)<br>Register kept at "tracing centres" and essential services |

| Indicator | Possible measurement tools/sources of information |
|---|---|
| Social workers, camp managers, service providers know the rights of separated children and how to communicate these rights to them. | Structured interview (with social workers, camp managers, service providers)<br>Observation checklist of communication sessions with separated children |
| The affected community knows the signs of abuse, trafficking, molestation; how-to report it and are doing it. | Structured interview with sample of affected community members<br>Registers at centres dealing with abuse, trafficking and molestation |
| Affected children know to report abuse to them or their friends and are doing it | Focus group with children<br>Registers at centres dealing with abuse |

# HOW TO DESIGN A RADIO SPOT

Depending on the impact of the disaster as well as the availability and reach of technology, radio might be a very useful channel to quickly share information and disseminate messages on health, child protection, immunization, water, hygiene and sanitation, safe motherhood or HIV and AIDS in an emergency situation. Take care to find out if the affected community has access to radio and prefers it as a communication source. This information would be best gathered in the emergency preparedness phase of your BCC initiative, but it can be explored in various participatory assessments that you facilitate in the emergency's initial response.

If you find that the affected community prefers and has access to radio, and you have to design a radio spot, or judge the quality of drafts presented to you, consider following points:[1]

**Step 1: Present one idea**
Each radio spot should have one main message, which should be repeated several times during the spot.

**Step 2: Choose a credible source of information**
Engage and feature a source of information (e.g. a well known public figure) that is suggested or accepted by the affected communities.

### Step 3: Break the mould

Try innovative ideas and formats.

### Step 4: Touch the heart as well as the mind of the listener

Make the listener *feel* something after hearing the spot or programme — happy, confident that they can do something – but make them *feel*.

### Step 5: Stretch the listener's imagination

The voices, music and sound effects can and should evoke pictures and create images in the listener's mind.

### Step 6: Write for the ear

Radio spots should have the same natural, spontaneous sound as conversation.

### Step 7: Write to the individual

Imagine the face of a person within your participant group and write for that person.

### Step 8: Ask listeners to take action

Be explicit about what the listeners can do to resolve their problem.

### Step 9: Provide consistency

Develop a similarity of sound in all of your radio materials, providing continuity to the radio materials.

### Step 10: Plan more than one spot

Plan a serious of spots in concentrated numbers (e.g., 10 spots per evening for a week – if evening is the preferred listening time, rather than one spot per day).

## Footnotes

1 Source: Adapted from United Nations Children's Fund, 'A manual on communication for water supply and environmental sanitation programmes', *Water, Environment and Sanitation Technical Guidelines Series, No. 7*, UNICEF, New York, 1999, pp. 72 - 73.

# HOW TO DESIGN PRINT MATERIALS

Before you develop any print materials, review the behavioural objectives of your communication initiative and consider the main groups you want to reach (e.g. affected caregivers, children, health workers, teachers and/or others); whether they can they read, and if so, whether they like to read. This would be best done before a disaster strikes because it would allow for significant pre-testing, translation to local dialects, and the input of various groups within the affected community. Working on print materials pre-disaster also allows you to design materials with greater assurance that the messages and graphics are culturally, religiously and gender-appropriate.

## When designing print materials, keep the following principles in mind:[1]

### The number one principle is: community engagement

- Involve affected community members in all phases of material development – this goes beyond pre-and-post testing of your print material. Emergency preparedness allows you to engage the affected community to the fullest.

### Choose a simple, logical design and layout

- Present only one (1) message per illustration.
- Make materials interactive and creative.
- Limit the number of concepts and pages of materials.
- Messages should be in the sequence that is most logical to the group.
- Use illustrations to help explain the text.
- Leave plenty of white space to make it easier to see the illustrations and text.

### Use illustrations and images

- Use simple illustrations or images.
- Use appropriate styles: (1) photographs without unnecessary detail, (2) complete drawings of figures when possible, and (3) line drawings.
- Use familiar images that represent objects and situations to which the affected community can relate.
- Use realistic illustrations.
- Illustrate objects in scale and in context whenever possible.
- Don’t use symbols unless they are pre-tested with members of the affected community.
- Use appropriate colours.

### Use text to your advantage

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

### Provide supervision for material production

- Without careful supervision, materials may end up in wrong colours, incorrect alignment, or careless print jobs. Have an experienced member of your team providing close supervision to the printing work.

## Special Note:

### Combine print materials with small community media, IPC approaches and other participatory communication strategies.

Printed IEC materials are most effective when combined with other forms of communication. In the initial response, print media can be used to quickly dispense life-saving messages to large numbers of affected people. Experience has shown, however, that print materials are more effective when combined with interpersonal communication. This allows the affected community to discuss the new information with someone that they trust.

## Footnotes

1 Source: Adapted from United Nations Children’s Fund, ‘A manual on communiction for water supply and environmental sanitation programmes’, *Water, Environment and Sanitation Technical Guidelines Series, No. 7*, UNICEF New York, 1999, p. 74

# PRINCIPLES AND GUIDELINES FOR ETHICAL REPORTING ON CHILDREN AND YOUNG PEOPLE UNDER 18[1]

Reporting on children and young people has its special challenges, especially in emergencies. In some instances reporting on children places them or other children at risk of retribution or stigmatisation.

The following principles have been developed to assist journalists as they report on issues affecting children. They are offered as guidelines that UNICEF believes will help the media to cover children in an age-appropriate and sensitive manner. The guidelines are meant to support the best intentions of ethical reporters**: serving the public interest without compromising the rights of children**.

## I. Principles

1. The dignity and rights of every child are to be respected in every circumstance.
2. In interviewing and reporting on children, special attention is to be paid to each child's right to privacy and confidentiality, to have their opinions heard, to participate in decisions affecting them and to be protected from potential and actual harm and retribution.
3. The best interests of each child are to be protected over any other consideration, including advocacy for children's issues and the promotion of child rights.
4. When trying to determine the best interests of a child, the child's right to have their views taken into account are to be given due weight in accordance with their age and maturity.
5. Those closest to the child's situation and best able to assess it are to be consulted about the political, social and cultural ramifications of any news reports.

6. Do not publish a story or an image which might place the child, siblings or peers at risk – even when identities are changed, obscured or unused.

## II.Guidelines for interviewing children

1. Do no harm to any child; avoid questions, attitude statements,opinions or comments that are judgmental and insensitive to cultural values, that place a child in danger or expose a child to humiliation, or that reactivate a child's pain and grief from traumatic events.
2. Do not discriminate your choice of children to interview because of sex, race, age, religion, status, educational background or physical abilities.
3. No staging: Do not ask children to tell a story or take an action that is not part of their own history.
4. Ensure that the child and the guardian know they are talking with a reporter. Explain the purpose of the interview and its intended use.
5. Obtain permission from the child and his/her guardian for all interviews, videotaping and, when possible, for documentary photographs. When possible and appropriate, this permission should be in writing.
6. Obtain permission in all circumstances to ensure that the child and the guardian are not coerced in any way and that they understand and agree that they are part of a story that might be disseminated locally and globally. This is usually only ensured if the permission is obtained in the child's language, and if the decision is made in consultation with an adult the child trusts.
7. Pay attention to where and how the child is interviewed. Limit the number of interviewers and photographers. Try to ascertain that the child is comfortable and able to tell his/her story without pressure from anyone, including the interviewer. In film, video and radio interviews, consider what the choice of visual or audio background might imply about the child and her or his life and story. Ensure that the child would not be endangered or adversely affected by showing their home, community or general whereabouts.

## III. Guidelines for reporting on children

1. Do not further stigmatise any child; avoid categorisations or descriptions that expose a child to negative reprisals - including additional physical or psychological harm, or to lifelong abuse, discrimination or rejection by their local communities.
2. Always provide an accurate context for the child's story or image.
3. Always change the name and obscure the visual identity of any child who is identified as:
   a. A victim of sexual abuse or exploitation.
   b. A perpetrator of physical or sexual abuse.

c. HIV positive, living with AIDS or has died from AIDS (unless the child, a parent or a guardian gives fully informed consent).
d. Charged or convicted of a crime.

4. In certain circumstances of risk or potential risk of harm or retribution, change the name and obscure the visual identity of any child who is identified as:
   a. A current or former child combatant.
   b. An asylum seeker, a refugee or an internally displaced person (IDP).
5. In certain cases, using a child's identity – his or her name and/or recognisable image – is in the child's best interests. Take note, that when the child's identity is used, the child must still be protected against harm and supported through any stigmatisation or reprisals.
   Some examples of these special cases are:
   a. When a child initiates contact with the reporter, wanting to exercise his/her right to freedom of expression and his/her right to have their opinion heard.
   b. When a child is part of a sustained programme of activism or social mobilisation and wants to be so identified.
   c. When a child is engaged in a psychosocial programme and claiming his/her name and identity is part of his/her healthy development.
6. Confirm the accuracy of what the child has to say, either with other children or an adult, preferably with both.
7. When in doubt about whether a child is at risk, report on the general situation for children rather than on an individual child, no matter how newsworthy the story.



## Footnotes

1 Sources: The Convention on the Rights of the Child; *Child Rights and the Media: Guidelines for Journalists*, International Federation of Journalists; Media and Children in Need of Special Protection (internal document), UNICEF's Division of Communication; and Second International Consultation on HIV/AIDS and Human Rights, United Nations Secretary-General.

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