Provider Behavior Change Implementation Kit

Changing the Behavior of Community Health Workers and Facility Based Providers

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Using SBCC to Change Provider Behavior and Improve Client Outcomes

Understand and prioritize barriers healthcare providers face; identify whether those barriers can be addressed by a social and behavior change communication (SBCC) approach; and develop an SBCC intervention to influence attitudes, beliefs and norms that undermine providers' willingness and ability to perform their jobs well.

What Is Provider Behavior Change?

Providers play a crucial role in the health system, especially because of their regular interactions with clients. Provider behavior toward clients is influenced by many factors, such as values, social norms, supervision, skills, knowledge, and structural context. Provider Behavior Change seeks to positively influence provider behavior by addressing those factors and providing solutions for improvement. This I-Kit focuses on the role social and behavior change communication (SBCC) can play in changing provider behavior by placing providers as the *audience* for SBCC.

What Is the Purpose of This I-Kit?

This I-Kit provides step-by-step guidance on using SBCC to change provider behavior, and thereby improve client outcomes.

The I-Kit is designed to help you understand factors that influence provider behavior, design an assessment to understand the specific barriers your providers face, and develop an SBCC intervention to address those barriers.

Who Is This I-Kit for?

The I-Kit is intended for anyone working with and interested in changing provider behavior and improving services. This may include service delivery and SBCC program managers and designers.

How to Use This I-Kit

This I-Kit is divided into four main sections:

1. Learn

Review background and key concepts on providers, the factors that influence them and how SBCC can be used to address those factors.

2. Assess

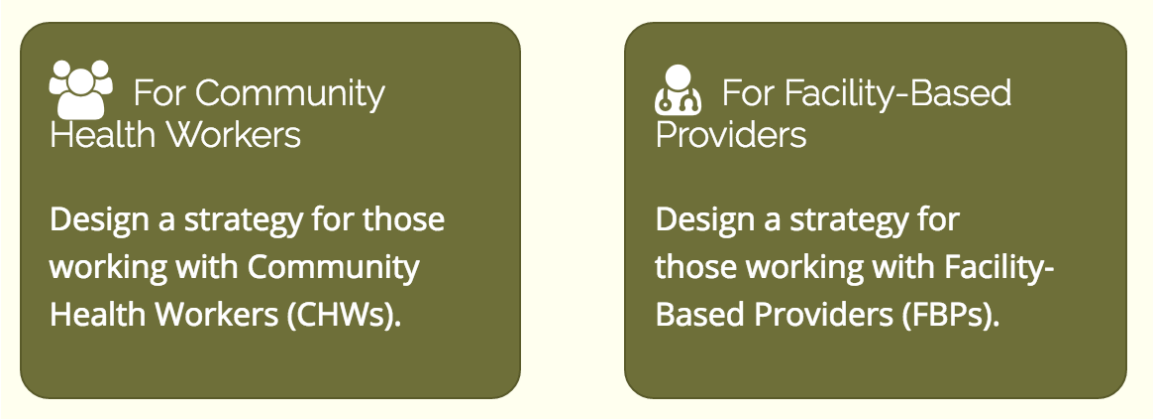
Identify and prioritize barriers to quality service provision. Design a tailored assessment using the step-by-step process in the Provider Needs Assessment. Or, use data you have already collected and frame the results using the Needs Summary Table.

3. Determine

Determine whether SBCC is appropriate for addressing the prioritized barriers.

4. Design

Design an SBCC intervention to change provider behavior. Use the step-by-step SBCC strategy guidance to address the motivational factors identified.



Learn About Provider Behavior Change Communication

Before you begin the process of assessing provider barriers and designing an SBCC intervention for provider behavior change, it is important to understand providers, what influences them, and what SBCC is. Take time to familiarize yourself with these key concepts, as they form the basis of the I-Kit:

Types of Providers

There are many types of healthcare providers. This I-Kit separates providers into two broad groups: Community Health Workers (CHWs) and Facility-Based Providers (FBPs).

Community Health Workers

A Community Health Worker is a health worker who receives standardized training outside of the formal nursing or medical curricula to deliver a range of basic health, promotional, educational and mobilization services, and has a defined role within the community system and larger health system. Some CHWs are paid and others are volunteers. Some examples include: Auxiliary Health Workers, Health Extension Workers and Community Health Volunteers.

Categories of CHWs

	Terms Of Service, Training, Recruitment	Functions
Auxiliary Health Workers	Salaried and full-time; pre-service training lasting one or more years (in a specialized training institution); not necessarily recruited from the area. May be hired through some unit of local government or through national civil service structure.	These workers often provide routine clinical preventive services (e.g., immunizations, FP), as well as case management, for a limited range of conditions (e.g., childhood illness). These functions may be provided from a very peripheral health unit (e.g., a health post) or, at least in part, from outreach sites.
Health Extension Workers (HEWs)	Salaried and expected to work more or less full-time; initial training generally at least several months (usually provided after recruitment); in some cases, this can be for up to a year. Usually recruited from the area, but may or may not originate in the community where they are serving.	This is the highest level of cadre that is commonly referred to as a CHW, though they may also be considered a type of AHW. Their functions may be very similar to those described above for AHWs.
Community Health Volunteers-Regular (CHVs-R)	Volunteer with certain regular duties (usually with at least some activity every week); possibly with regular episodes of short training (up to several days at a time) and may have some initial training lasting several weeks. They are from and live within their local communities.	May be involved in case management of childhood illness and in dispensing (e.g., birth control pills, condoms, and antenatal iron). In rare cases, may give injectable contraceptives, such as Depo-Provera or other injections. In some programs, duties and terms of service of CHVs-R start to approach those of HEWs (see above), with significant t part-time involvement (e.g., 10–20 hours/week) and financial incentives representing an important source of revenue. These may be performance- or commission-based. In other programs, though these CHVs perform regular functions, they normally put in less time (e.g., 5 hours/week or less) and financial incentives may be minimal or not used at all.
Community Health Volunteers-Intermittent (CHVs-I)	Volunteer, relatively light, intermittent commitment; minimal orientation/training; may be numerous; local.	Typically have functions limited to health promotion, though they may also support periodic campaign activities (e.g., distribution of insecticide-treated bed nets, ivermectin, or vitamin A) and support for immunization campaigns.

Facility-Based Providers

A **Facility-Based Provider** is a health worker who has received formalized training with a nursing or medical curricula, and is a paid employee at a public, private, or non-governmental organization health facility. Some examples include: Doctors, Nurses, Nurse-Midwives, Medical Assistants, Technicians, Clinical Officers, and Technicians.

Providers are the critical link between the larger health system and the end beneficiaries – the clients. However, providers face numerous challenges to fulfilling their roles including: limited resources, insufficient training and supplies, and the burden of too many responsibilities. If these challenges are unaddressed, health systems will continue to fall short of their potential valuable contribution through low motivation, poor retention and overall under performance.

Factors Influencing Providers

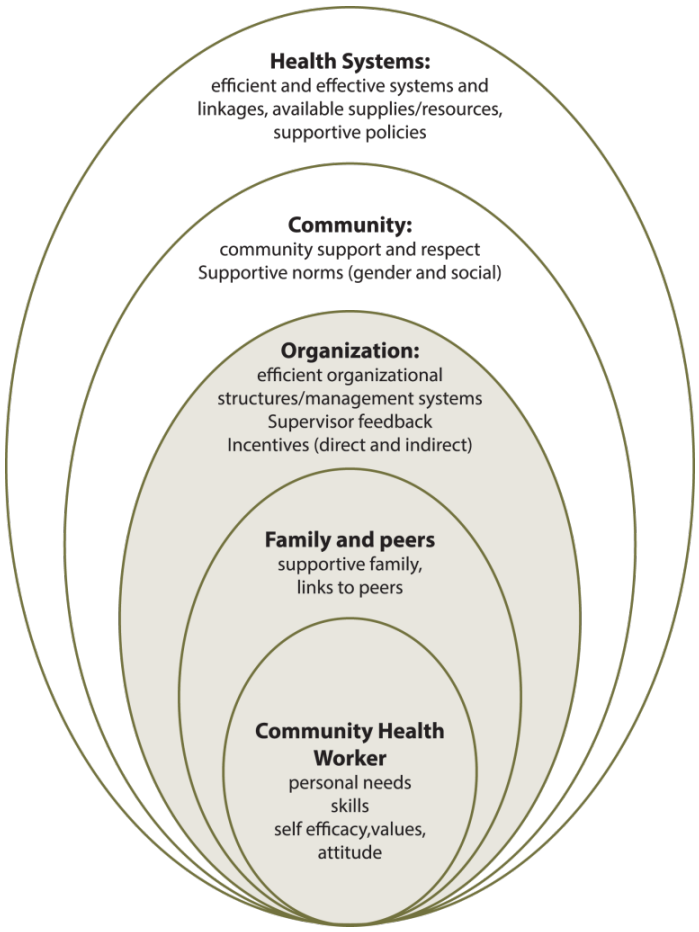
Provider behavior is influenced by multiple factors at multiple levels. This I-Kit organizes those factors into four categories:

These four factors form the framework for the I-Kit and are the basis of the Provider Assessment. The framework is informed by the Socio-Ecological Model, which shows how providers are influenced by factors at multiple levels: individual, family/peer, community, organizational, and health system.

Level	Description	Framework Category
Individual	At the *individual* level, provider behavior is influenced by whether personal needs (e.g. compensation, recognition, work load, prestige) are met. Values, attitudes, beliefs, and perceived importance of the work also play an important role. Providers' capacity and perception of capacity are critical influencers.	Ability, Motivation
Family/Peer	At the *family and peer* level, provider behavior is influenced by the level and type of support from family members. Providers' relationships with peers and colleagues can also impact behavior.	Motivation

Community	At the *community* level, provider behavior is influenced by the level of respect and support received from the community. Social and gender norms – especially regarding use of services, stigma, value of life, and hierarchy – impact provider behavior.	Opportunity, Motivation
Organizational	At the *organizational* level, provider behavior is influenced by both the level of support and type of feedback from supervisors, the work environment, and the health of the organizational systems that govern the way providers function (e.g. policies for training, learning, and promotion.)	Expectation, Opportunity
Health System	The strength of the overall *health system* including the existence of policies and systems that support providers, the availability of necessary materials and supplies, and the strength of relationships between providers and supervisors impacts providers' ability to the their job and their attitudes toward their job and clients.	Expectation, Opportunity

The relationship between these levels and provider behavior is illustrated in the graphic below.



The Importance of Attitudes

Attitudes – both positive and negative – are typically formed by life and work experience or by deeply held beliefs and/or values. Designing an effective intervention to improve attitudes and, ultimately behavior, requires an understanding of the factors that have caused the resulting attitudes. For example, a CHW may have a negative attitude toward recommending IUDs to adolescent girls because she feels the counseling required for IUDs takes longer than other methods, she's overburdened and doesn't have the time (experience). On the other hand, another CHW may have negative attitudes about FP methods due to her strongly held religious beliefs that condemn premarital sex (beliefs and values).

Efforts to Change Provider Behavior

There have been many efforts to change provider behavior and improve provider performance over the years, with much success. To date, most of the interventions that address provider behavior for improved performance – including their willingness and ability to adhere to policies and better practices – have targeted structural factors linked to worker environment, access to transportation, equipment, job aides and the availability of resources and direct incentives (payments, promotions and awards). Interventions have also sought to better manage provider workloads and improve their knowledge and skills through training (MCHIP, 2013).

While these types of *external motivation* interventions have been successful in improving provider performance, it is also known that highly motivated providers can often overcome obstacles such as poor working conditions and inadequate equipment. A growing body of evidence shows that providers have a number of *internal* motivating factors that must also be addressed to change their behavior.

Internal Motivation

Personal needs met (e.g. status, perceived social support, self efficacy, personal rewards), supportive social and gender norms, personal values and attitudes, feeling of connectedness to community and health system

External Motivation

Adequate resources available, supportive policies, health system responsiveness, available training, timely and appropriate feedback from supervisors

Internal motivations are often influenced by a number of factors including: personal attitudes and beliefs, social norms, personal and community values, status within the community and within the health system, perceived importance of work, recognition, and feelings of connectedness and social cohesion among supervisors and peers.

This I-Kit will focus primarily on addressing internal motivational factors for three reasons.

1. Internal motivation is often neglected in programs seeking to change provider behavior.
2. Motivation as a driver of behavior is a combination of psychological, interpersonal and contextual factors that make it uniquely suited to SBCC interventions.
3. A number of tools and resources already exist that help program planners address the other external motivation factors.

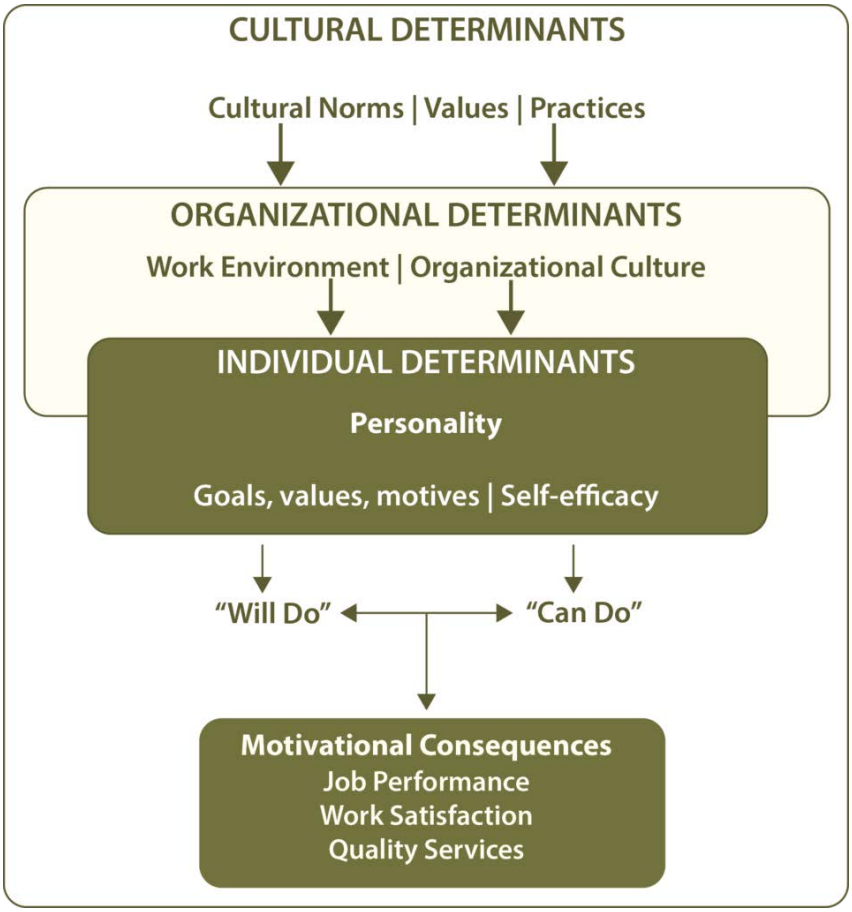
Influencing HEWS in Ethiopia

When female Health Extension Workers (HEW) in rural Ethiopia were asked how a program could sustain HEW volunteerism, many highlighted the importance of non-financial incentives to improve their motivation. HEWs suggested strategies that would promote their work among community members. Suggestions included community outreach to communicate the significance and voluntary nature of their work; public certification and award ceremonies that would recognize them for their contributions to community health; and strategically engaging influential community and religious leaders to publicly promote HEWs. All of these can be effectively addressed by SBCC.
Last 10 Kilometers Project, Working Paper No. 1. JSI, 2009.

Provider Motivations

Worker motivation is critically important in the health sector. Evidence has shown that motivated workers come to work more regularly, work more diligently, and are more flexible and willing and reflect better attitudes towards the people they serve. (HWM, Hornby and Sidney 1988).

Motivation is a complex process. A provider's motivation to deliver high-quality services is impacted by the interaction of many factors at the Individual, Organizational, and Cultural levels (Mathauer and Imhoff, 2006 http://human-resources-health.biomedcentral.com/articles/10.1186/1478-4491-4-24). SBCC interventions need to address determinants across these categories to improve motivation and service provision. The graphic below shows how these factors interact to develop motivation.



Adapted from Mathauer and Imhoff, 2006.

Attitudes, beliefs, values, and norms play an important role in provider motivation and on the patient's health care experience. In addition to having an impact on their interaction with their patient, providers' attitudes and beliefs can also influence their motivation to make changes to their own practices and behaviors, how they perform their jobs, and their desire to continue as a member of the health care workforce altogether.

While factors from the Expectation, Opportunity, and Ability categories can impact Motivation, this I-Kit will focus mainly on the internal motivating factors to provider behavior. See **Appendix OO** for examples of interventions that have addressed Expectation, Opportunity, and Ability factors.

Different cadres of health workers have different motivations. To design an effective SBCC intervention, it is critical to understand those motivations. The step-by-step guidance will help you identify specific motivators for your intended audience. This section will provide

background research on the most common motivational factors for Community Health Workers and Facility-Based Providers.

Motivating CHWs in Tanzania

A study of CHW motivating factors in Tanzania determined that motivating factors for CHWs often differed across socio-demographic characteristics. For example, older and less educated CHWs were more likely to be motivated by altruism, intrinsic needs, community respect and getting new skills. Wealthier CHWs indicated quality job aides were important to job satisfaction and motivation.

Mpembeni, R. N., Bhatnagar, A., LeFevre, A., Chitama, D., Urassa, D. P., Kilewo, C., … & George, A. (2015).Motivation and satisfaction among community health workers in Morogoro Region, Tanzania: nuanced needs and varied ambitions. Human resources for health, 13(1), 44.

COMMUNITY HEALTH WORKER MOTIVATIONS

Factors impacting CHW motivation and desire to perform well can be grouped into five categories:

- **Perceived status and social support:** The extent to which a CHW feels recognized or appreciated by their respective community, peers, facility- based providers and/or the larger health system.
- **Level of connectedness:** Feeling connected to one's CHW peers, supervisor, community and formal health system.
- **Incentives and personal rewards:** The feeling that one or more of an individual's personal needs are met. These vary by CHW but typically include: feeling of social responsibility, desire for achievement, opportunities for personal growth and career development, financial and non-financial incentives.
- **Supportive social and gender norms:** The extent of feeling enabled or restricted by prevailing social and gender norms in both the organizational system or community at large.
- **Personal attitudes and beliefs:** Provider values, attitudes and beliefs, as well as individual personality factors.

PERCEIVED STATUS AND SOCIAL SUPPORT

Perceived social status and support is critical to improving CHW performance and is closely tied to CHW retention. Because CHWs are either volunteer or minimally paid, and have the lowest levels of education and economic status, they are often looked down upon by some members of

the community and by trained health providers. In comparison to other health workers, CHWs are often considered the lowest status within the health system. (Said, et al. 2014)

Negative attitudes from communities and health providers directed toward CHWs can result in conflicts with health providers, long wait times at clinics or rejection of referrals made by CHWs. Sometimes community members do not trust what the CHW says because the CHW is not a doctor or because the CHW is just somebody's neighbor. Ministries of health often do not want to treat them as another cadre of health worker in order to ensure the CHWs stay "of the community." Tensions result, which often lessen CHWs sense of inclusion in, and support from, the health system.

The lack of family support, including unwillingness to take on CHW household tasks neglected due to CHW responsibilities and open or implied discouragement from peers or family members, have also been documented as limiting CHW motivation.

In some cases, becoming a CHW can elevate status, creating a barrier between the CHW and the client. CHW attitudes of being "better" than the clients because they received education or were chosen by community members need to be addressed as well.

LEVEL OF CONNECTEDNESS

The extent to which a CHW feels connected to their community, the health system, to their peers and to their supervisors is critical to CHW motivation, retention and effectiveness.

- **Community Connectedness**– The extent to which a CHW feels rooted in the local community and tied to the community goals and objectives is a key factor to CHW motivation. One of a CHW's primary duties is to tailor health promotion and service delivery strategies in a way that reflects the norms and cultural dynamics of the community. This requires that the CHW is known and trusted by the community.
- **Peer Connectedness**– Interaction with other CHWs can be a critical motivator for people who often work with little supervision or tangible evidence of their effectiveness. Many volunteers work independently and may not have an opportunity to interact with their peers, leaving them to feel alone and lacking support.
- **Connectedness to Supervisor**– While the level and type of interaction with a supervisor is impacted by cultural norms and values, feelings of connectedness to supervisors and management, it is often identified as key to CHW motivation. Additionally, weak, inadequate (punitive instead of coaching) and inconsistent supervision is frequently cited as a cause of low CHW motivation, morale and high attrition.
- **Connectedness to Health Facilities**– CHWs play an important role in creating demand for and making referrals to services provided in health facilities. It is critical that CHWs are well connected to and supported by the broader health system. For example, CHWs need a clear job description with defined tasks and a system for incentives and/or payment. Additionally, CHWs should receive training, materials, and routine support

from the health system. The absence of these things is directly tied to low CHW job satisfaction, lack of status, and feelings of exclusion.

INCENTIVES AND PERSONAL REWARDS

A considerable focus has been placed on material or 'direct' incentives and to some extent indirect or non-material incentives as a means of motivating CHWs. Recognizing that most CHWs represent poor communities and are themselves often lower income, offering CHWs some form of financial incentive can positively impact motivation. However this is often not enough as not all CHWs find sufficient personal reward in material compensation. There should also be caution in using financial rewards since those extrinsic motivators can crowd out intrinsic motivators.

Usually, CHWs are motivated by a mix of financial and non-financial rewards. The types of rewards and incentives that motivate providers are influenced both by individual needs and desires, local socio-economic context, and cultural and social norms. Some examples include:

- → A feeling of social responsibility, a desire to help others and make a difference
- → Desire for achievement and advancement
- → Opportunities for growth, including learning or training opportunities and being exposed to new situations
- → Recognition or appreciation for the work they have done – from community members, peers, and supervisors
- → Non-financial incentives, including use of a tablet or phone, special work attire, or education opportunities for family members
- → Financial incentives, including salaries and bonuses

SOCIAL AND GENDER NORMS

Community health workers both represent and are influenced by the social context in which they live and work. Prevailing social norms impact the beliefs, values and attitudes of both CHWs and their clients. Broad cultural values and social norms can translate into specific types of work behaviors, including the way in which providers interact with community members and clients and vice versa. For example, in many countries individuals are more likely to believe that fate is outside of one's control. This may impact a client's willingness to listen to or accept information from a CHW, leading the CHW to potentially feel ineffective and not valued. In many places cultural beliefs forbid sex before marriage, and as a result CHWs may believe that adolescents should not use contraceptives and refuse to counsel or provide them contraceptives.

Prevailing norms about what is considered "women's work," and whether women work outside of the home may influence the number of women referred as CHWs, the amount of time they can commit to the work and/or the level of support they receive from partners to take on household chores when they do become busy with CHW. In northeastern Bangladesh, for example, female CHWs cited family expectations including prioritizing marriage, stigma towards

female CHWs or social norms that limit women's work at night or outside of the home as reasons for drop out. In Uganda, some male CHWs feel pressure from families because their volunteer work limits their ability to meet expectations to be a material provider. In Lesotho as in many countries, CHW work is generally considered "female work" and men rarely apply.

The table below summarizes how three key dimensions of culture: conservatism, level of hierarchy, mastery versus harmony may also impact CHW motivation, attitudes and performance and interactions between clients and CHWs. It is important to understand which if any of these are relevant in your local context as you adapt or design programs to address social and cultural norms.

Dimensions	Description
Conservatism vs. autonomy: the relationship between the individual and group	The degree to which individuals are embedded in the collectivity, find meaning largely through social relationships, or whether individuals find meaning in their own uniqueness and individual action.
Hierarchy vs. egalitarianism: assuring responsible social behavior	The degree to which individuals are socialized and sanctioned to comply with obligations and rules attached to their roles, as ascribed by a hierarchical system. Or a more egalitarian view, where individuals are portrayed as moral equals and people are socialized to internalize a commitment to voluntary cooperation and concern for others.
Mastery vs. harmony: the role of humankind in the natural and social world	The degree to which people see their roles as one of submitting, fitting in or exploiting the natural social world in which they live.

Source: Schwartz, "Values and Culture."

PERSONAL ATTITUDES AND BELIEFS

A CHW's personal attitudes, values, and beliefs are strongly influenced by the wider social norms. However, each CHW's attitudes and beliefs will be different due to participation in different social groups, family dynamics, and individual personality traits.

These personal attitudes and beliefs can influence a CHW's willingness to interact with a client or provide certain services as well as the way they treat the client. They can result in stigmatizing or aloof behavior. Some of the most relevant attitudes and beliefs include:

- → Attitudes toward their work, positions and responsibilities
- → Attitudes toward co-workers and superiors
- → Attitudes/beliefs about the health topic, particularly if it is controversial, taboo, or difficult to discuss
- → Attitude toward the client, influenced by the client's socioeconomic status, current behaviors, occupation, ethnicity, religion, or language
- → Beliefs about the products and services they offer and who should be able to access them
- → Beliefs about the health behavior, what should and should not be done, and acceptability of use

FACILITY-BASED PROVIDER MOTIVATIONS

Factors impacting FBP motivation and desire to perform well can be grouped into five categories:

- → **Self-efficacy**: The extent to which providers believe their efforts will be successful.
- → **Social and gender norms:** The extent of feeling enabled or restricted by prevailing social and gender norms in both the organizational system or community at large.
- → **Perceived place in social hierarchy/status:** Where the providers feel they fit in the larger social structure, or perceived status relative to the clients and community members.
- → **Rewards:** The extent to which the providers feel personally fulfilled by their work and sense that others care about what they are doing.
- → **Work environment:** The extent to which providers have a supportive work environment and the health team has norms for providing quality services.

SELF-EFFICACY

Even when providers are adequately trained and possess the knowledge and skills to do their jobs, they still may feel unmotivated. A key determinant to motivation is providers' *belief* in their ability to succeed. They must believe that what they are doing will be effective and that they have the ability to complete the task. If providers believe they are unlikely to succeed, they are usually not motivated to begin or continue a particular task or behavior.

Feelings of self-efficacy have a significant effect on the level of motivation and amount of extended effort a provider demonstrates. High levels of self-efficacy are associated with an increased level of goal setting, which leads to a firmer commitment in achieving goals that have been set and greater resolve to persevere in the face of obstacles.

In the health center context, three factors influence provider self-efficacy: environment, degree of autonomy, and self-perception.

1. **Environment**: A provider's learning and working environment shape feelings of self-efficacy. Within the health center, there must be resources, supportive procedures, and

team support to help providers feel confident that they will be able to diagnose, counsel, and treat effectively. For example, verbal praise or recognition from a supervisor and low levels of conflict can help increase feelings of self-efficacy while a heavy workload, lack of job clarity, and poor cooperation among team members can limit feelings of self-efficacy. Within the community, providers need to feel able to treat without fear of reprisal and feel confident that their counsel will be followed to ensure treatment efficacy. For example, if a nurse sees that her clients repeatedly discontinue their course of antibiotics, she will feel less effective with her clients and less able to have a positive impact.

2. **Degree of autonomy**: To feel confident in their ability to succeed, providers need to have the flexibility to problem-solve and a sense that they have some control over the situation. Being able to use individual discretion and critical thinking skills increases feelings of self-efficacy because they provide a sense of ownership and self-determination over the tasks at hand. If providers believe that external forces determine success, they are unlikely to believe that what they do will make a difference. Even when a goal should be easy to achieve, if providers sense that they do not have control over a situation, self-efficacy decreases. For example, if a nurse is bound by strict regulations and is told that he can only take orders from the doctor, he will be less creative in addressing problems as they arise. He will feel that his actions will not change the outcome and will feel ineffective with his clients.
3. **Self-perception**: Providers beliefs about their own attributes influence how successful they will be with a given task. A provider's belief about how strong or capable she is, or what kind of person she is can facilitate or prevent behaviors. For example, if a doctor thinks she just isn't the empathic type or believes that she isn't assertive enough to get the support she needs, she will be less successful with those behaviors.

SOCIAL AND GENDER NORMS

Facility-based providers both represent and are influenced by the social context in which they live and work. Prevailing social norms impact the beliefs, values and attitudes of both the providers and their clients. Broad cultural values and social norms can translate into specific types of work behaviors, including the way in which providers interact with community members and clients and vice versa. The attitudes providers adopt due to the larger social norms can impact both the $what$ and the how of service provision.

What: Providers may not be willing to provide certain services or products to certain populations. For example, a cultural norm that a newlywed couple needs to prove fertility and have a child soon after marriage can influence a provider's willingness to offer contraceptives to the couple. Or, a provider may refuse service to men who have sex with men because society believes that homosexuality is immoral.

How: Providers often offer lower quality services to certain populations due to cultural beliefs and norms. For example, providers may make public announcements in the waiting room that

all sex workers present should line up at the back or stand in a separate line because their occupation is socially unacceptable. Or, providers may spend less time with socially stigmatized populations or not respect their confidentiality.

Gender norms may also impact how a provider interacts with a client. Some topics may be taboo or providers and clients might feel uncomfortable asking relevant questions. A provider's sex can even influence the type and topic of training received, making it difficult for some providers to effectively counsel or treat.

PERCEIVED PLACE IN SOCIAL HIERARCHY

Due to their education level and the respect accorded their position, providers often enjoy a higher status in the larger social hierarchy than many of their clients. This elevated status may motivate providers, given that they feel recognized and valued for their contribution to society. Their elevated status may also contribute to client trust and compliance. However, a provider's perceived status can also be a barrier to quality service provision.

Providers' perceptions about their own status can influence their personal values and beliefs, particularly about their clients. Providers often spend years on their education, between their initial training and continuing education. Frequently, this training encourages providers to be different from their communities, creating a culture of social distance between provider and client. This can contribute to disrespectful attitudes where providers believe that they know better and that they do not need to listen to their clients. Providers often have a higher socioeconomic status, which places them on a different level than many of their clients. Their advanced education, socioeconomic status, and experience can lead providers to believe they have earned the right to treat clients poorly, particularly in a class conscious society. Providers' relationships with clients are frequently framed through a culture of paternalism that assumes clients – especially if less educated, younger, or female, have limited awareness or agency in health-related decision-making. This power imbalance between providers and clients can lead to poor treatment and health outcomes. For example, doctors or nurses might yell at clients, scold, humiliate, or discount their pain. Some laboring women report being hit, shouted at, and threatened by nurses and doctors.

Clients' past experience with poor treatment, humiliation, or being refused treatment due to this power imbalance also impacts the way they interact with providers. Some clients may decide not to come to the health facility at all. Judgmental and rude treatment have been found to be major barriers to seeking care. Others may come but choose not to share certain information or ask important questions that could impact a diagnosis or treatment decision. Thus, status and hierarchy issues need to be addressed at both the provider and the client level.

PERSONAL REWARDS

Provider motivation increases when their own needs are met and when they feel that others care about the good work they are doing. Motivation is likely to suffer when workers think that

nobody will notice their hard efforts or when they see workers whose productivity is low receiving rewards equal to those who try harder. These rewards can be *intrinsic* or *extrinsic*.

Intrinsic

- **Perceived importance of work**: When providers perceive that what they are doing has great value, they are more willing to try new behaviors or strategies to improve client outcomes. They are also more able and willing to endure hardships, including low pay and lack of resources. When providers are able to see that what they are doing improves or saves lives, motivation often increases. The perceived sense of importance impacts providers' attitudes toward their work and their clients.
- **Learning opportunities and personal development:** Provider motivation, performance, and job satisfaction are all strongly linked to opportunities for training and learning new skills. Providers value continuing education as a chance to expand their understanding, enhance effectiveness, and increase likelihood of advancement. These learning opportunities allow providers to assume more demanding duties and make advancement more likely. The skills learned can also help providers problem solve and cope with their jobs.
- **Appreciation and recognition**: A major motivator for providers (often right behind pay) is appreciation or recognition. This appreciation can come from supervisors/management, colleagues/peers, and clients. Providers need to hear specifically how they are appreciated and feel supported to achieve goals. They want to see that they are being useful to society and know that the community trusts and values them. Appreciation can be as simple as praise for a job well done or recognition of the difficulties endured. Or, it can be a more involved recognition campaign where providers are recognized publically for their contributions or where health centers are awarded for reaching quality standards.

Extrinsic

- **Financial gains:** Financial compensation – in the form of salary, bonuses, or other financial rewards – is often one of the more important motivating factors. However, financial rewards are rarely sufficient to motivate providers. There should also be caution in using financial rewards since those extrinsic motivators can crowd out intrinsic motivators. Usually, a mix of financial and non-financial rewards works best to motivate providers.
- **Other incentives:** Other non-monetary incentives can also motivate providers. Improved clinic environment, opportunities to use annual leave, and improved working conditions – including addressing high workloads – can improve motivation. Providers are also often interested in better staff accommodations, good schools and teachers for their children, and health care benefits.

- → **Career advancement:** Providers are also motivated by chances for career advancement. This can include opportunities for specialization through further training, or merit-based promotion. When there are opportunities for specialization and promotion, providers believe that their good work is noticed and appreciated, and that they have an adequate amount of challenge in their work. Providers have a sense of pride when they perceive there are opportunities to progress.

WORK ENVIRONMENT

A provider's work environment is foundational to being able to provide quality services. Providers' relationships with colleagues, the type and quality of supervision, and the group norms within the health center all impact motivation.

The relationships a provider has with colleagues play a major role in the provider's attitude toward work and levels of motivation. High levels of conflict, rivalries between cadres, a competitive environment, and lack of appreciation contribute to dissatisfaction and low desire to be at work. On the other hand, relationships characterized by high levels of trust, mutual respect, and appreciation lead to increased motivation and performance.

The type and quality of supervision, as well as the kind of relationship providers have with management, are critical determinants of motivation. Often supervision visits focus on record-keeping, attendance, and fault-finding. Supervisory practices that are consistent, relevant, and positive are linked to improved motivation and performance. Providers need to have regular interaction with their supervisors, and the interaction needs to go beyond corrective action. Motivation can be improved through enhancements to supervisory practices, including continuous supervision occurring in a variety of contexts rather than only periodic visits by external supervisors, provision of on-site technical support and training and joint problem solving, and regular follow-up. Supportive supervision where providers receive positive feedback, reinforcement, and support for problem solving is important to maintaining motivation.

Supervisors also need adequate management and leadership skills that enable them to motivate their providers. In many settings, due to insufficient resources, supervisors are not trained and are not equipped to lobby on behalf of their providers. Without those skills and commitment, providers suffer and motivation decreases.

Group norms and teamwork are another key component of provider motivation. All the employees in the health center make up a team. Every team creates group norms, some explicit and others implicit. These norms govern how the team works together. Successful teams are characterized by two norms: equal participation, and social sensitivity. In the health center, norms about including all employees in health facility management meetings, allowing all to speak roughly the same amount, and offering opportunities to participate in decision-making processes, can provide a sense of ownership and develop motivation. Norms around seeking to understand how others feel and being sensitive to those feelings creates a safe space filled with

trust and respect. People on the team are comfortable saying what they think and being themselves. These two norms create a positive working environment where employees work together.

It is also important to foster positive norms around how employees treat clients and a common vision for quality service provision. Typically, those norms flow from the equal participation and social sensitivity norms that begin to impact personal values and beliefs about others. When there are positive group norms and teamwork, providers feel more motivated and the health center is more effective at reaching its goals.

SBCC and Provider Behavior Change

SBCC is the use of communication to change behaviors. SBCC coordinates messaging across a variety of communication channels to reach multiple levels of society. While SBCC has been widely used to change behaviors among populations at risk for various health challenges (women of reproductive age, adolescents, male household heads), SBCC can also be successfully used to influence the behavior of other audiences, including facility-based providers and community health workers.

At its core, SBCC is audience centered as opposed to program centered. Effective SBCC relies on gaining an intimate understanding of the audience's key drivers, beliefs and values before developing an intervention and ensuring the resulting intervention marries those needs with the program goals.

SBCC works to change provider behavior by either engaging providers as the primary audience to influence their knowledge, attitudes, self-efficacy, beliefs and values or by identifying other influencing audiences (community leaders, religious leaders, government officials) to change prevailing community and social norms that impact providers' work.

While SBCC cannot address all of the challenges that providers face, it can play a role in addressing many barriers linked to provider motivation and performance. Specifically, SBCC can:

- → Encourage providers to challenge negative attitudes and beliefs they may hold towards certain stigmatized populations and/or services that prevent their adherence to key service delivery policies and guidelines (i.e. long acting contraceptive methods for adolescents, condoms for men who have sex with men)
- → Facilitate social and normative changes that impact how providers work and the kinds of attitudes and values they possess
- → Influence decision-makers, family and peer networks to recognize provider contributions and ensure better resources are made available
- → Influence policymakers to ensure supportive national policies and availability of commodities
- → Mobilize communities, peers and management to recognize providers' efforts and contributions

- → Engage both clients and providers to improve provider-client interactions
- → Motivate providers to better adhere to national service delivery policies and guidelines
- → Encourage peer, management and social support

Recognizing that SBCC cannot respond to all provider barriers, the I-kit assumes that users will use these guidelines, approaches and resources to complement efforts to address other identified key barriers and demotivators to provider performance, namely those caused by inequities in capacity, supportive policies, health systems and/or available resources that may require interventions other than SBCC.

Provider Needs Assessment Framework and Tools

This section of the I-Kit provides an approach to assessing health providers' needs, barriers and facilitators to quality service provision at the organizational, regional or national level. The approach includes a needs analysis framework and implementation tools that engage health service delivery stakeholders in the identification of capacity strengthening needs, as well as guidance on identifying interventions that address them. Throughout this section and the case study, Community Health Workers (CHWs) are used as an example. However, this framework and corresponding tools can be used for health providers at any level of the health system, including Facility-Based Providers.

Purpose

To provide individuals and organizations a systematic approach to assess provider needs and change provider behavior. This approach situates the provider as someone who performs within a holistic context and regards the provider as a professional to be influenced and supported, rather than as a problem to be fixed. Moreover, it builds the capacity of individuals and organizations in social and behavior change communication (SBCC) as a strategy to improve provider performance.

Caveats and Limitations

One of the key focus areas for the framework is the use of SBCC to influence provider motivation, beliefs and attitudes that affect their performance. However, a variety of needs are likely to surface that cannot be addressed solely through communication interventions. It is recommended that the assessment be conducted with full engagement of community stakeholders in both the data collection and in the ownership to ensure action is taken against all identified needs. This will help ensure that communities come together to address all factors affecting the performance of health providers and the health of the communities in which they serve.

Gender Transformative Approaches

This framework and its tools were created in accordance with USAID preference for inclusion of gender considerations in capacity-building, advocacy and integration in reproductive health. Therefore, as a "gender aware" approach, these tools deliberately include gender-related outcomes as part of the investigative process. All factors that impact the performance of health providers are also examined through a gender equity lens for analysis, needs identification, and intervention planning.

Structure

The needs assessment is structured around the major steps of the needs analysis framework. The first section reviews the framework itself, including some of the major activities required

and the desired output of each framework step. The sections that follow provide tools to support the completion of each step and guidance for completing the needs analysis.

Audience

The intended users of this needs analysis framework and its tools are government health agencies, NGOs, and concerned civil society organizations interested in improving health provider performance and thereby improving the health of communities. Keys to success include: engagement of key stakeholders, availability and access to individuals and information, sound project planning and management, representative data collection and analysis, and a willingness to address the many different needs that may be identified to support better provider performance.

Illustrative Case Study

Throughout this needs assessment, many tools will be introduced to help you conduct a needs analysis. Each tool will first be presented and explained, and then will be shown in use through an example based on the following general case:

Cecilia is the Project Director of a nonprofit initiative supporting CHWs in the remote, tropical community where she grew up. Her project is looking specifically at child and maternal health issues, with targets that support governmental public health goals. Cecilia is aware of several other projects operating locally and nationally that all touch upon reproductive health in the region. All of these groups are interested in how to best support CHWs at every level and ensure they have what they need to perform their best. Cecilia has met with the directors of several of these projects and with local Ministry of Health officials to work together in identifying what issues and barriers are keeping CHWs from performing at their best on the job. As a result, a Steering Committee has been created to oversee a formal Needs Analysis of CHWs in the region. Cecilia is proud and excited to have been chosen as the facilitator of the process and looks forward to working with the Steering Committee to complete the analysis.

Roles

A needs assessment is best accomplished by a team of individuals with both an interest in improving the performance of health providers, and the resources to conduct the assessment. Specific individuals to include on the team are defined below.

- **Facilitator** – this individual is the primary owner and driver of the overall needs analysis process from conception, through analysis, intervention identification, and impact measurement
- **Stakeholder** – these individuals have an interest in the analysis itself and are willing to help guide and support the analysis; these can be healthcare providers, supervisors, or patients, or any individual who helps create public health targets or fulfill them—including funders, suppliers, measurement specialists or clinic managers
- **Measurement & Evaluation Specialist** – where possible, it is helpful to have the support of individuals with expertise in data collection and analysis
- **Steering Committee** – this is a group of stakeholders who serve as the board of guidance and management of the needs

analysis. Ideally, it will be as diverse a group as possible and should include individuals with sufficient access to the providers, their supervisors, and local communities. Subgroups of this committee will take on specific responsibilities during the needs analysis.

Outcomes

This framework and tool set will uncover a variety of needs that, when addressed, will support performance. These needs will include both environmental influences, and those associated directly with the performers themselves, such as skills and knowledge and personal motivation to perform. The Design sections (specifically in Step 7) of this I-Kit provide a variety of tools to help address providers' motivational needs.

Two main categories of motivation are explored in the I-Kit:

1. **Internal Motivation**, which includes personal needs (e.g. status, perceived social support, self-efficacy, personal rewards), and a feeling of connectedness to the community and the health system.
2. **External Motivation**, which includes adequate availability of resources, supportive policies, effective links to health facilities and respect from health systems, availability of training, timely and appropriate feedback from supervisors, and supportive social and gender norms.

The Needs Analysis Framework

A needs analysis framework outlines a process for identifying gaps between the expectations of individual or organizational performance, and the reality of their current delivery on those expectations. What follows is a generic seven-step framework for conducting a needs analysis on any group. This high-level framework becomes applied through the sections that follow, which introduce tools for implementing the framework with a team of stakeholders who are committed to the improvement of community health through support of health providers in their area.

The 7 Steps of the Needs Analysis Framework

1 **Identify Goals and Performers –** working with the community or organization, clarify what you are trying to achieve and who is involved in reaching those achievements

Input: community (or organization) vision, mission, and plans for achievement; identification of performers who are key to achieving goals

1. What are the goals and objectives for the performance overall?
2. How are the goals and objectives currently measured? What is the status of those measures?

3. Who are the key stakeholders in identifying the goals and objectives, and in tracking their achievement?
4. Who are the key groups involved in taking action to achieve these objectives?
5. How does the action of the groups lead to the achieved objectives and community goal?

Output: established needs analysis Steering Committee, clear performer expectations and a model of how performer actions are measured in pursuit of goals

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2 **Create Needs Analysis Investigative Questions –** these are the questions your needs analysis is being designed to answer; they should be balanced across the four essential factors that support performance

1. **Expectation – I understand the performance expected:** for each group of providers determine if performance is defined in a clear and detailed manner
2. **Ability –** I am able to do it: for each group of providers, determine if they have the skills and knowledge to perform well
3. **Opportunity –** I have the opportunity to do it: for each group of providers, determine if the environment allows and resources are available to support their performance
4. **Motivation –** I want to do it: for each group of providers, determine if there is sufficient motivation, reward, lack of negative consequences, and supportive attitudes and beliefs to support performance

Output: identified questions for the investigation and the corresponding data sources or audiences that might have information or evidence to help answer them

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3 **Develop Data Collection Plan –** identify which individuals or data sources can provide information to answer your questions and how will you engage with them.

1. Who or what has insight or information to help answer each of your investigative questions?
2. What will you accept as evidence to support their input? Will this evidence be credible to all stakeholders?
3. Are there multiple sources of information for each investigative question?
4. Are there sources of contradictory information for each investigative question?
5. What is the best way to collect information from each data source?

Output: full data collection plan, including data sources, methods of collection, storage, and access for analysis

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4 Create instruments for Collection and Capture of Data.

1. Take inventory of all data sources and proposed collection methods
2. Test each data collection approach for all data sources against factors of collection and choose those appropriate to limitations
3. Create instruments for all self-administered methods; pilot with appropriate members of target population and update where necessary
4. Create instruments for all administered methods; pilot with data collectors and members of target data source populations and update where necessary
5. Test data capture instruments (electronic or paper) and housing methods in all pertinent physical locations
6. Train data collectors for all methods (live interviews, document reviews, questionnaire delivery, etc.)
7. Identify sample populations for each instrument
8. Establish schedule and tracking plan to ensure data is collected as intended

Output: full suite of tested data collection instruments and methods; plan for scheduling and tracking data collection

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5 Collect Data

1. Implement data collection plan
2. Ensure captured data are flowing appropriately into electronic or paper based housing structures
3. Thank data sources as appropriate for participation
4. Inform stakeholders as needed

Output: data fully collected and all contributors and stakeholders aware of progress; data housed in accessible format, ready for analysis

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6 Analyze data and identify needs

1. Conduct analysis for each method and data instrument as appropriate; assure inter-rater reliability and validity of data where appropriate
2. Combine data from all sources and summarize how it answers each of the investigation's questions
3. Note areas of gap between data reported and acceptable performance

Output: draft analysis and results for major investigative questions; list of identified needs for performer excellence

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7 Summarize findings and report

1. Share analysis and identified gaps with key stakeholders
2. Agree on prioritized needs to be addressed and action to be taken
3. Determine methods, resources and timeline for implementation
4. Identify leads for each prioritized action
5. Establish timing for check-in and impact measurement
6. Determine cycle for future round of needs analysis

Process Overview – Needs Analysis and Action Planning

Below is a view of the process "at a glance" to assist with planning and stakeholder engagement.

Step	Key Players	Approximate Elapsed Time	Keys To Success
1. Identify goals and performers	Facilitator and Steering Committee	½ day	Committed diverse team
2. Create needs analysis investigative questions	Facilitator and Steering Committee	1 day	Broad perspective on factors affecting performance
Decision Point: (A) high M&E resource setting? or (B) Adapted Success Case approach?			
3. Develop data collection plan	Facilitator, Steering Sub-Committee, M&E Specialist	1-2 days	Knowledge of data sources and collection methods
4. Create and pilot instruments for data collection	M&E Specialist	1 week ↑ M&E or 1 day Adapted Success Case	Audience access and representative sampling
5. Collect data	M&E Specialist	2-3 weeks ↑ M&E or 3-5 weeks Adapted Success Case	Consistency
6. Analyze data and identify needs	Facilitator, Steering Sub-Committee, M&E Specialist	1-2 weeks	Valid methods and sound conclusions

7.	Summarize findings and report	Facilitator, Steering Committee	2 days	Action identification and clear ownership

Once the needs have been identified, guidance and support on motivational needs is available through the **Designing an SBCC Intervention for CHW Behavior Change** and the **Designing an SBCC Intervention for FBP Behavior Change** I-Kits.

Step 1: Identify Goals and Performers

AT A GLANCE

Who are the performers and what are they trying to achieve?

In Step 1, you will work with community or organization representatives to clarify what you are trying to achieve and who is involved in reaching those achievements.

Tools to Help

- → Performer Analysis Worksheet
- → Stakeholder Analysis Worksheet
- → Logic Model Worksheet

Who is Involved

The group initiating the needs analysis will draft a performer analysis and a logic model; stakeholders will review through membership in a Steering Committee.

Output

Move on to the next step when you have clear performer expectations and a model of how the actions of these performers are measured in pursuit of goals.

1 How to Get Started

Begin by identifying which performers you will focus on. Use the **Performer Analysis Worksheet Template** to capture as much detail as possible about your target performance group. The better you can describe this group and the specifics of their work the more accurate—and actionable—your needs analysis will be.

Appendix A: Performer Analysis Worksheet Template

Appendix B: Performer Analysis Worksheet Example

2 Next

Identify who creates or influences objectives and work goals of your identified performers. Use the **Stakeholder Analysis Worksheet** to capture the key groups, organizations, or agencies that influence performer goals. Identify specific individuals from among these stakeholders that you will invite to participate on the Steering Committee to guide the needs analysis and take action on its findings.

Appendix C: Stakeholder Analysis Worksheet Template

Appendix D: Stakeholder Analysis Worksheet Example

3 Then

Consider the option of developing a *Logic Model* that shows the connections between the work of your targeted performers and the overall goals of the healthcare community. It's a great tool to help anyone involved with the needs analysis understand these connections.

Appendix E: Logic Model Worksheet Template

Appendix F: Logic Model Worksheet Example

4 Finally

Call your stakeholder group together to create a Steering Committee for your needs analysis. This Steering Committee will help identify resources, assist in access to data, witness the evidence of the needs your analysis will identify, and help target owners and drivers for improvement where necessary.

Resources

How to Develop a Logic Model: http://www.thehealthcompass.org/how-to-guides/how-develop-logic-model-0

Step 2: Create Investigative Questions

AT A GLANCE

What is helping or hindering performers in achieving their goals?

In Step 2, you will develop a series of questions that guide your entire needs analysis, and use them to create audience-specific question sets that guide your data collection plan and instrument development

Tools to Help

- → Question Matrix
- → Acceptable Evidence Worksheet

Who is Involved

Investigation questions can be drafted by the Facilitator of the needs analysis, but should be thoroughly discussed and agreed upon by the Steering Committee to ensure buy-in and support; Steering Committee Champions for each performance factor should facilitate agreement on acceptable evidence for each factor.

Output

Move on to the next step when you have identified the key investigative questions, the potential sources of data to answer those questions and the evidence that will confirm acceptable performance in the eyes of your stakeholders.

1 How to Get Started

Begin with the questions your Steering Committee members want to have answered by the needs analysis; ensure these questions cover all four factors of performance: expectations, ability, opportunity, and motivation. Ask for four Steering Committee volunteers to lead sub-groups through the *Question Matrix* for each area, and add or remove questions as appropriate. Allow the full Committee to review the overall matrix for discussion and consensus.

Appendix G: Question Matrix

Appendix H: Question Matrix Example

2 Next

Keep in mind that the CHWs themselves will have perspectives on these four factors, but so will their patients, their supervisors and the general community. For each question, think about which audiences are in a position to provide direct evidence and which might have a unique

perspective or information that could contribute to an answer. Ensure your questions are not only identifying problems or needs, **but also the underlying reasons or causes of the problems.**

3 Then

Identify any and all sources of existing data that could contribute to an answer. Consider performance reviews, quarterly reports, supply requisitions, budget trackers, existing survey results or reports, patient tracking records, community assessments, employee satisfaction surveys or any other documentation that may give you acceptable evidence to answer your questions. Ask Steering Committee to help identify and access data. The more recent, relevant information you can capture from existing sources, the less you will have to collect. Ensure there is a reasonable balance across data sources, and strive for *three* or more sources of data for each question, as this *triangulation* helps support the validity of your findings.

4 Finally

Engage with Steering Committee members to complete the **Acceptable Evidence Worksheet**. For each major question, define what you would expect to find in the analysis if there were **no** problems or needs. In other words, identify how you will know that everything is "OK" around a given issue or question and what will signal that a need has been found.

Appendix I: Acceptable Evidence Worksheet

Appendix J: Acceptable Evidence Worksheet Example

Follow steps **3A, 4A, 5A and 6A** if you are conducting this Needs Analysis with support from a trained measurement and evaluation specialist. This individual should have the knowledge and skills to help you pull representative samples from the general CHW population, develop and pilot specific data collection instruments, and conduct qualitative and quantitative analysis on the collected data in order to answer your investigative questions.

If you do not have the support of measurement and evaluation specialists, please follow steps **3B, 4B, 5B and 6B** for **Low M&E Resource Setting – Adapted Success Case Approach.**

Steps **3B, 4B, 5B** and **6B** are for those who do not have measurement and evaluation technical support and are unable to conduct representative sampling, data instrument development, data collection and analysis without it. To provide the best possible evidence of needs without the traditional, robust methods, we suggest using an adaptation of *Robert O. Brinkerhoff's Success Case Method*. Originally designed to evaluate the impact of training interventions, this method will allow for a high level overview of current performance. It will also allow you to collect evidence on what factors might be supporting or diminishing performance.

Step 3A: Develop a Data Collection Plan

HIGH M&E RESOURCE SETTING

AT A GLANCE

Who can provide answers and how will we find them?

In Step 3A, you will create a plan for gathering the data needed to answer the investigative questions developed with your Steering Committee and key stakeholders.

Tools to Help

- → Sampling Overview
- → Data Collection Considerations
- → Data Collection Planning Worksheet

Who is Involved

The M&E Specialist should create the plans with input from the Facilitator and approval from the Steering Committee.

Output

Move on to the next step when you have a full plan for data collection, including data sources, methods of collection, storage and access for analysis.

1 How to Get Started

Here are a series of steps to kick things off:

- Sort the completed **Question Matrix** from Step 2 by audience and save the result of each sort in a document titled with the name of each group or data source.
- For each group or data source, are there already existing sources of data concerning this group? For example, have recipients of CHW services been interviewed already over the past few months? Are there any systematic data sources, such as regular exit interviews with patients or statistics on how many patients are seen by each CHW? How often is this data collected? By whom?
- If there is any documentation that already captures information on the right topics from the identified individuals consider accessing that data first, before planning for unique data collection that will consume additional time and resources.
- Flag those items that will require specific data collection from each data source population.

2 Next

Consider the size of each group of individuals you would like to gather data from. Where are they located and what resources are available to reach them for collecting data? Use the **Sampling Overview** document to think through all of the issues associated with outreach to each of the individuals or sources that will provide data.

Appendix K: Sampling Overview

3 Then

Review the **Data Collection Considerations** tool, and identify the opportunities and constraints associated with each population that will provide data to answer your questions.

Appendix L: Data Collection Considerations

Important!

Whether you are using the High M&E Resource Setting or Adapted Case Study method, please ensure that the health workers you are gathering data from remain ANONYMOUS. It is critical that your sources of data feel they can be honest and frank about their successes and challenges without fearing for potential repercussions. You can assign numbers and/or letters as identifiers for each health worker that is surveyed or interviewed throughout the process.

4 Finally

Use the conclusions you reach through these steps to complete a **Data Collection Planning Worksheet** that you can share with your stakeholder Steering Committee for input and buy-in. Your Committee can be instrumental in helping you collect data in a low-cost and time-efficient manner by ensuring access and support from the individuals involved.

Appendix M: Data Collection Planning Worksheet

Appendix N: Data Collection Planning Worksheet Example

Step 3B: Adapted Success Case Approach

FOR LOW RESOURCE M&E SETTINGS

AT A GLANCE

Who can provide answers and how will we find them?

In Step 3B, you will edit the draft data collection plan for use in your situation.

Tools to Help

- → Adapted Success Case Overview
- → Adapted Success Case Data Collection Planning Worksheet

Who is Involved

The Facilitator of the needs analysis and members of the Stakeholder Steering Committee.

Output

Move on to the next step when you have a full plan for applying the Adapted Success Case Method.

1 How to Get Started

Review the **Adapted Success Case Overview** to become familiar with the two phases of the approach. Work with Steering Committee members to identify the full population of CHWs to be included in Phase 1 of the study. If your needs analysis is local or regional, consider including all members of the population in the initial phase. If the study is national or over large regions, you may want to choose a representative sample – either random or purposive depending on your areas of concern and Investigative Questions.

Appendix O: Adapted Success Case Overview

2 Next

Consider the logistics of delivering the Phase 1 Survey to your chosen population—either in self-administered questionnaire format through such tools as Google Forms or using physical forms distributed geographically and collected for data entry and analysis. If your target group is small enough you may choose to deliver the Phase 1 Survey via Skype or phone instead. Because this is a brief survey face-to-face engagements are not cost effective unless subjects are immediately nearby.

3 Then

Assess the resources available to conduct the Phase 2 case interviews. Are individuals available to focus on this for the time needed? Are there any gender issues that might arise during the interview and what can be done to alleviate them? Is there administrative support available to assist with scheduling? These interviews can take place over any medium—internet, phone or in person. If travel is required, how will it be supported? If you interview CHWs during their work day, is compensation required? How will you inform supervisors in clinical settings, who may need to plan accordingly for the CHW's absence for 20-30 minutes during the interview session?

4 Finally

Use the conclusions you reach through these steps to complete a **Data Collection Planning Worksheet** that you can share with your stakeholder Steering Committee for input and buy-in. Your Committee can be instrumental in helping you collect data in a low cost and time efficient manner by ensuring access and support from the individuals involved.

Appendix P: Adapted Success Case Data Collection Planning Worksheet

Appendix Q: Adapted Success Case Data Collection Planning Worksheet Example

Step 4A: Create Data Collection Instruments

HIGH RESOURCE M&E SETTING

AT A GLANCE

Who are the performers and what are they trying to achieve?

In Step 4A, you will create and test data collection instruments and plan for their use.

Tools to Help

- → Documentation Worksheet
- → Focus Group Worksheet
- → Interview Worksheet
- → Questionnaire Development Worksheet

Who is Involved

The M&E Specialist should complete the work with Facilitator's support.

Output

Move on to the next step when you have a full suite of piloted data collection instruments and methods that are in the hands of the individuals who will collect the data.

1 How to Get Started

Use the completed **Data Collection Planning Worksheet** to create a list of all data collection instruments that are required. Next determine which investigative questions will be posed to which audiences through the instruments identified. One way to facilitate this is to sort the Worksheet by its "Data Source" column and compare this with the completed **Question Matrix** to ensure that no items have been overlooked. Create one document for each instrument and audience, and on it list each investigative question and sub-question.

2 Next

Consider the type of instruments you will need and plan to create all those of a similar type at the same time. For example, create all the questionnaires you will need and then move on to all interview protocols, documentation worksheets, etc. Tackling the tasks in this manner helps you leverage the work from one instrument to the next of its type. Use the **Documentation Worksheet**, **Focus Group Worksheet**, **Interview Worksheet**, and **Questionnaire Development Worksheet** to guide your work. Questionnaire items you write for CHWs can be edited slightly

to become appropriate for CHW Supervisors, for instance, and so grouping the work will help you complete it more quickly.

Appendix R: Documentation Worksheet

Appendix S: Focus Group Worksheet

Appendix T: Interview Worksheet

Appendix U: Questionnaire Development Worksheet

3 Then

Identify individuals from each data source group to serve as pilot participants for the data collection instruments you have created. It's fine to choose those close at hand, but if there are important subgroups, or strata, among the target population it's a good idea to pilot with each subgroup to ensure the instrument is sensitive to their differences. Once the instruments are ready the team must prepare for their use.

4 Finally

Once the instruments are ready, the data collection team must be prepared for their use. For self-administered questionnaires provide electronic or print copy as needed to those responsible for distribution and collection. For administered instruments like surveys or interview protocols, hold a training session with data collectors to ensure they understand what each question is designed to capture, the importance of following the question language order, and how they should document the responses they receive. One effective training approach this is to have an experienced interviewer conduct a real interview in front of the collector trainees, who will follow and document the responses individually. Then compare the captured data of the experienced interviewer with that of the trainees to ensure greater consistency.

Step 4B: Adapted Success Case Approach

LOW-RESOURCE M&E SETTING

AT A GLANCE

How will we ask them?

In Step 4B, you will create the data collection instruments you will need to implement your data collection plan.

Tools to Help

- → Phase 1 Survey Questionnaire
- → Phase 2 Interview Protocol

Who is Involved

The Facilitator of the needs analysis should conduct this work, with approval from the Steering Committee.

Output

Move on to the next step when you have a full suite of tested data collection instruments.

1 How to Get Started

Create the Phase 1 instrument you will use by adapting the **Phase 1 Survey Questionnaire** to meet the needs of your specific investigative questions, culture and language. Pilot the questionnaire items with a few members of the CHW audience and edit as needed. Consider actively seeking instrument pilots based on gender, age, class or ethnic groups as appropriate to your region. This will ensure the questions are sensitive to issues of importance to these groups and do not violate any group specific norms. For self-administered surveys, like questionnaires, it's important to be sure the directions are clear as well as the questions. To test this, always try to structure the pilot of any instrument to be as realistic as possible. For administered surveys, think through how the survey administrator will capture answers and be sure to pilot this as well.

Appendix V: Adapted Success Case Phase 1 Survey Questionnaire

Appendix W: Adapted Success Case Phase 1 Survey Questionnaire Example

2 Next

Plan for the consolidation of the Phase 1 data. If online questionnaires will be created, think about how data will be pulled from the tool. If physical questionnaires or survey capture instruments will be used, think about the best way to transfer that information into electronic format. You may choose to use forms that can be scanned or enter the data by hand. Also, be sure you plan for data backup and security.

3 Then

While the Phase 1 data is being collected you can turn your attention to creating the **Phase 2 Interview Protocol**. A protocol is a guide for the interviewer to follow, to ensure that all intended topics are raised and discussed. It is not as formal as an administered survey, and allows the interviewee to provide information in a free flowing format.

Appendix X: Adapted Success Case Phase 2 Interview Protocol

Appendix Y: Adapted Success Case Phase 2 Interview Protocol Example

Step 5A: Collect Data

HIGH RESOURCE M&E SETTING

AT A GLANCE

Who are the performers and what are they trying to achieve?

In Step 5A, you will manage the implementation of your data collection plan.

Tools to Help

- → Data Collection Planning Worksheet
- → Data Collection Tracking Tool

Who is Involved

The M&E Specialist should complete the work with the Facilitator's support.

Output

Move on to the next step when you have completed the data collection process and all of the data are ready for analysis.

1 How to Get Started

Use the **Data Collection Planning Worksheet** to identify all Administrators in charge of collecting data for the needs analysis and ask each one to create a version of the **Data Collection Tracking Tool**, which is really an expanded version of the Planning Worksheet.

Appendix Z: Data Collection Tracking Tool

Appendix AA: Data Collection Tracking Tool Example

2 Next

As data are collected, ensure appropriate security of print materials and back-up of electronic files are in place to avoid losses. If the team is electronically entering information from print questionnaires, ensure that spot checks are conducted to support data quality.

3 Then

Once the data been submitted and prepared for analysis, it's a good idea to do one last validation to ensure you have the number of records expected… in the format you expect them to conduct your analysis.

4 Finally

Be sure that all individuals who have coordinated activities, provided information or provided access to data sources have been thanked for their time and effort in supporting the needs analysis investigation.

Step 5B: Adapted Success Case Approach

LOW-RESOURCE M&E SETTING

AT A GLANCE

How will we capture their responses?

In Step 5B, you will manage the implementation of your data collection plan.

Tools to Help

- → Phase 2 Case Selection Worksheet
- → Interview Data Capture Tool

Who is Involved

The Facilitator of the needs analysis should plan the work, while trained interviewers gather the data.

Output

Move on to the next step when you have identified Phase 2 cases, completed all of the Phase 2 interviews and are ready for analysis.

1 How to Get Started

Begin by ensuring that all Phase 1 data are summarized in a single location—ideally a spreadsheet that lists questions in columns and individuals in rows. If some data was collected on paper, be sure you have resources and opportunity to key that data into a central spreadsheet. Consider both the direction and the scale of questions as you key in data. For example, when entering data for a question such as "how often do you encounter problems in delivering services" among questions such as "how often do you have the resources needed to deliver services" ensure you reverse the scale as you enter the response electronically so all positive answers are reflected by high numbers. Scales can be automatically adjusted on most online questionnaires. Conduct a simple review and calculate the arithmetic averages (or mean) of responses of averages across each of the Phase 1 questions to get a general "pulse" of the population as a whole.

2 Next

Focus on those at the extreme ends of the scale across all questions. For example, how many individuals were overall the **most** positive about their work in terms of expectations, ability, opportunity and motivation, and which were **least** positive across the same factors? These will

make up your pool of success and non-success cases. Use the **Phase 2 Case Selection Worksheet** as a guide, and from these two pools, select the initial 8 to 10 individuals for Phase 2 data collection. If the success and non-success pools are very large, you can use a random number generator to select individuals. If the pools are small enough you can write the names on paper and draw from a hat to decide which to include. Be sure to consider key demographic issues such as gender, ethnicity or location, and deliberately choose among those strata if necessary.

Appendix BB: Adapted Success Case Phase 2 Case Selection Worksheet

Appendix CC: Adapted Success Case Phase 2 Case Selection Worksheet Example

3 Then

Train interviewers on the **Phase 2 Interview Protocol** (from Step 4B) and the use of the **Interview Data Capture Tool**, and have them conduct interviews with the chosen cases from each pool.

Appendix DD: Phase 2 Interview Data Capture Tool

Appendix EE: Phase 2 Interview Data Capture Tool Example

4 Finally

Consolidate the interview data and look for consistency of themes among success and non-success cases. If themes are generally consistent in the four essential factors (expectation, ability, opportunity, motivation) across those interviewed in each pool, you can begin to summarize. If themes are very different, you may choose to include a few more cases to ensure you have uncovered all of the most pressing issues.

Step 6A: Analyze Data and Identify Gaps

HIGH-RESOURCE M&E SETTING

AT A GLANCE

What are the identified needs?

In Step 1, you will analyze the data you have collected and identify any gaps between what should be happening and what is happening.

Tools to Help

- → Acceptable Evidence Worksheet
- → Question Matrix

Who is Involved

The M&E Specialist and Facilitator conduct analyses with input, as needed, from Steering Committee members.

Output

Move on to the next step when you completed the analysis and drafted the results for each investigative question, which includes a draft list of identified needs to assure performer excellence.

1 How to Get Started

Review the **Acceptable Evidence Worksheet** to ensure the parameters for identifying needs are fresh in mind.

2 Next

Conduct the appropriate type of analysis on each form of data. For example, conduct qualitative thematic analysis on focus group data and quantitative, statistical analysis on data from electronic questionnaires. Here is where reliance on the expertise of your M&E Specialist is most important. Be sure to note any differences by group, which should be fairly straight forward if you have triangulated your data by getting input on the same question from multiple sources.

3 Finally

Capture the results of the analysis, by data source, for each item in the **Question Matrix**, and note those areas that fall short of expected minimums on the **Acceptable Evidence Worksheet**.

Once you have completed Steps 3A through 6A with the support of your measure and evaluation specialist, please continue to **Step 7: Summarize Findings & Prioritize Actions**.

Step 6B: Adapted Success Case Approach

LOW-RESOURCE M&E SETTING

AT A GLANCE

What are the identified needs?

In Step 6B, you will analyze the data you have collected and identify any gaps between what should be happening and what is happening.

Tools to Help

- → Acceptable Evidence Worksheet
- → Question Matrix

Who is Involved

The Facilitator should conduct this work, with support from the Steering Committee.

Output

Move on to the next step when you completed the analysis and drafted the results for each investigative question, which includes a draft list of identified needs to assure performer excellence.

1 How to Get Started

Review the **Acceptable Evidence Worksheet** to ensure the parameters for identifying needs are fresh in mind.

2 Next

Conduct an initial review of the Phase 2 interview data to look for themes and answers to your investigative questions. This is best accomplished by having two or more people code both success case and non-success case interview data. **Coding** is a process of identifying portions of qualitative data that exhibit relation to a particular theme or topic. Multiple coders help ensure validity for your codes, and ensure a single individual's biases do not influence the findings. In our situation, your coders should be focused on two specific areas:

- → Coding on the four essential factors and the Question Matrix items associated with them, and
- → Coding on general themes that are consistent within success and non-success cases, or are opposing in the two groups

3 Then

Once the codes are identified they should be reviewed to determine if the themes are consistent across groups of specific interest, such as gender or geography.

- → Are there consistent issues raised over and over?
- → Or is there great variance?
- → Where do you see the greatest differences between success and non-success responses in terms of the four essential factors of expectations, ability, opportunity, and motivation? Of the motivational items, are they primarily internally or externally focused?
- → In the area of motivation, are there specific challenges (a) meeting personal needs, (b) social status and social support, (c) family support, (d) self-efficacy, (e) connectedness, or (f) social and gender norms?
- → What factors seem to be most essential for good performance in success cases?
- → Is there any evidence that these factors are missing, or surface as clear needs in the non-success cases?

If you do not see any consistency in the responses from either success or non-success groups, you may choose to hold additional interviews in order to ensure all key issues are being uncovered. In most cases, however, you will likely have at least *some* issues in clear patterns that help highlight needs and answer your investigative questions.

4 Finally

Map out the thematic differences between success and non-success cases for each of the four essential factors and determine how you can apply these themes in answering the items in the **Question Matrix**. Do any of them rise to the level of a need as defined by the **Acceptable Evidence Worksheet**?

Step 7: Summarize Findings & Prioritize Actions

AT A GLANCE

How will we work together to address these needs?

In Step 7, you will work with community or organization representatives to review the data collected and its analysis, identify needs, agree on prioritization of these needs and plan action(s) to address them.

Tools to Help

- → Needs Summary Table
- → Prioritization Matrix and Action Tracker

Who is Involved

The Facilitator of the needs analysis should conduct this work, with support from the Steering Committee.

Output

The cycle ends when the stakeholders agree on who will address what need, how and when the group will check in to learn about the progress of actions taken, and when to begin a new round of review for the same group of performers.

1 How to Get Started

The first step in summarizing your findings is to capture the needs you identified for the population as a whole, and for any specific groups of interest such as gender, age, or geography. The **Needs Summary Table** is a great tool to help lay out these needs visually for consideration by the Steering Committee.

Appendix FF: Needs Summary Table

Appendix GG: Needs Summary Table Example

2 Next

Once the Committee has reviewed and agreed with the identified needs, it's time to consider which needs you will agree to address, who will consider what options are strategically and practically viable to address each need, including creation of an SBCC strategy, and the general timelines for that work. The **Priority Matrix and Action Tracker** will let you build that information for each identified need. You will likely want to start by identifying which needs are the most critical for delivery of services and that, if not resolved, can block the delivery of any services whatsoever. These should be your top priorities—needs like safety, supplies, and any

other component that affects the work to such an extent that *minimum* standards of service delivery cannot be met until they are addressed.

Appendix HH: Prioritization Matrix and Action Tracker

Appendix II: Prioritization Matrix and Action Tracker Example

3 Then

Consider which identified needs should be addressed if resources are still available after meeting critical needs. In general, those needs that interact with others are usually excellent candidates for their good use of funds and effort in solving multiple problems. Be sure that you are equitably addressing needs across *each of the essential factors*, since addressing all the needs in only one area is unlikely to raise performance overall. Keep in mind that addressing the underlying reasons behind each need will be important in the design and implementation of an intervention to address it.

4 Finally

The Steering Committee should work as a team to identify a logical owner for each need as well as a timeframe for assessing the impact of actions taken. Setting up this accountability for Committee members is essential for ensuring the work will get done and that the team truly feels the communal engagement with one another and can enjoy the successful outcomes as a team.

Determine the Role of SBCC

Using social and behavior change communication (SBCC) can be a powerful way to change provider behavior. However, SBCC cannot address all the challenges providers face, and should be used alongside health systems strengthening approaches. Use this checklist to determine if SBCC is appropriate for addressing the barriers your providers face.

Is SBCC Appropriate?

- [ ] Is there a need to positively influence social and gender norms, especially those related to stigma toward specific health services or populations, norms that influence the way health providers interact with clients, status and expectations of providers?
- [ ] Is there a need to foster more support for providers?
- [ ] Is there a need to strengthen provider peer networks?
- [ ] Is there a need to influence national, regional or organizational policy change and/or resource allocation for providers?
- [ ] Is there a need to encourage an increased capacity for local planning and implementation of health improvement efforts?
- [ ] Is there a need to improve client-provider interaction?
- [ ] Is there a need to strengthen supervisors and management staff relationships with providers?
- [ ] Is there a need to influence providers' attitudes, values, and beliefs?

If you checked any of the boxes, SBCC has a role to play in addressing the barriers your providers face. Proceed to the Design section of the I-Kit to design an SBCC intervention for changing provider behavior.

Designing an SBCC Intervention for CHW Behavior Change

Now that you have learned about provider behavior change, assessed barriers to quality FBP service provision, and determined that SBCC has a role to play in addressing those barriers, you are ready to design an SBCC intervention for FBP behavior change.

This section of the I-Kit will help you design an SBCC intervention to change FBP behavior by addressing the Motivational barriers you identified: Self-Efficacy, Social and Gender Norms, Perceived Place in Social Hierarchy/Status, Rewards, and Work Environment.

Follow the step-by-step guidance to develop an SBCC intervention for CHW behavior change:

Steps

Step 1: Analyze the Situation

Step 2: Identify the Core Problem

Step 3: Define Your Audience

Step 4: Develop Communication Objectives

Step 5: Determine the Key Promise and Support Points

Step 6: Define Your Strategic Approach

Step 7: Match Communication Approach to Identified Motivation Barrier

Step 8: Develop an Implementation Plan

Step 9: Monitor and Evaluate

Step 1: Analyze the Situation

A **situation analysis** is the first step in the social and behavior change communication change (SBCC) process including one that focuses on CHWs. The situation analysis answers questions about existing opportunities, resources, challenges and barriers related to improved CHW behavior.

You can conduct this step using one of the following two options:

Conduct CHW Assessment

Follow the steps in the **Provider Performance Assessment** tool (preferred).

Gather Secondary Data

Gather the information you need for the Situation Analysis through secondary data.

Whichever method you use, make sure you answer these fundamental questions:

- → What is the performance problem, the level of severity and its causes frame around Expectation, Ability, Opportunity and Motivation?
- → Who are the groups of people affected by the problem (what types of providers, what motivations do they possess, where do they live and work, what are the psychographic details, etc.)?
- → What is the broad context in which the problem exists?
- → What are the factors inhibiting or facilitating behavior change among CHWs?
- → What other interventions are in place or planned to address CHW behaviors?
- → What are CHWs' preferred sources of information and communication channels?

The following summarizes the key activities for the situation analysis:

1 Conduct a Review of Program Data

This includes service records, quarterly reports, policy documents and informal interview. Then develop a focused problem statement. This statement will help to ensure the intervention focuses on one specific behavioral issue at once. Example: "Community Health Workers are not consistently referring women of reproductive age for family planning services."

2 Draft a Shared Vision

A shared vision provides a picture of what the situation will look like when the SBCC effort is completely successful. Example: "In 2020, CHWs spend time discussing methods with newly married couples and encourage them to ask questions and refer those with demonstrated need for FP services." Guidelines on what to consider when drafting this vision.

3 Gather Information and Summarize Findings

If you chose to conduct the CHW Performance Assessment, follow the steps to gather the information and summarize your findings through the link. If you chose to conduct a literature review, follow the steps in this how-to guide for conducting a Situation Analysis using secondary data to answer the key questions about CHWs and their work environment.

Examples of secondary data you might consider to gather this information include:

- CHW monitoring or support supervision reports
- Service delivery statistics
- Program reports
- Key informant interviews
- Government, partner and donor activity evaluation reports
- Government policy documents regulating CHWs and primary health services

Whether you use the CHW Performance Assessment or a Literature Review to conduct the assessment, the findings of your situation analysis should be framed around the four categories of CHW performance:

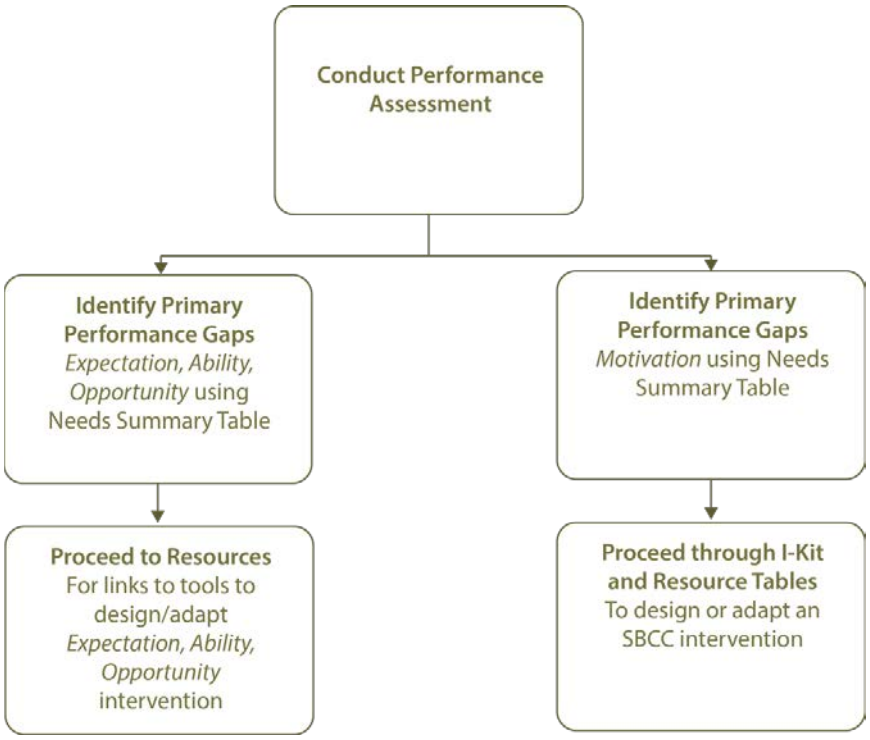
- **Expectation** – Do CHWs have the environment and necessary resources available to support performance?
- **Opportunity** – Do CHWs understand the performance expected and the definition of quality?
- **Ability** – Do CHWs have the skills and knowledge necessary to do the tasks in his/her scope of work and feel competent in doing so?
- **Motivation** – Is there sufficient reward and lack of negative consequences to make CHWs want to do his/her job?

Use the Needs Summary Table (Appendix FF) from the CHW Performance Assessment to summarize the findings. Then prioritize those needs using the Prioritization Matrix and Action Tracker (Appendix HH).

If you prioritized *Expectation, Opportunity* or *Ability* barriers, proceed to Other Resources for tools, resources and programmatic examples to improve Expectation, Opportunity and Ability performance gaps.

If you prioritized *Motivation* barriers, identify which motivational barriers are relevant to your CHWs and then proceed through the I-Kit to design your intervention.

The graphic below describes how to navigate the results of the Assessment or literature review to use this I-Kit.



4 Review the Data

Review the data you collected through the CHW Performance Assessment or Literature Review. Study the five categories of factors impacting CHW motivation in the Learn section. Determine which motivational factors are most relevant to the CHWs you are working with.

SITUATION ANALYSIS OUTPUTS

At the end of the situation analysis, you should have:

- → Problem Statement
- → Shared Vision Statement
- → Analysis Findings

Record these outputs in the Step 1 section of the **SBCC Strategy Template** (Appendix JJ)

Resources

- **Designing a Social and Behavior Change Communication Strategy Implementation Kit**
- **How to Conduct a Situation Analysis**
- **Understanding the Situation: A Practitioners Handbook**

Step 2: Identify the Core Problem

For an SBCC intervention to be effective, it must address the core, underlying problem – not simply the outward effects of the problem. A **root cause analysis** will help you understand why there is a difference between where you want to go (shared vision) and what is happening now (current situation). Once you understand what is truly causing the problem, you can design a strategy to address that core problem.

CHW behavior results from a complex interaction of cultural, political, health systems, personal and managerial factors. You have already identified factors that influence your CHWs' behavior. In this root cause analysis, you can explore how those factors interact and what is truly driving the problem. It is important to consider:

- → Larger social norms that impact CHWs' values, attitudes and practices
- → Status indicators that influence how a CHW interacts with clients
- → Policies and regulations that determine what a CHW can and cannot do
- → The value the local community and health system places on CHWs

The following are the key steps to identifying the core problem:

1 Write down the problem you are addressing in the Root Cause Template. For example, CHWs are not referring clients to the health center, or CHWs are treating clients rudely.

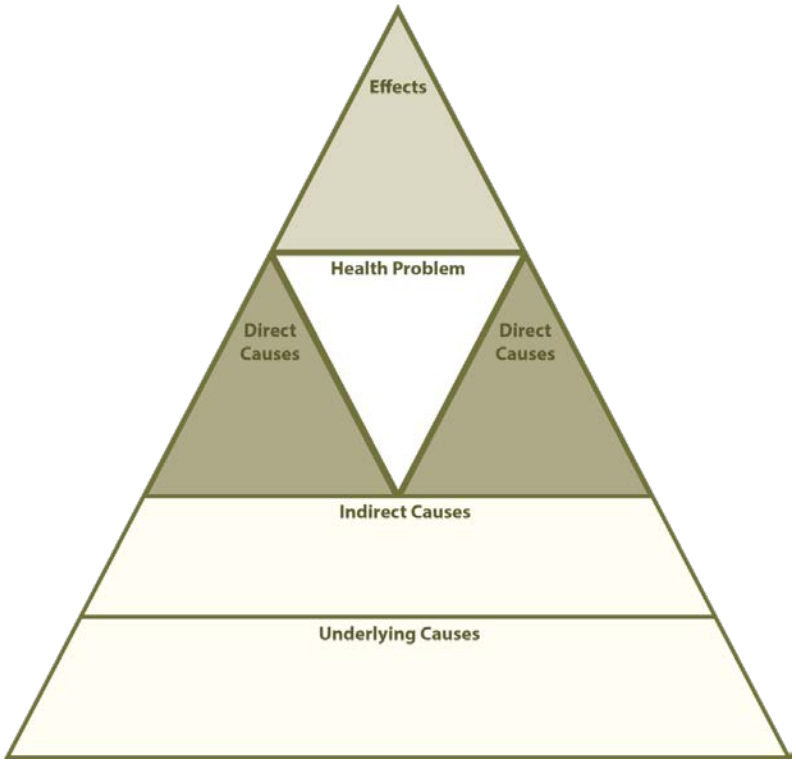
2 Start by identifying the direct causes of the problem (those things that cause or contribute to the problem). By identifying the direct causes you will begin to understand "why" we have this health problem. For example, if the problem is that CHWs are treating clients rudely, ask "why are CHWs treating clients rudely?" Write your responses on either side of the problem in the template.

3 After you determine the direct causes, brainstorm the indirect causes by asking "why do we have these direct causes?" Record the answers in the "indirect causes" of the activity template.

4 Root or underlying causes are seldom found in the most obvious causes. It is important to dig deeper and continue to ask "why?" until nearly all responses have been exhausted or roots that seem important to address are reached. If there are underlying causes that impact the health problem, you may need to address those before you can address the direct causes. For example, consider power dynamics in the community and health system, perceptions of CHWs, gender norms that govern interactions or cultural taboos. List those underlying causes in the space provided.

5	Once you have identified the underlying causes, determine the effects of the problem. These may include issues such as high rates of mother and child mortality, loss of manpower hours or other effects. List these at the top of the chart.
6	Take a look at the underlying causes you have identified and ensure they can be addressed through SBCC efforts. If you have more than one underlying cause that can be addressed through SBCC, decide which to address first by ranking them in order of importance.

Root Cause Analysis Pyramid Template (Appendix KK)



Record your prioritized core problem in the Step 2 section of the **SBCC Strategy Template (Appendix JJ)**

Step 3: Define Your Audience

Before designing any SBCC intervention, it is important to analyze the intended audience to gain a better understanding of who they are, including their current behaviors, and to decide which sub-segment or "primary audience" you will address.

This same process is used when designing an intervention to improve CHW behavior. CHWs are similar to other audiences identified for SBCC in that they have their own set of needs, desires, biases and attitudes that need to be understood in order to identify SBCC solutions. The Audience Analysis is an important step to understand CHWs as an audience.

The following are the key steps to audience analysis:

1 Review Audience Information

Review what you collected in the situation analysis (either through the Performance Needs Assessment or the Literature Review) to understand:

- → Current levels of performance
- → Key barriers to quality service provision by category (Expectation, Ability, Opportunity and Motivation)
- → Total number of providers, geographic location and services provided
- → Socio-demographic characteristics like age, years of experience, education level and religion
- → Beliefs, attitudes, knowledge levels and current behaviors
- → Psychographic data like CHWs' needs, aspirations, hopes, fears and habits
- → Other information as appropriate

Additional audience research may need to be gathered. See the Audience Analysis and Formative Research how-to guides for more guidance.

2 Decide Whether to Segment

Audience segmentation is the process of dividing the larger CHW audience into smaller groups or "segments" of similar individuals. Segmentation is important because different people respond differently to SBCC messages and interventions. It helps program teams better channel resources and narrow focus on a "primary audience." For programs working with providers, segmentation also helps better target monitoring, coaching and routine support supervision activities. If after the review of audience information it is determined that smaller groups with similar behaviors, needs, values and/or characteristics (segments) exist within the larger audience, it is best to segment.

One Method to Segment Providers – Population Services International

Population Services International (PSI) uses one method, adapted from the commercial pharmaceutical sector, to determine whether it is necessary to segment health providers before introducing a performance improvement approach. The approach uses two primary criteria: 1) Is there potential for health impact (i.e., are the providers working in a region or with clients who have a need for health improvement) and 2) Are the providers currently providing services or performing the desired behavior. Using these criteria, the segments are categorized in a Provider Segmentation Matrix:

BEHAVIORS	
High Potential/Low Behavior These providers are working in high density communities highly populated by members of their intended audience (i.e., women of reproductive age or children under 5), but who see very few clients or are not consistently performing the desired behavior.	**High Potential/High Behavior** These providers work in high-density communities and see high numbers of clients and are already providing good quality services. They are designated as "stars."
Low Potential/High Behavior These providers have a low client load, perhaps because they are not located in an area where people demand services from CHWs or there is low population density, but they are providing high quality services to the small number of clients they see.	**Low Potential/Low Behavior** These providers have a very low client load and for whatever reason are not offering services or performing the desired behavior.

Using this method, PSI determines whether there are distinct segments among the providers and which groups should be prioritized. Prioritized segments are providers who demonstrate both potential to improve health impact – in areas where there is demand for health services that is not already met – and who are not currently performing the desired behavior. This often results in prioritizing providers in the A and B quadrants.

3 Determine Segmentation Criteria

If segmentation is required, look at the audience and identify traits that make one sub group different from another. A significant difference is one that requires a different message or approach. These distinctions can be categorized by socio-demographic, geographic, behavioral and psychographic. See the table below for unique criteria for CHWs.

Socio-Demographic	Geographic	Behavioral	Psychographic
▪ Age ▪ Gender ▪ Level of education and/or clinical training ▪ Ethnicity/language ▪ Years of service	▪ Urban ▪ Rural ▪ Peri urban	▪ Current behavior (high performer/low performer) ▪ Barriers to behavior – Expectation, Ability, Opportunity, Motivation	▪ Benefits sought through CHW work ▪ Attitudes/opinions about CHW, clients

4 Segment the Audience

Segment your audience using criteria identified in Step Three. Consider using a segmentation table, such as the one below:

Segmentation Table Template (Appendix LL)

Potential Audiences	Potential Primary Audiences	Potential Influencing Audiences
Demographic Characteristics Age, gender, years of training and years as CHW		
Geographic Characteristics Region, urban or rural, and area of conflict		
Socio-Cultural Characteristics Language, culture, place in society, religion and ethnicity		
Behavioral Characteristics Behaviors that affect or impact the challenge		
Psychographic Characteristics Personality, values, attitudes, interests, lifestyle and reasons for wanting to be a CHW		
Ideational Characteristics		

Potential Audiences	Potential Primary Audiences	Potential Influencing Audiences
May include knowledge, beliefs and attitudes about CHW work, expectations and attitudes about clients served, perceived risk, self-efficacy, social support and influence, environmental supports and constraints, emotions, norms and self-image		

5 Assess Proposed Audience Segments

Once segments have been selected, ensure they are valid and usable. Use a checklist to ensure each segment meets the criteria for effective segmentation. If a defined segment does not meet the criteria, it is best to drop it and consider other segments.

Consider using this segmentation analysis checklist to assess audience segments.

Homogeneous	Yes	**What it Means:** The members of the audience segment are similar in a relevant way.	**Why It is Important:** This is the basis of audience segmentation – that the members of each segment are similar in terms of needs, values and/or characteristics.
Heterogeneous	Yes	**What it Means:** Each segment is relatively unique, as compared to the other segments that have been identified.	**Why It is Important:** This demonstrates that the broader audience has been effectively divided into sets of differing communication needs.
Measurable	Yes	**What it Means:** Data from the situation analysis or other research should indicate the size of the audience segment.	**Why It is Important:** Measurements allow programs to evaluate whether to focus on a particular element.
Substantial	Yes	**What it Means:** The audience segment is	**Why It is Important:** Programs should have a minimum expectation

		large enough, in terms of potential impact on public health, to warrant the program's attention.	for the impact of their investment. Therefore, programs should only consider segments that are big enough or important enough to impact public health.
Accessible	Yes	**What it Means:** The audience segment is reachable, particularly in terms of communication and access to products or services needed to address the problem.	**Why It is Important:** Each segment needs to be able to be reached and communicated with efficiently.
Actionable/Practical	Yes	**What it Means:** The program is able to implement a distinctive set of messages and interventions for each audience segment.	**Why It is Important:** The program must have the resources and ability to address the segments identified.
Responsive	Yes	**What it Means:** Each audience segment can be expected to respond better to a distinct mix of messages and interventions, rather than a generic offering.	**Why It is Important:** If the segment will not be more responsive to a distinct approach, then the segment can probably be combined with another similar segment.

6 Prioritize Audience Segments

Deciding which segments to prioritize and how to approach them is critical. If the program team identified more audience segments than it can or needs to reach, narrow the list and finalize which segments the program will focus on. Ultimately, the decision about which segments to

prioritize is based heavily on available resources and program goals. Some questions to consider when prioritizing audience segments are:

- → How much does this segment impact the overall program objectives?
- → How easy are they to reach?
- → Do they have significantly different views about their work than their peers?
- → How ready are they for behavior change?
- → What stage in the behavior change process are they currently?

More details on **How to Do Audience Segmentation**.

7 Create CHW Audience Profiles

An audience profile may enable you to obtain a personal sense of the people to be reached through your SBCC efforts. Focus first on the primary audience and think about what you know about them. Then draw an outline of a person who is a typical member of this audience and write a brief description of a single person as a composite of the group.

This profile could describe the CHW's geographic location, gender, age, cadre, years/level of training, concerns, current behaviors, years of service, where she gets information, what motivates her to be a CHW, current performance, beliefs, values or family situation.

Include findings from the performance assessment such as: the identified barriers and facilitators to improved performance considering the performance factors (Expectation, Opportunity, Ability and Motivation) and anything you know about specific motivational factors to perform well.

You might write "a day in the life" of the provider as a way to capture what is most important to the individual and to better understand their day-to-day experience as a CHW. This profile should be based on data including that gathered during the situation analysis and the performance gap assessment.

Remember: Audience profiles are needed for each prioritized audience segment.

NOTE: If you have determined that CHW motivation is heavily influenced at other levels (health system, community, organization, family and peers), identify which individual(s) are the most critical secondary (influencing) audience(s) and develop a profile for them as well.

Record your selected audiences, audience segments, and audience profiles in the Step 3 section of the SBCC Strategy Template.

Sample CHW Profile

Name: Halyman

Location: Works in a rural area outside the capital city.

Type: Voluntary Community Health Worker working part time, she has been a CHW for 11 years.

Incentives: She sometimes receives small gifts from the families she serves, such as bus fare.

Education: She has a primary school education.

Family Life: She is married with three children.

Services Provided: She has 260 eligible families in her community and she tries to see five families per day. She provides family planning counseling. She is not allowed to dispense IUDs or any family planning methods but can counsel and provide referrals to the local health clinic located less than half a kilometer from her home. She also provides basic information for child health including nutrition.

Why She Is a CHW: She wants to help people in her community. She is motivated by the satisfaction she feels when people in her community tell her she was a big help to their family.

Resources

- **Designing a Social and Behavior Change Communication Strategy**
- **PSI Coaching Toolkit**
- **How to Conduct an Audience Analysis**
- **How to Do Audience Segmentation**

Step 4: Develop Communication Objectives

Setting good communication objectives is important to keeping your SBCC efforts focused and on track. By linking your objectives to indicators, you can also track progress and demonstrate impact.

Good communication objectives should be:

S Specific

Does the objective say who or what is the focus of the effort? Does this objective say what type of change is intended? Does the objective cover only one challenge?

M Measurable

Can your objective be measured in some way? Does the objective include a verifiable amount or proportion of change expected?

A Appropriate

Is the objective sensitive to audience needs and preferences? Is the objective sensitive to societal norms and expectations?

R Realistic

Can you realistically achieve the objective with the time and resources available? Is the degree of expected change reasonable given these conditions?

T Time-bound

Does the objective state the time period for achieving change?

Good communication objectives focus on addressing the core problem you identified in Step 2.

The communication objectives should answer the following three questions:

- → What is the desired change in behavior, social norms or policies?
- → How much change can be expected of the audience? How will this change affect the CHW, the community, the health system and society?
- → What is the timeframe required for the change? By when do we want these changes?

You will answer these questions by completing the following activities:

1 What Is the Desired Change?

Each of the primary and influencing audiences will require its own set of communication objectives. Refer to your audience profiles and situation analysis to answer the following questions:

- → What type of behavioral change do you want each of your audiences to make?
- → What type of impact do you want this to have? For example, a change in social norms, a change in policy or change in number of clients seen.
- → Are the desired changes **specific** and **appropriate**?

Next

Indicate the intended audience segment – whose behavior do you intend to change through the SBCC intervention (e.g., rural CHWs with one to two years' work experience or urban CHWs working in FP and reproductive health)? Record this in the table below under Audience Segment.

Then fill in the "Desired Change" column for each of your audience segments in the Final Communication Objectives table.

Final Communication Objectives Table (Appendix MM)

2 How Much Change Can Be Expected?

To make a reasonable estimate on how much change can be made, consider the overall context of the problem, experiences of similar programs in the past, and the resources and timeframe available.

Context of the problem

Remember the barriers you identified that affect CHWs and any secondary audience's behavior. Your communication objectives will need to address these barriers. Referring back to your situation analysis and root cause analysis, consider the motivational barriers you identified.

- → What are the barriers to change?
- → What are the incentives **not** to change?
- → Which of these barriers and/or incentives not to change will you address?
- → Add this information to the "Barriers to Change" column in the **Final Communication Objectives table (Appendix MM)**

Prior experiences

- → Examine available research data and reports that describe prior communication programs related to the challenge to be addressed.
- → What changes were achieved?
- → Based on this information, what changes do you think are **realistic** and feasible?

Resources and timeframe available

- → Consider the resources available and what is manageable within the strategy's timeframe.
- → Can the objectives be accomplished with the available resources?
- → Are communication approaches sufficient to reach the intended audience?
- → Can services meet increased demand?

Determine the amount of change expected

- → State the existing baseline measure as well as the expected measure.
- → What is the numerical or percentage change expected?
- → Is the amount of change measurable and realistic?
- → If there is no baseline data, use secondary data and grey literature such as technical reports from government agencies or research groups, working papers, white papers or preprints.

Add the amount of change expected under the "How much change?" column in the **Final Communication Objectives table**. **(Appendix MM)**

3 What Is the Timeframe for the Desired Change?

Identify the timeframe in which change will be achieved. This will ensure your objectives are **time-bound**.

- → What is the timeframe for your objectives? They can be stated in either months or years.
- → Does the timeframe provide adequate time for change to effectively take place?
- → Is the timeframe **realistic**?

Add this information to the "Timeframe" column in the **Final Communication Objectives table**. **(Appendix MM)**

Motivational-based Communication Objectives (Example)

At the end of 3 years, 50% of CHWs in the targeted area express positive attitudes toward their jobs.

At the end of 2 years, 33% of CHWs will indicate they feel the communities they serve actively support their work.

At the end of 18 months, 40% of community members in targeted area recognize CHW logo as a sign of quality service.

Record your final communication objectives in the Step 4 section of the **SBCC Strategy template**. **(Appendix JJ)**

For additional information on setting good objectives for SBCC, see **Designing an SBCC Strategy Implementation Kit**.

Resources

- Designing an SBCC Strategy I-Kit

Step 5: Determine the Key Promise and Support Points

Now that you have determined what you want your CHW audience to do (*desired behavior change)* you need to identify how the CHW will benefit from taking that action. This is the **key promise** your SBCC intervention is making to your audience.

Determine the Key Promise

Take some time to review what your primary audience cares about, hopes for, aspires to and needs. These represent benefits your CHW audience would respond to. Some examples might include: being respected, making a difference, being seen as a leader in their community, or making money. Think about what you are asking your audience to do, then imagine a CHW asking, "Why should I do this?" or "How will this help me?" Write down responses to those questions keeping in mind what kind of benefits the CHWs would care about. The promise must be true, accurate and of real benefit. The key promise is not the message the CHW will see or hear, but it is the benefit that will be conveyed in all the messages and materials you produce.

After brainstorming benefits, develop the key promise using an "if…then…" statement: "If you (do this new behavior) then you will (benefit)." For example, "If you treat clients with respect regardless of their background, then you will be viewed as a leader your community can turn to." It can be helpful to develop a few alternative options and pretest them with your audience to see which benefit resonates best with them. Convey the key promise in all the messages, activities and materials you create.

Identify Support Points

Your audience needs believable, persuasive and truthful information to support the key promise. These can be in the form of facts, testimonials, celebrity or opinion leader endorsements, comparisons or guarantees. The kind of support points used will depend on what will appeal and be credible to your particular CHWs.

Based on the key promise you developed, identify information that supports the promise. As you develop those support points, consider who your CHWs trust or aspire to be like, where and how they prefer to get their information, and what kind of appeals will best reach them. For instance, would your CHWs trust a promise given by another CHW, a health system manager or a community leader?

Some examples of support points include:

- → Using the new referral system has saved 200 lives (fact, comparison)
- → A fellow CHW testimonial: "I listened to my clients and I am now all the community members come to me for guidance."

Record your key promise and support points in the Step 5 section of the **SBCC Strategy Template (Appendix JJ)**.

Step 6: Define Your Strategic Approach

At this stage, it is important to make decisions about which broad communication approach is most appropriate to achieve your communication objectives. In doing so, it is critical to consider both the needs and preferences of your intended audience and how well various approaches will work with your specific objectives and barriers and in your current context. An SBCC strategy may include more than one approach.

To determine which type of approach is the most appropriate, it is important to first answer a set of key questions:

- → **Which motivational barrier or barriers are you trying to address**? Perceived Status, Incentives and Personal Rewards, Level of Connectedness, Social and Gender Norms, Personal Attitudes and Beliefs or others.
- → **How complex is the barrier?** Complex barriers like social norms and attitudes are better addressed with approaches that allow for dialogue.
- → **How sensitive are the issues to be addressed?** Issues that the audience may not want to discuss publicly or that they feel may compromise their compensation, promotion opportunities or standing among peers require approaches that are more confidential and one-on-one.
- → **What is the level of literacy and/or technical comfort among the intended audience?** Community radio and group discussions which require less reading and/or more active engagement may be more appropriate for those with lower reading and educational levels.
- → **What is the desired reach?** How large is the intended audience segment and how wide is the geographic location in which they work? Some approaches are limited in reach but allow for greater depth in coverage of a particular issue.
- → **What are the cost considerations?** What is known about cost per person reached and the known cost effectiveness of a particular approach? Does this fit within the available budget?
- → **What is the level of acceptability of approach for the intended audience?** The format should be appropriate for the intended audience in terms of what they are used to and comfortable using. For example, some CHWs may be resistant to support supervision, peer support and more interactive coaching styles, particularly if supervisors are younger or the intended audience is more comfortable with a hierarchical management style.
- → **What is the level of technology and innovation and is it appropriate for the intended audience?** Lower level, less educated or even older CHWs may be more resistant to new technological methods like tablets, smart phones and formats that use social media or mobile health technologies or they may not have access to these types of tools.

COMMUNICATION APPROACHES TO BE CONSIDERED

The table below does not include every possible approach, but it describes some communication approaches that have been used successfully in programs to improve CHW performance. See the SBCC Strategy I-Kit for more examples of strategic approaches.

Approach	Definition	Barriers Addressed	SBCC Examples For CHWs
Advocacy	A deliberate process, based on evidence, to directly and indirectly influence decision-makers, stakeholders and relevant audiences to support and implement actions that contribute to health and human rights.	▪ Policy ▪ Resource allocation ▪ Legal changes ▪ Perceived status ▪ Connectedness to health facilities ▪ Social and gender norms	Using evidence informed communication targeting leaders at Ministry of Health to allocate resources enabling CHWs to receive a small stipend, reward or recognition as incentive for good performance.
Branding	Process of developing a symbol, logo and design that distinguishes one product, service or idea from the competition.	▪ Incentives and rewards ▪ Perceived status ▪ Social support ▪ Peer connectedness ▪ Connectedness to community	Developing a mark or symbol and making it visible on trained CHWs' clothing, bags and homes, etc., to identify them as high-quality service providers.
Mobile Health	A tool to expand access to health information and services using mobile and wireless technologies such as mobile phones, tablets and mobile software applications.	▪ Ability barriers ▪ Perceived status ▪ Connectedness to peers ▪ Connectedness to the health system ▪ Connectedness to supervisor ▪ Incentives and rewards	Sharing short videos through Bluetooth technology to demonstrate better IMCI counseling practices among select CHW members who own smart phones or feature phones.
Role Modeling	Process of strategically engaging people whose behavior or success can be emulated by others to	▪ Social status ▪ Incentives and rewards ▪ Social and gender norms	Identifying high-performing, well-liked CHWs and partnering them with new or demotivated CHWs for scheduled "work- alongs."

Approach	Definition	Barriers Addressed	SBCC Examples For CHWs
	influence behavior change.		
Satisfied Client	An intervention which enlists individuals who have successfully adopted a select behavior, service or product to conduct outreach with individuals who are non users/non-adopters.	▪ Connectedness to community	Select and engage young mothers who recently received high-quality community-based counseling and who are also willing to speak out in local radio talk shows or community activities to encourage local families' support of CHWs.
Support Supervision and Coaching	A feedback approach that promotes mentorship, joint problem-solving and communication between supervisors and their staff.	▪ Connectedness to supervisor	A supervisor may apply interpersonal communication techniques during routine monitoring to jointly identify behavioral and performance goals, techniques to address individual barriers and coach CHWs on ways to improve performance.

Identify several communication approaches you would like to use by answering the questions above. Use the following table to analyze any potential approaches you are considering. For each audience and each communication objective, write the approach and evaluate it against the selection criteria.

Key Approach	Intended Audience	Communication Objective
Criteria	**Meets this Criteria (Y/N)**	
1. Matches the identified motivational barrier.		
2. Is appropriate for the level of complexity of the barrier.		
3. Is appropriate for the level of sensitivity of the barrier.		
4. Matches audience literacy level.		
5. Meets reach requirements for audience.		

Key Approach	Intended Audience	Communication Objective
6. Is within program budget.		
7. Is an acceptable approach to the intended audience.		
8. Technology and innovation level is appropriate.		

Key Approach Table (Appendix NN)

SELECTING COMMUNICATION CHANNELS

Once you determine your broad approach, the next step is to select specific communication channels. Channels are the specific set of communication tools you want to use. Generally, channels can be organized into four main categories: interpersonal, community based, mass media and social media. The following table defines the different channels and provides examples of how these channels may be applied in CHW programs.

Channel Types	Definition	Examples
Interpersonal: Counseling, peer to peer, client-provider and supervisor to CHW	The process by which two or more small groups of providers exchange information and ideas through face-to-face interaction.	▪ Site visits with leaders and politicians to advocate for policy change ▪ Coalition building meetings for improved connectedness to communities ▪ CHW peer meetings to improve connectedness to peers ▪ Support supervision visits, team meetings to improve connectedness to supervisors
Community Based: Community dialogue, community drama, community radio and community events	A process that engages and motivates a wide range of partners and allies at national and local levels to raise awareness of and demand for a particular objective through dialogue.	▪ Community dialogues to develop selection criteria for CHWs ▪ Community events to recognize high-quality CHWs
Mass Media: Radio and TV; serial dramas, game shows,	Diversified media technologies that are intended to reach large audiences via mass	▪ Radio soap opera modeling effective CHW/client interaction

Channel Types	Definition	Examples
websites, newspaper, magazines and posters	communication including radio, film, and television.	▪ Radio talk shows with CHWs on air as guests to build links to community ▪ Newspaper articles recognizing successful CHWs
Social Media: Facebook, WhatsApp, SMS, blogs and podcasts	Internet services where the online content is generated by users of the services including blogging, social network sites and Wikis, etc.	▪ Facebook page for CHWs ▪ Motivational videos shared on WhatsApp among CHWs ▪ Blog for CHWs ▪ Social media user group among CHWs to enable their sharing of better practices, learnings and new techniques related to their work

Refer to the resources section below for detailed guidance on how to select the best channel.

Once the most appropriate communication approach is determined, work with a creative team to develop messages and materials. Don't forget to ensure that these materials are pre-tested with your primary CHW audience before being finalized and produced!

Record your selected communication approach(es) and communication channels in the Step 6 section of the **SBCC Strategy Template (Appendix JJ**).

Resources

- Setting Strategic Approaches
- PSI Coaching Toolkit
- PSI IPC Toolkit – Implementation Chapter
- How to Develop a Channel Mix Plan

Resources for Materials' Development:

- Beyond the Brochure: Alternative Approaches to Effective Health Communication
- Clear and Simple: Developing Effective Print Materials for Low Literate Readers
- Scientific and Technical Information Simply Put
- C-Modules – Module 2
- How to Develop SBCC Creative Materials
- How to Conduct a Pretest

Advocacy

- Smart Chart 3.0
- UNICEF Advocacy Toolkit
- Advocacy: Building Skills for NGO Leaders

Branding

- Branding Part 1
- Branding Part 2
- Branding Part 3
- DELTA Companion (PSI)

mHealth

- mHealth Working Group
- WHO mHealth Toolkit
- Support Supervision

Social Media

- The Health Communicators Social Media Toolkit

Step 7: Match Communication Approach to Identified Motivation Barrier

At this stage, you have identified your key barriers to CHW motivation, identified your intended audience(s), defined your objectives and the general strategic approach you plan to use.

This step pulls together resources, toolkits and guidelines that guide the development of SBCC approaches that will help address the identified barriers to CHW motivation. These can be adapted to your context and intended audience as you see fit.

The tools and resources have been organized around the five main categories of CHW motivation discussed previously:

1. Perceived Status and Social Support
2. Level of Connectedness
3. Incentives and Personal Rewards
4. Supportive Social and Gender Norms
5. Personal Attitudes and Beliefs

Review your findings from your situation, root cause and audience analyses to remind yourself of the motivation barriers your CHW audience faces. Consider the approaches you have chosen to address those barriers. Then, read the relevant sections below and access the resources that will help you in designing your SBCC intervention.

PERCEIVED STATUS AND SOCIAL SUPPORT

SBCC can play a role in improving community and family support through efforts to build CHW status and encourage greater community involvement. Some examples include: using mass media to publicly praise CHWs (used in Indonesia); designing branding strategies to help identify and recognize high quality CHWs; providing CHWs with bags, badges and high-quality counseling materials with identifying logos; identification cards to secure preferential treatment in health clinics (in Ghana); and securing letters of appreciation from government officials. In Bangladesh, one community service provider noted that simply being seen on a periodic basis by a headquarters-based supervisor, demonstrating a clear support system from a larger technical resource, is a boost to one's status among community members.

Providing CHWs with tablets and mobile phones that include SBCC materials and electronic guidelines has been used not only to improve CHW capacity in interpersonal counseling but also to improve their status among the communities where they work. SBCC can also be used to advocate for improved government policy to raise the social status and support of CHWs. In India, for example, CHWs are given access to credit programs for income generating projects and are prioritized for literacy classes.

Regardless of the approach, it is important to ground techniques to improve social status in an understanding of the CHWs working in the community. What may be desired by one CHW may not be the same for another. These preferences are often influenced by age, gender, current social status within the community and level of education.

The Motivation Resource Table below details some documented programs and approaches, which have used various techniques to improve CHW social support and status.

Motivation Resource Table: Perceived Status and Social Support

	Toolkits/Guidance Resources	Select Literature
Perceived Status and Social Support	1. Open source mobile applications for health care management. 2. Hesperian Health Guides. Library of digital tools for health promotion designed for people with limited computer or internet access. 3. InScale Project in Uganda – YouTube video 4. An interactive voice response training program for CHWs to improve recognition and status among community members 5. Providing netbooks to field workers in Bangladesh equipped with an eToolkitand 8 eLearning courses improved client confidence and increased field worker status. 6. Image-building TV spot for Lady Health Workers in Pakistan	1. Amare, Yared. 2009. Non-Financial Incentives for Voluntary Community Health Workers: A Qualitative Study. Working Paper No. 1, The Last Ten Kilometers Project, JSI Research & Training Institute, Inc., Addis Ababa, Ethiopia. 2. Improving Health Communications in Kenya: A feasibility study on engaging frontline health care workers in using mobile technology. The Internews Center for Innovation and Learning. 2012. Aggrey (K4H) Willis Otieno

LEVEL OF CONNECTEDNESS

Community Connectedness – CHW programs integrated with the Primary Health Care system and managed well can ensure continuum of care. A well-run CHW program will directly engage the community, which includes but is not limited to: enabling community members to help define CHW roles and job descriptions, selecting and recruiting CHWs, and helping monitor CHW performance and resulting health outcomes. Community-led advocacy can also ensure that the appropriate structures are in place to select and monitor CHWs and ensure their activities provide efficient links to health services. SBCC plays a large role in all of these activities.

The Communication for Healthy Living Project in Egypt developed its Community Health Program through a multi-step process, which sought to ensure community health workers were linked to the community management structures. The process included:

- → Community mobilization to establish a village health committee based on identified community needs and together with the Village Council and Primary Health Care Unit
- → Conducting village assessments to identify community needs and present to the Village Council through community meetings
- → Revitalizing the Primary Healthcare Unit Board to help review proposed activities
- → Identifying community health volunteers and leaders through the Village Health Committee to conduct group discussions for men and women, family health interventions, health clinic discussions

Peer Connectedness – SBCC approaches can help address the loneliness and lack of support CHWs feel by connecting them to their peers. Some examples include bringing peer educators together for award ceremonies or refresher trainings, developing and distributing newsletters or conducting routine meetings for status updates.

The Care Community Hub (CCH) project's Community Health Nurse (CHN) on the Go developed a mobile app to improve motivation and job satisfaction among frontline health workers working in maternal, newborn and child health in rural Ghana. By providing this mobile phone app to community health officers, community health nurses and their supervisors, CNH on the Go will combine virtual peer-to-peer support with improved connectedness to a professional network and supervisors. The Community Health Nurse on the Go app aims to improve motivation among frontline health workers through a mobile technology application.

Connectedness to Supervisor – Some programs have employed SBCC approaches that allow supervisors to use interpersonal communication to counsel CHWs to discuss problems and exchange information. One example is PSI's Provider Behavior Change Communication approach, which has applied an interpersonal-based coaching and support supervision approach, which helps build CHW capacity, improves self-efficacy and reduces CHWs feelings of isolation.

In Zambia, the Malaria Communities Program partners implemented a variety of supervision systems, including conducting joint supervision visits with MOH staff and holding monthly meetings with volunteers. Supervisory visits were tremendously motivating to volunteers, providing opportunities to recognize their efforts and reinforce their credibility in communities. Monthly or quarterly meetings encouraged a cohesive spirit of teamwork and motivated volunteers to continue their work.

Connectedness to Health Facilities – SBCC approaches can be used to help advocate for improved CHW connectedness to health facilities and stimulate community support and

demand for CHW led health services as an extension of facility based health services. It can also be used to training and support materials to help them in their work.

As a means of addressing poor motivation tied to increased demand for CHW services in Kailahun District in Sierra Leone, in 2012 the Innovations Project and Catholic Relief Services implemented the Quality Circles Project. *Quality Circles* consisted of regular quality improvement group meetings with health volunteers and health facility staff to address peer learning, foster peer support and develop joint problem solving strategies to improve health services and health worker morale. Many "change ideas" sought to improve Traditional Birth Attendants' (TBAs) relationships with their communities and with health workers, such as training TBAs to assist with non-clinical tasks in the health facility. Issues that could not be resolved by health workers and TBAs themselves were presented as part of an advocacy strategy to the District Health Management Teams for their action, enhancing communication on health system issues in the district.

Motivation Resource Table: Level of Connectedness

	Toolkits/Guidance Resources	Select Literature
Connectedness to Health Facilities	1. Mobile Technologies and Community Case Management: Solving the Last Mile in Health Care Delivery. Frog, UNICEF 2. Developing and Strengthening Community Health Worker Programs at Scale A Reference Guide for Program Managers and Policy Makers, Chapter 11, MCHIP 3. inSCALE Uganda and Mozambique: CHWs receive phones with which they can send their weekly reports, receive immediate automated feedback on performance and access a closed user group with their supervisors in order to increase communication and support	1. Integrated Community Case Management: Findings from Senegal, The Democratic Republic of the Congo and Malawi. A Synthesis Report. September 2013, MCHIP. 2. Ghana: Improving Motivation and Job Satisfaction Among Frontline Community Health Workers. Concern Worldwide.
Connectedness to Communities	1. Community Health Worker Code of Ethics. Scott J., Dunning, L. Harrison Institute of Public Law at the Georgetown University Law Center, American Association of Community Health, 2008	1. Building Community Capacity in Malaria Control. Case study. PMI, MCHIP. November, 2013.

	2. Strengthening Health Worker-Community Interactions through Health Literacy and Participatory Approaches 3. inSCALE Uganda uses a community engagement process called Village Health Clubs with CHWs at the center to facilitate communities and CHWs in solving child health problems	
Connectedness to Supervisors and Peers	1. Situation Behavior Impact demonstrative video 2. PSI IPC Toolkit – Supervision and Feedback Chapter	1. Initial Experiences and innovations in supervising community health workers for maternal, newborn and child health in the Morogoro region in Tanzania. T. Roberton et al. Human Resources for Health. 2015 13:19 2. Taking Knowledge for Health the Extra Mile: Participatory Evaluation of a Mobile Phone Intervention for Community Health Workers in Malawi. Global Health Science and Practice 2014: Volume 2, Number 1.

INCENTIVES AND PERSONAL REWARDS

SBCC interventions can advocate for and use both financial and non-financial incentives to motivate CHWs. It is important to keep in mind that financial incentives alone are rarely sufficient. CHWs in Nepal, for example, are motivated to serve their communities due to the influence of religious customs that promote the importance of altruism and volunteering for community good, and not as much by financial compensation. Financial rewards also come with a number of issues, including:

- → How do you ensure sustainability?
- → How do you manage inequity of distribution?
- → How do you prevent the appearance of preferential treatment?

For this reason, it is important to identify other ways to incentivize CHWs. Many programs use a combination of financial and non-financial incentives. The AIN-C Program in Honduras, for example, regularly provides non-financial incentives to their "monitoras" including publicly recognizing families who support the volunteers, letters of appreciation from government officials and community leaders and, community parties and events – all of which are seen as incentives.

Before designing any type of incentive structure, including one that offers non-material incentives, it is important to ensure the incentives offered match the needs of the selected CHWs and the environment and context in which they work. The situation analysis and audience analysis in the SBCC process are key steps to understanding these needs.

The table below summarizes the types of financial and non-financial incentives widely used in CHW programs. Many of the non-financial incentives can be addressed by SBCC techniques. Some have been mentioned earlier – support supervision, community recognition programs, branded giveaways and tokens of appreciation.

Direct Incentives	
Financial Incentives	**Non-Financial Incentives**
Terms and conditions of employment: salalry/stipend, pension, insurance, allowances and leave *Performance payments:*performance-linked bonuses or incentives. *Other financial support:*reimbursement of costs (travel, airtime), fellowships, loans and ad hoc	*Job satisfaction/work environment*: autonomy, role clarity, supportive/facilitative supervision and manageable workload *Preferential access to services:* health care, housing and education *Professional development:* continued training, effective supervision, study leave, career path that enables promotion and moving into new roles *Formal recognition*: by colleagues, health system, community and wider society *Informal recognition*: T-shirts, name tags, bicycles and access to supplies/equipment, etc.

Indirect Incentives	
Health System	**Community Level**
Well-functioning health systems: effective management, consistent M&E, prompt monthly payments, safe environment, adequate supplies and working equipment	Community involvement in CHW selection and training
Sustainable health systems: sustainable financing, job security	Community organizations that support CHWs
Responsive health systems: trust, transparency, fairness and consistency	CHWs witnessing visible improvements in health of community members

Complementary/Demand-Side Incentives	
Health System	**Community Level**
Health care workers witnessing and grateful for visible improvements in health of community members	Community members witnessing and grateful for visible improvements in health of its members
Policies and legislation that support CHWs	Successful referral to health facilities
Funding for CHW activities from state or communities	CHW associations

Motivation Resource Table: Incentives and Personal Rewards

	Toolkits/Guidance Resources	Select Literature
Personal Needs Rewards	1. Standards-Based Management and Recognition: A Field Guide.	1. Searching for Common Ground on incentive packages for community

	2. Guidelines: Incentives for Health Professionals. International Council of Nurses, International Pharmaceutical Federation, World Dental Federation, World Medical Association, International Hospital Federation, World Confederation for Physical Therapy, 2008 3. Developing and Strengthening Community Health Worker Programs at Scale: A reference guide for Program Managers and Policy Makers. Chapter 10 What Motivates Community Health Workers? Designing Programs that incentivize Community Health Worker Performance and Retention Incentives. MCHIP. 2013	workers and volunteers in Zambia: A review of Issues and recommendations. Dr. Kanyanta Sunkuntu. July 2009 2. Non-Financial Incentives for Voluntary Community Health Workers: A Qualitative Study. L10K Working Paper No. 1, 2009.

The table below summarizes some key questions programmers may consider before determining whether to employ indirect incentives as part of a CHW motivation.

QUESTIONS TO CONSIDER REGARDING INDIRECT AND COMPLEMENTARY INCENTIVES

Clear roles, responsibilities and feedback	▪ Do CHWs have clear job descriptions and distinct roles? ▪ Are the other health care workers aware of these roles? Are there areas of ambiguity or overlap? ▪ Do CHWs have the chance to get and give feedback from other staff and managers on a regular basis?
Personal growth and professional development	▪ What elements of the CHW role promote personal growth (e.g., social, emotional, psychological, intellectual skills and development)? ▪ How can these elements be strengthened in the program? ▪ What elements of the CHW role promote basic professional development (e.g., computer, administrative, financial or logistical skills)? How can these elements be strengthened in the program?
Day-to-day working relationships	▪ Do CHWS ever get the chance to work with each in their daily work? ▪ Are there CHW associations or networks?

	▪ How do CHWs and healthcare professionals relate to each other? How does the work environment affect these relationships? ▪ How are conflicts between CHWs and other health care workers addressed?
Accountability in the health system and community	▪ Are there multiple or confusing lines of accountability for CHWs (e.g., do they report to both the health system and the community or civil society managers)? ▪ How are conflicts or issues of poor performance among CHWs handled and by whom? ▪ How can overlapping or confusing lines of accountability be clarified or reconciled?
CHW "champions"	▪ Are there "champions" behind the CHW programs in your context, whether from the community, the health system or civil society? ▪ How do they contribute to the program and what risks does their participation involve? ▪ Is the policy environment flexible enough to allow champions to emerge and contribute to CHW programs in a positive way?
Role of civil society partners	▪ What is the character of civil society (e.g., NGOs, community-based organizations, faith-based organizations and other forms of community organization) and how does civil society engage with CHWs? ▪ Who runs these organizations and do they represent broader community interests and perspectives? ▪ How does the relationship between civil society and the health system afect CHW motivation? To what extent does the CHW program's success rely on civil society?
Community's relationship to the health system and government	▪ What is the historical relationship between the local community and the health system/government? ▪ If one of antagonism and mistrust, how does this impair CHW motivation? ▪ If one of solidarity and confidence, how does this promote CHW motivation?

The **Incentives and Personal Rewards Motivation Resource Table** above presents a list of programs, toolkits and guides of recent programs that have incorporated incentives (direct or indirect) into their CHW programs.

SOCIAL AND GENDER NORMS

Before employing an SBCC approach to improving provider motivation and performance, it is important to understand what are the most important prevailing social and gender norms and the underlying reasons why they exist. Some of this information may come out in the Situation Analysis, but you will likely need to conduct additional formative research to understand local

norms. This can be done through key informant interviews, focus group discussions or interactive research techniques.

Once you understand what social and gender norms need to be addressed, you can design focused interventions. Normative change typically requires dialogue – between partners, families and communities. People often need to confront their values and openly discuss the impact of those values on their community. Social change also requires early adopters that others who are considering change can look to. SBCC effectively uses modeling to convey the sense that a certain behavior is widely acceptable, and to show others how that behavior can be done.

SBCC programs have successfully employed community dialogue, TV/radio listeners' groups, community mobilization, mass media, peer-to-peer and other approaches to stimulate normative change.

In designing programs for CHWs that will target gender-related norms, consult the **Gender Equality Continuum** as a means of evaluating whether your program contributes to gender equity.

The **Social and Gender Norms Motivation Resource Table** (below) presents a list of programs, toolkits and guides of recent programs that have addressed social and gender norms (direct or indirect) as part of their CHW performance improvement efforts.

Motivation Resource Table: Social and Gender Norms

	Toolkits/Guidance Resources
Social and Gender Norms	1. Engaging Men at the Community Level. ACQUIRE Project/Engender Health and Promundo, 2008 2. E- Course – Foundations of Gender Equality in the Health workforce. HRH Global Resource Center. 3. Addressing the Role of Gender in the Demand for RMNCH Commodities: A Programming Guide. July 2014

PERSONAL ATTITUDES AND BELIEFS

Changing attitudes, beliefs and values is central to SBCC efforts. SBCC can be used to influence how CHWs view their clients, the health topic or behavior, and the products and services they offer.

There are many SBCC interventions that can influence CHWs' attitudes and beliefs. Included here are a few examples. One example involves using a positive deviance approach to identify CHWs with supportive attitudes and beliefs, then creating peer discussion or working groups to normalize those attitudes. Another approach involves using mass media to spark thinking on a

topic, then allowing space (either formal or informal) for reflection. Values assessments can also help CHWs confront what they believe and how they act. Some CHWs are swayed by emotional or rational appeals where they are shown how their attitudes and actions impact the lives of their clients.

Defining quality services alongside community members can also help shift CHW perceptions. The Puentes project in Peru brought communities and health workers together to create participatory videos that identified barriers to utilization of services. Together, they defined what quality services looked like and came up with an action plan for improvements. Health workers saw issues in a new way and were able to shift attitudes about the services they offered and the community they served.

The **table** below contains examples of programs and guidance for addressing personal attitudes and beliefs.

Motivation Resource Table: Personal Attitudes and Beliefs

	Toolkits/Guidance Resources	Select Literature
Personal Attitudes and Beliefs	1. The Woman Friendly Hospital Initiative in Bangladesh setting: standards for the care of women subject to violence. 2. Health Workers for Change 3. Using a mHealth tutorial application to change knowledge and attitude of frontline health workers to Ebola virus disease in Nigeria: a before-and-after study	1. Evaluating the effectiveness of patient education and empowerment to improve patient-provider interactions in antiretroviral therapy clinics in Namibia. 2. Impacts of a Peer-Group Intervention on HIV-Related Knowledge, Attitudes, and Personal Behaviors for Urban Hospital Workers in Malawi 3. Evaluation of a Health Setting-Based Stigma Intervention in Five African Countries 4. The impact of an intervention to change health workers' HIV/AIDS attitudes and knowledge in Nigeria: a controlled trial. 5. Attitudes, Skills and Knowledge Change in Child and Adolescent Mental Health Workers Following

		AOD Screening and Brief Intervention Training

Reflect on the examples and resources you have seen in this section. In the Step 7 section of the **SBCC Strategy Template (Appendix JJ)**, write down ways you might adapt or use some of the ideas presented here in your own intervention.

Step 8: Develop an Implementation Plan

At this point, you have completed a situation analysis, identified your intended audience, developed communication objectives framed around the key barriers to CHW motivation, and identified the tools and resources you will either develop or adapt for your intervention. The next step is to determine how, by when and by whom your SBCC intervention will be implemented.

The steps to developing an implementation plan for SBCC that addresses CHWs performance are identical to other types of SBCC interventions and follow these fundamental steps:

1 Determine Partner Roles and Responsibilities

Ask the following key questions:

- → What competencies are needed to implement the strategy?
- → What potential partners have these competencies?
- → How will coordination for implementation be handled?
- → Who will serve as the lead implementer of the communication strategy?
- → Are there any capacity strengthening needs?

2 Outline Activities

Answer the following questions and assign responsibility:

- → What are the activities that need to be implemented?
- → What are the intermediate steps for each activity?
- → What is the necessary sequence?

3 Establish a Timeline

This plan outlines the time schedule for development, implementation and evaluation of activities. It is flexible and should be reviewed periodically.

4 Determine a Budget

This task determines how much funding is needed to implement the communication strategy.

C-Change developed a budget tool (see pg. 14) to guide the outline of the major budgeting categories for SBCC.

5 Finalize Implementation Plan

This activity summarizes how the SBCC strategy will be implemented answering the *who?, what?, when? and how much?* C-Change developed an implementation plan template (see pg. 3) you can use as a guide.

Record partner roles, activities, timeline and budget in the Step 8 section of the **SBCC Strategy Template. (Appendix JJ)**

Resources

- Designing a Social and Behavior Change Communication Strategy Implementation Kit
- C-Change C-Module 4 – Implementation and Monitoring

Step 9: Monitor and Evaluate

All SBCC programs, including those that focus on CHWs, must include a monitoring and evaluation (M&E) component. While M&E is introduced in Step 9 of this I-kit, it is important to remember that throughout the SBCC design process, you made key decisions that are a key part of M&E. Specifically:

- → **Step 1: Situation Analysis/Performance Needs Assessment** – You identified what were the key behavioral problems that needed to be addressed and subsequently measured in your evaluation.
- → **Step 2: Identify the Core Problem** – You identified the core problem that needed to be addressed.
- → **Step 3: Define Key Audience Segments** – You identified which cadre of CHWs you would focus on in order to change behavior.
- → **Step 4: Develop Communication Objectives** – You determined which specific motivational factors you would address and developed SMART objectives to measure them.
- → **Step 5: Determine the Key Promise and Support Points** – You developed a promise telling your audience what they would receive by changing their behavior and supported this with evidence.
- → **Step 6: Define and Prioritize Communication Approach** – You determined the communication channels you would use throughout implementation, and those you would subsequently track throughout implementation.
- → **Step 7: Match Communication Approach to Identified Barrier** – You matched the communication channels to your SMART objectives.
- → **Step 8: Develop Implementation Plan** – You developed the overall implementation plan to inform both your monitoring and evaluation activities.

Your M&E efforts help you to compare the effects of your SBCC intervention with your program objectives and identify factors that helped or limited the program's success. Motivation cannot be observed or measured directly and as a result, monitoring and evaluation must measure the key factors of motivation. For CHWs these are defined as: *connectedness, social status, social and gender norms, incentives and personal rewards, and personal attitudes and beliefs*.

Developing a monitoring and evaluation plan to measure your program's success is important. However, before developing a Monitoring and Evaluation plan for SBCC, it is important to understand the difference between Monitoring and Evaluation and the indicators they measure.

MONITORING

Monitoring tracks and measures program activities. It helps you quantify **what** has been done, **when** it has been done, **how** it has been done and **who** has been reached. Monitoring also

help you identify any problems so that adjustments can be made. The indicators tracked by monitoring are called Process Indicators.

Process Indicators

Process indicators measure the extent to which SBCC activities were implemented as planned. Examples include: the number of community events conducted, the number of SMS messages sent to CHWs, the number of leaders met and the number of support supervision visits conducted.

C-Change created guidelines on how to develop an **SBCC monitoring plan** (see pg. 24).

Examples of performance monitoring and routine support supervision tools:

- → **Situation Behavior Impact (SBI)** – An interactive performance monitoring and coaching technique that can be used by CHW supervisors to monitor CHW job performance.
- → **PSI's IPC Toolkit** – Guidelines and resources to monitor IPC activities including routine monitoring for providers and CHWs.
- → **PSI's Provider Behavior Change Toolkit on Coaching and Feedback** – Tools to provide structured routine support supervision and feedback to health workers.

EVALUATION

Evaluation is data collected at discrete points in time to systematically investigate whether an SBCC program has brought about the desired change in an intended population or community. Evaluation enables the SBCC program to determine whether the communication strategy and activities were effective.

Evaluation requires a comparison of variables and the measurement of changes in them over time. It measures what has happened among the intended audiences as a result of program activities and allows SBCC practitioners to answer questions like:

- Were the barriers to improved CHW motivation reduced by our efforts?
- Did these changes improve our program success?

Evaluation indicators for SBCC typically include *Output, Outcome* and sometimes *Impact* Indicators.

Output Indicators

These indicators will measure:

1. Changes in the key factors of CHWs motivation as defined by: connectedness, social status and support, perception in changes of social and gender norms and perceived changes in personal needs being met.
2. The extent to which these changes correlate with exposure to SBCC activities.

Example: The proportion of CHWs who now feel an improved sense of connectedness to the community or health system as a result of community mobilization activities to promote the importance of CHWs' work.

Outcome Indicators

Outcome indicators measure:

1. Changes in audiences' behavior.
2. The extent to which these changes correlate with program exposure.

Example: The proportion of CHWs who participated in training, support supervision and coaching who now provide quality family planning counseling to young people ages 15-24.

Impact Indicators

Impact indicators measure changes in health outcomes.

Examples: The number of youth accessing modern contraceptives in the CHW's village; Percent decrease in malaria cases among children under 5; Percent decrease in HIV incidence

While effective SBCC programs have the potential to contribute to health impact it may not be possible to attribute this impact entirely to SBCC. As a result, while impact indicators are defined above, most SBCC programs – including those that target CHWs – track process, output and outcome indicators.

To increase the utility of M&E data, indicators should be disaggregated to facilitate more in-depth analysis of program performance. It is recommended that indicators are also disaggregated by gender, experience level, geographic location and type of provider, etc.

Because the SBCC component of your program may be part of a larger health systems strengthening or CHW performance improvement plan, if M&E plans already exist, add appropriate outcome or impact indicators and provide input into the existing M&E plan.

C-Change has more guidelines on developing an **SBCC Evaluation Plan and indicators**.

Record your M&E indicators in the Step 9 section of the **SBCC Strategy Template.(Appendix JJ)**

Resources

- Situation Behavior Impact
- IYCF Support Supervision tools
- Coaching (PSI PBC)
- Developing and Strengthening Community Health Worker Programs at Scale

- Community Health Worker Assessment and Improvement Matrix (CHW AIM): A Toolkit for Improving CHW Programs and Services
- How to Develop Monitoring Indicators
- How to Develop Monitoring and Evaluation Plan

Designing an SBCC Intervention for FBP Behavior Change

Now that you have learned about provider behavior change, assessed barriers to quality FBP service provision, and determined that SBCC has a role to play in addressing those barriers, you are ready to design an SBCC intervention for FBP behavior change.

This section of the I-Kit will help you design an SBCC intervention to change FBP behavior by addressing the Motivational barriers you identified: Self-Efficacy, Social and Gender Norms, Perceived Place in Social Hierarchy/Status, Rewards, and Work Environment.

Follow the step-by-step guidance to develop an SBCC intervention for CHW behavior change:

Steps

Step 1: Analyze the Situation

Step 2: Identify the Core Problem

Step 3: Define Your Audience

Step 4: Develop Communication Objectives

Step 5: Determine the Key Promise and Support Points

Step 6: Define Your Strategic Approach

Step 7: Match Communication Approach to Identified Motivation Barrier

Step 8: Develop an Implementation Plan

Step 9: Monitor and Evaluate

Step 1: Analyze the Situation

A **situation analysis** is the first step in the social and behavior change communication change (SBCC) process including one that focuses on FBPs. The situation analysis answers questions about existing opportunities, resources, challenges and barriers related to improved FBP behavior.

You can conduct this step using one of the following two options:

Conduct FBP Assessment

Follow the steps in the **Provider Performance Assessment** tool (preferred).

Gather Secondary Data

Gather the information you need for the Situation Analysis through secondary data.

Whichever method you use, make sure you answer these fundamental questions:

- → What is the performance problem, the level of severity and its causes frame around Expectation, Ability, Opportunity and Motivation?
- → Who are the groups of people affected by the problem (what types of providers, what motivations do they possess, where do they live and work, what are the psychographic details, etc.)?
- → What is the broad context in which the problem exists?
- → What are the factors inhibiting or facilitating behavior change among FBPs?
- → What other interventions are in place or planned to address FBP behaviors?
- → What are FBPs' preferred sources of information and communication channels?

The following summarizes the key activities for the situation analysis:

1 Conduct a Review of Program Data

This includes service records, quarterly reports, policy documents and informal interview. Then develop a focused problem statement. This statement will help to ensure the intervention focuses on one specific behavioral issue at once. Example: "Facility-based providers do not treat clients with respect and kindness."

2 Draft a Shared Vision

A shared vision provides a picture of what the situation will look like when the SBCC effort is completely successful. Example: "In 2025, every employee at the health center treats clients with respect and kindness, regardless of the clients' background, behaviors, appearance, or current situation. Health center employees treat each client like they would a family member." Guidelines on what to consider when drafting this vision.

3 Gather Information and Summarize Findings

If you chose to conduct the FBP Performance Assessment, follow the steps to gather the information and summarize your findings. If you chose to conduct a literature review, follow the steps in this how-to guide for conducting a Situation Analysis using secondary data to answer the key questions about FBPs and their work environment.

Examples of secondary data you might consider to gather this information include:

- FBP monitoring or support supervision reports
- Service delivery statistics
- Program reports
- Key informant interviews
- Government, partner and donor activity evaluation reports
- Government policy documents regulating FBPs and primary health services

Whether you use the FBP Performance Assessment or a Literature Review to conduct the assessment, the findings of your situation analysis should be framed around the four categories of FBP performance:

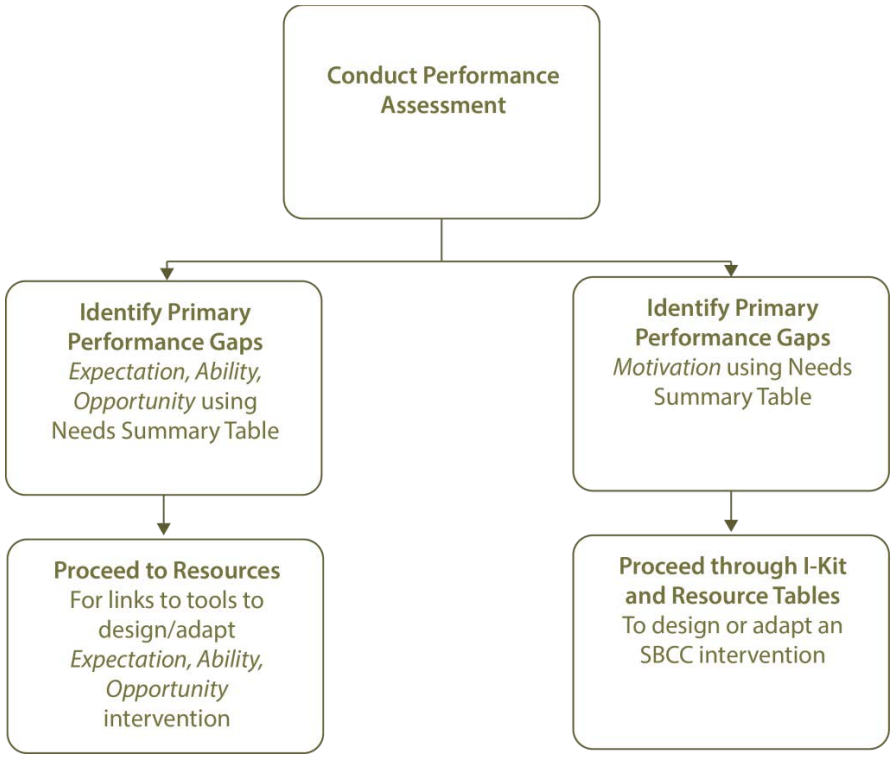
- **Expectation** – Do FBPs have the environment and necessary resources available to support performance?
- **Opportunity** – Do FBPs understand the performance expected and the definition of quality?
- **Ability** – Do FBPs have the skills and knowledge necessary to do the tasks in his/her scope of work and feel competent in doing so?
- **Motivation** – Is there sufficient reward and lack of negative consequences to make FBPs want to do his/her job?

Use this Needs Summary Table (Appendix FF) from the FBP Performance Assessment to summarize the findings. Then prioritize those needs using the Prioritization Matrix and Action Tracker (Appendix HH).

If you prioritized ***Expectation***, ***Opportunity*** or ***Ability*** barriers, proceed to Other Resources **(Appendix OO)** for tools, resources and programmatic examples to improve Expectation, Opportunity and Ability performance gaps.

If you prioritized *Motivation* barriers, identify which motivational barriers are relevant to your FBPs and then proceed through the I-Kit to design your intervention.

The graphic below describes how to navigate the results of the Assessment or literature review to use this I-Kit.



4 Review the Data

Review the data you collected through the FBP Performance Assessment or Literature Review. Study the five categories of factors impacting FBP motivation in the Learn section. Determine which motivational factors are most relevant to the FBPs you are working with.

SITUATION ANALYSIS OUTPUTS

At the end of the situation analysis, you should have:

- → Problem Statement
- → Shared Vision Statement
- → Analysis Findings

Record these outputs in the Step 1 section of the **SBCC Strategy Template. (Appendix JJ)**

Resources

- **Designing a Social and Behavior Change Communication Strategy** Implementation Kit
- **How to Conduct a Situation Analysis**
- **Understanding the Situation: A Practitioners Handbook**

Step 2: Identify the Core Problem

For an SBCC intervention to be effective, it must address the core, underlying problem – not simply the outward effects of the problem. A **root cause analysis** will help you understand why there is a difference between where you want to go (shared vision) and what is happening now (current situation). Once you understand what is truly causing the problem, you can design a strategy to address that core problem.

FBP behavior results from a complex interaction of cultural, political, health systems, personal and managerial factors. You have already identified factors that influence your FBPs' behavior. In this root cause analysis, you can explore how those factors interact and what is truly driving the problem. It is important to consider:

- → Larger social norms that impact FBPs' values, attitudes and practices
- → Status indicators that influence how a FBP interacts with clients
- → Policies and regulations that determine what a FBP can and cannot do
- → The value the local community and health system places on FBPs

The following are the key steps to identifying the core problem:

1 Write down the problem you are addressing in the Root Cause Template (Appendix KK). For example, FBPs will not provide contraceptives to youth, or nurses are yelling at laboring mothers.

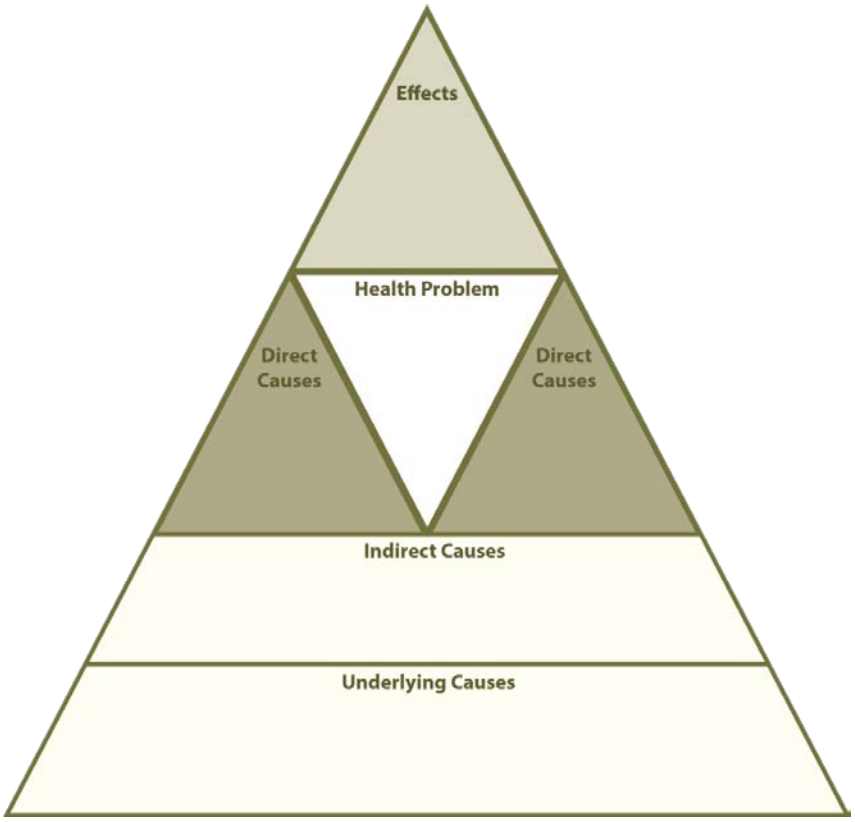
2 Start by identifying the direct causes of the problem (those things that cause or contribute to the problem). By identifying the direct causes you will begin to understand "why" we have this health problem. For example, if the problem is that FBPs are not providing contraceptives to youth, ask, "Why aren't FBPs providing contraceptives to youth?" Write your responses on either side of the problem in the template.

3 After you determine the direct causes, brainstorm the indirect causes by asking "why do we have these direct causes?" Record the answers in the "indirect causes" of the activity template.

4 Root or underlying causes are seldom found in the most obvious causes. It is important to dig deeper and continue to ask "why?" until nearly all responses have been exhausted or roots that seem important to address are reached. If there are underlying causes that impact the health problem, you may need to address those before you can address the direct causes. For example, consider power dynamics in the community and health system, perceptions of FBPs, gender norms that govern interactions or cultural taboos. List those underlying causes in the space provided.

5	Once you have identified the underlying causes, determine the effects of the problem. These may include issues such as high rates of mother and child mortality, loss of manpower hours or other effects. List these at the top of the chart.
6	Take a look at the underlying causes you have identified and ensure they can be addressed through SBCC efforts. If you have more than one underlying cause that can be addressed through SBCC, decide which to address first by ranking them in order of importance.

Root Cause Analysis Pyramid Template (Appendix KK)



Record your prioritized core problem in the Step 2 section of the **SBCC Strategy Template. (Appendix JJ)**

Step 3: Define Your Audience

Before designing any SBCC intervention, it is important to analyze the intended audience to gain a better understanding of who they are, including their current behaviors, and to decide which sub-segment or "primary audience" you will address.

This same process is used when designing an intervention to improve FBP behavior. FBPs are similar to other audiences identified for SBCC in that they have their own set of needs, desires, biases and attitudes that need to be understood in order to identify SBCC solutions. The Audience Analysis is an important step to understand FBPs as an audience.

The following are the key steps to audience analysis:

1 Review Audience Information

Review what you collected in the situation analysis (either through the Performance Needs Assessment or the Literature Review) to understand:

- → Current levels of performance
- → Key barriers to quality service provision by category (Expectation, Ability, Opportunity and Motivation)
- → Total number of providers, geographic location and services provided
- → Socio-demographic characteristics like age, years of experience, education level and religion
- → Beliefs, attitudes, knowledge levels and current behaviors
- → Psychographic data like FBPs' needs, aspirations, hopes, fears and habits
- → Other information as appropriate

Additional audience research may need to be gathered. See the ***Audience Analysis*** *and* ***Formative Research*** *how-to guides for more guidance.*

2 Decide Whether to Segment

Audience segmentation is the process of dividing the larger FBP audience into smaller groups or "segments" of similar individuals. Segmentation is important because different people respond differently to SBCC messages and interventions. It helps program teams better channel resources and narrow focus on a "primary audience." For programs working with providers, segmentation also helps better target monitoring, coaching and routine support supervision activities. If after the review of audience information it is determined that smaller groups with similar behaviors, needs, values and/or characteristics (segments) exist within the larger audience, it is best to segment.

One Method to Segment Providers – Population Services International

Population Services International (PSI) uses one method, adapted from the commercial pharmaceutical sector, to determine whether it is necessary to segment health providers before introducing a performance improvement approach. The approach uses two primary criteria: 1) Is there potential for health impact (i.e., are the providers working in a region or with clients who have a need for health improvement) and 2) Are the providers currently providing services or performing the desired behavior. Using these criteria, the segments are categorized in a Provider Segmentation Matrix:

BEHAVIORS	
High Potential/Low Behavior These providers are working in high density communities highly populated by members of their intended audience (i.e., women of reproductive age or children under 5), but who see very few clients or are not consistently performing the desired behavior.	**High Potential/High Behavior** These providers work in high-density communities and see high numbers of clients and are already providing good quality services. They are designated as "stars."
Low Potential/High Behavior These providers have a low client load, perhaps because they are not located in an area where people demand services from FBPs or there is low population density, but they are providing high quality services to the small number of clients they see.	**Low Potential/Low Behavior** These providers have a very low client load and for whatever reason are not offering services or performing the desired behavior.

Using this method, PSI determines whether there are distinct segments among the providers and which groups should be prioritized. Prioritized segments are providers who demonstrate both potential to improve health impact – in areas where there is demand for health services that is not already met – and who are not currently performing the desired behavior. This often results in prioritizing providers in the A and B quadrants.

3 Determine Segmentation Criteria

If segmentation is required, look at the audience and identify traits that make one sub group different from another. A significant difference is one that requires a different message or approach. These distinctions can be categorized by socio-demographic, geographic, behavioral and psychographic. See the table below for unique criteria for FBPs.

Socio-Demographic	Geographic	Behavioral	Psychographic
▪ Age ▪ Gender ▪ Ethnicity/language ▪ Level of education and/or clinical training ▪ Job satisfaction ▪ Perceived level of autonomy ▪ Years of service	▪ Urban ▪ Rural ▪ Peri urban	▪ Current behavior (high performer/low performer) ▪ Barriers to behavior – Expectation, Ability, Opportunity, Motivation	▪ Benefits sought through work/Reasons for being a provider ▪ Attitudes/opinions about clients ▪ Feelings about opportunities for career development

4 Segment the Audience

Segment your audience using criteria identified in Step Three. Consider using a segmentation table, such as the one below:

Segmentation Table Template (Appendix LL)

Potential Audiences	Potential Primary Audiences	Potential Influencing Audiences
Demographic Characteristics Age, gender, years of training and years as a provider		
Geographic Characteristics Region, urban or rural, and area of conflict		
Socio-Cultural Characteristics Language, culture, place in society, religion, ethnicity and status in health facility		
Behavioral Characteristics Behaviors that affect or impact the challenge		
Psychographic Characteristics		

Potential Audiences	Potential Primary Audiences	Potential Influencing Audiences
Personality, values, attitudes, interests, lifestyle and reasons for wanting to be a provider		
Ideational Characteristics May include knowledge, beliefs and attitudes about provider work, expectations and attitudes about clients served, perceived risk, self-efficacy, social support and influence, environmental supports and constraints, emotions, norms and self-image		

5 Assess Proposed Audience Segments

Once segments have been selected, ensure they are valid and usable. Use a checklist to ensure each segment meets the criteria for effective segmentation. If a defined segment does not meet the criteria, it is best to drop it and consider other segments.

Consider using this segmentation analysis checklist to assess audience segments.

Homogeneous	Yes	**What it Means:** The members of the audience segment are similar in a relevant way.	**Why It is Important:** This is the basis of audience segmentation – that the members of each segment are similar in terms of needs, values and/or characteristics.
Heterogeneous	Yes	**What it Means:** Each segment is relatively unique, as compared to the other segments that have been identified.	**Why It is Important:** This demonstrates that the broader audience has been effectively divided into sets of differing communication needs.
Measurable	Yes	**What it Means:** Data from the situation analysis or other research should indicate the size of the audience segment.	**Why It is Important:** Measurements allow programs to evaluate whether to focus on a particular element.

Substantial	Yes	**What it Means:** The audience segment is large enough, in terms of potential impact on public health, to warrant the program's attention.	**Why It is Important:** Programs should have a minimum expectation for the impact of their investment. Therefore, programs should only consider segments that are big enough or important enough to impact public health.
Accessible	Yes	**What it Means:** The audience segment is reachable, particularly in terms of communication and access to products or services needed to address the problem.	**Why It is Important:** Each segment needs to be able to be reached and communicated with efficiently.
Actionable/Practical	Yes	**What it Means:** The program is able to implement a distinctive set of messages and interventions for each audience segment.	**Why It is Important:** The program must have the resources and ability to address the segments identified.
Responsive	Yes	**What it Means:** Each audience segment can be expected to respond better to a distinct mix of messages and interventions, rather than a generic offering.	**Why It is Important:** If the segment will not be more responsive to a distinct approach, then the segment can probably be combined with another similar segment.

6 Prioritize Audience Segments

Deciding which segments to prioritize and how to approach them is critical. If the program team identified more audience segments than it can or needs to reach, narrow the list and finalize which segments the program will focus on. Ultimately, the decision about which segments to prioritize is based heavily on available resources and program goals. Some questions to consider when prioritizing audience segments are:

- How much does this segment impact the overall program objectives?
- How easy are they to reach?
- Do they have significantly different views about their work than their peers?
- How ready are they for behavior change?

- What stage in the behavior change process are they currently?

More details on **How to Do Audience Segmentation.**

7 Create FBP Audience Profiles

An audience profile may enable you to obtain a personal sense of the people to be reached through your SBCC efforts. Focus first on the primary audience and think about what you know about them. Then draw an outline of a person who is a typical member of this audience and write a brief description of a single person as a composite of the group.

This profile could describe the FBP's geographic location, gender, age, cadre, years/level of training, concerns, current behaviors, years of service, where she gets information, what motivates her to be a FBP, current performance, beliefs, values or family situation.

Include findings from the performance assessment such as: the identified barriers and facilitators to improved performance considering the performance factors (Expectation, Opportunity, Ability and Motivation) and anything you know about specific motivational factors to perform well.

You might write "a day in the life" of the provider as a way to capture what is most important to the individual and to better understand their day-to-day experience as a FBP. This profile should be based on data including that gathered during the situation analysis and the performance gap assessment.

Remember: Audience profiles are needed for each prioritized audience segment.

NOTE: If you have determined that FBP motivation is heavily influenced at other levels (health system, community, organization, family and peers), identify which individual(s) are the most critical secondary (influencing) audience(s) and develop a profile for them as well.

Record your selected audiences, audience segments, and audience profiles in the Step 3 section of the **SBCC Strategy Template. (Appendix JJ)**

Sample FBP Profile

Name: Chime

Location: A clinic in a semi-urban environment serving a population of 9,000.

Type: Head Nurse at a Level 2 Primary Health Care clinic. She climbed the ranks at the health center quickly and has been in her current position for years. In total, she has been a nurse for 18 years.

Incentives: She mostly sees the same cases every day and no longer feels inspired by her work. She is frustrated with the clients who never listen to her advice and who keep engaging in unhealthy behaviors.

Education: She completed a college degree in the capital city.

Family Life: She is 42 and has children.

Services Provided: She feels the clinic provides good care under the circumstances but she prefers to take her own children to a private provider.

Why She Is a FBP: She became a nurse because her little brother died of pneumonia without any access to health care.

Resources

- **Designing a Social and Behavior Change Communication Strategy**
- **PSI Coaching Toolkit**
- **How to Conduct an Audience Analysis**
- **How to Do Audience Segmentation**

Step 4: Develop Communication Objectives

Setting good communication objectives is important to keeping your SBCC efforts focused and on track. By linking your objectives to indicators, you can also track progress and demonstrate impact.

Good communication objectives should be:

S Specific

Does the objective say who or what is the focus of the effort? Does this objective say what type of change is intended? Does the objective cover only one challenge?

M Measurable

Can your objective be measured in some way? Does the objective include a verifiable amount or proportion of change expected?

A Appropriate

Is the objective sensitive to audience needs and preferences? Is the objective sensitive to societal norms and expectations?

R Realistic

Can you realistically achieve the objective with the time and resources available? Is the degree of expected change reasonable given these conditions?

T Time-bound

Does the objective state the time period for achieving change?

Good communication objectives focus on addressing the core problem you identified in Step 2.

The communication objectives should answer the following three questions:

- → What is the desired change in behavior, social norms or policies?
- → How much change can be expected of the audience? How will this change affect the FBP, the community, the health system and society?
- → What is the timeframe required for the change? By when do we want these changes?

You will answer these questions by completing the following activities:

1 What Is the Desired Change?

Each of the primary and influencing audiences will require its own set of communication objectives. Refer to your audience profiles and situation analysis to answer the following questions:

- What type of behavioral change do you want each of your audiences to make?
- What type of impact do you want this to have? For example, a change in social norms, a change in policy or change in number of clients seen.
- Are the desired changes **specific** and **appropriate**?

Next

Indicate the intended audience segment – whose behavior do you intend to change through the SBCC intervention (e.g., head nurses with 10+ years of experience, or urban doctors working in HIV clinics)? Record this in the table below under Audience Segment.

Then fill in the "Desired Change" column for each of your audience segments in the Final Communication Objectives table.

Final Communication Objectives Table (Appendix MM)

2 How Much Change Can Be Expected?

To make a reasonable estimate on how much change can be made, consider the overall context of the problem, experiences of similar programs in the past, and the resources and timeframe available.

Context of the problem

Remember the barriers you identified that affect FBPs and any secondary audience's behavior. Your communication objectives will need to address these barriers. Referring back to your situation analysis and root cause analysis, consider the motivational barriers you identified.

- What are the barriers to change?
- What are the incentives **not** to change?
- Which of these barriers and/or incentives not to change will you address?
- Add this information to the "Barriers to Change" column in the **Final Communication Objectives table (Appendix MM)**

Prior experiences

→ Examine available research data and reports that describe prior communication programs related to the challenge to be addressed.
→ What changes were achieved?
→ Based on this information, what changes do you think are **realistic** and feasible?

Resources and timeframe available

- → Consider the resources available and what is manageable within the strategy's timeframe.
- → Can the objectives be accomplished with the available resources?
- → Are communication approaches sufficient to reach the intended audience?
- → Can services meet increased demand?

Determine the amount of change expected

- → State the existing baseline measure as well as the expected measure.
- → What is the numerical or percentage change expected?
- → Is the amount of change measurable and realistic?
- → If there is no baseline data, use secondary data and grey literature such as technical reports from government agencies or research groups, working papers, white papers or preprints.

Add the amount of change expected under the "How much change?" column in the **Final Communication Objectives table**. **(Appendix MM)**

3 What Is the Timeframe for the Desired Change?

Identify the timeframe in which change will be achieved. This will ensure your objectives are **time-bound**.

- → What is the timeframe for your objectives? They can be stated in either months or years.
- → Does the timeframe provide adequate time for change to effectively take place?
- → Is the timeframe **realistic**?

Add this information to the "Timeframe" column in the Final Communication Objectives table. **[Appendix MM]**

Motivational-based Communication Objectives (Example)

- → At the end of 5 years, 80% of population in the clinic's catchment area will feel they are treated with respect by the clinic staff.
- → At the end of 3 years, 50% of facility-based providers in the targeted area express positive attitudes toward their jobs.
- → At the end of 2 years, 33% of facility-based providers will indicate they feel appreciated by their clients and colleagues.

Record your final communication objectives in the Step 4 section of the **SBCC Strategy template**. **(Appendix JJ**)

For additional information on setting good objectives for SBCC, see **Designing an SBCC Strategy Implementation Kit**.

Resources

- Designing an SBCC Strategy I-Kit

Step 5: Determine the Key Promise and Support Points

Now that you have determined what you want your FBP audience to do (*desired behavior change)* you need to identify how the FBP will benefit from taking that action. This is the **key promise** your SBCC intervention is making to your audience.

Determine the Key Promise

Take some time to review what your primary audience cares about, hopes for, aspires to and needs. These represent benefits your FBP audience would respond to. Some examples might include: being respected, making a difference, being seen as a leader in their community, or making money. Think about what you are asking your audience to do, then imagine a FBP asking, "Why should I do this?" or "How will this help me?" Write down responses to those questions keeping in mind what kind of benefits the FBPs would care about. The promise must be true, accurate and of real benefit. The key promise is not the message the FBP will see or hear, but it is the benefit that will be conveyed in all the messages and materials you produce.

After brainstorming benefits, develop the key promise using an "if…then…" statement: "If you (do this new behavior) then you will (benefit)." For example, "If you use rapid diagnostic tests to diagnose malaria, you will be recognized for saving lives." It can be helpful to develop a few alternative options and pretest them with your audience to see which benefit resonates best with them.

Convey the key promise in all the messages, activities and materials you create.

Identify Support Points

Your audience needs believable, persuasive and truthful information to support the key promise. These can be in the form of facts, testimonials, celebrity or opinion leader endorsements, comparisons or guarantees. The kind of support points used will depend on what will appeal and be credible to your particular FBPs.

Based on the key promise you developed, identify information that supports the promise. As you develop those support points, consider who your FBPs trust or aspire to be like, where and how they prefer to get their information, and what kind of appeals will best reach them. For instance, would your FBPs trust a promise given by another provider, a government official or a family member?

Some examples of support points include:

Using rapid diagnostic tests helps reduce the risk of developing resistance to available drugs (fact)

Testimonial from a respected doctor: “I used to refuse treatment to sex workers. Now I take time to find a confidential place to treat them and listen to their concerns. It is so fulfilling to live up to my responsibility as a doctor.”

Record your key promise and support points in the Step 5 section of the **SBCC Strategy Template. (Appendix JJ)**

Step 6: Define Your Strategic Approach

At this stage, it is important to make decisions about which broad communication approach is most appropriate to achieve your communication objectives. In doing so, it is critical to consider both the needs and preferences of your intended audience and how well various approaches will work with your specific objectives and barriers and in your current context. An SBCC strategy may include more than one approach.

To determine which type of approach is the most appropriate, it is important to first answer a set of key questions:

- → **Which motivational barrier or barriers are you trying to address**? Self-Efficacy, Social and Gender Norms, Perceived Place in Social Hierarchy/Status, Rewards, and Work Environment.
- → **How complex is the barrier?** Complex barriers like social norms and attitudes are better addressed with approaches that allow for dialogue.
- → **How sensitive are the issues to be addressed?** Issues that the audience may not want to discuss publicly or that they feel may compromise their compensation, promotion opportunities or standing among peers require approaches that are more confidential and one-on-one.
- → **What is the technical comfort among the intended audience?** Group discussions, peer support groups, or mass media approaches that allow for longer explanation may be more appropriate for groups with lower technical levels to enable group or slower paced learning.
- → **What is the desired reach?** How large is the intended audience segment and how wide is the geographic location in which they work? Some approaches are limited in reach but allow for greater depth in coverage of a particular issue.
- → **What are the cost considerations?** What is known about cost per person reached and the known cost effectiveness of a particular approach? Does this fit within the available budget?
- → **What is the level of acceptability of approach for the intended audience?** The format should be appropriate for the intended audience in terms of what they are used to and comfortable using. For example, some FBPs may be resistant to support supervision, peer support and more interactive coaching styles, particularly if supervisors are younger or the intended audience is more comfortable with a hierarchical management style.
- → **What is the level of technology and innovation and is it appropriate for the intended audience?** Lower level, less educated or even older FBPs may be more resistant to new technological methods like tablets, smart phones and formats that use social media or mobile health technologies or they may not have access to these types of tools.

COMMUNICATION APPROACHES TO BE CONSIDERED

The table below does not include every possible approach, but it describes some communication approaches that have been used successfully in programs to improve FBP performance. See the SBCC Strategy I-Kit for more examples of strategic approaches.

Approach	Definition	Barriers Addressed	SBCC Examples For FBPs
Advocacy	A deliberate process, based on evidence, to directly and indirectly influence decision-makers, stakeholders and relevant audiences to support and implement actions that contribute to health and human rights.	▪ Policy ▪ Resource allocation ▪ Legal changes ▪ Status ▪ Social and gender norms ▪ Work environment	Using compelling evidence to advocate Ministry of Health leaders to enact task shifting policies that decrease burnout and improve the work environment.
Branding	Process of developing a symbol, logo and design that distinguishes one product, service or idea from the competition.	▪ Rewards ▪ Status ▪ Social norms ▪ Work environment	Developing a mark or symbol and making it visible on trained or qualified providers' lab coats, homes, or clinic signs to identify them as high-quality service providers.
Mobile Health	A tool to expand access to health information and services using mobile and wireless technologies such as mobile phones, tablets and mobile software applications.	▪ Status ▪ Rewards ▪ Ability ▪ Self-efficacy	Sharing technical videos on smart phones to help improve counseling techniques and remind providers of key technical information.
Role Modeling	Process of strategically engaging people whose behavior or success can be emulated by others to influence behavior change.	▪ Status ▪ Social and gender norms ▪ Rewards ▪ Self-efficacy	Identifying high-performing, well-liked FBPs and pairing them with less motivated providers for scheduled work-alongs.
Satisfied Client	An intervention which enlists individuals who have successfully adopted a select behavior, service or product to conduct outreach with	▪ Status ▪ Work environment	Engage couples who report having received high-quality family planning counseling and ask them to appear in clinic-based testimonial posters or local radio shows

Approach	Definition	Barriers Addressed	SBCC Examples For FBPs
	individuals who are non users/non-adopters.		to discuss the quality service they received.
Support Supervision and Coaching	A feedback approach that promotes mentorship, joint problem-solving and communication between supervisors and their staff.	▪ Work environment ▪ Rewards	A supervisor works jointly with a FBP to identify areas and methods for improvement, then checks in regularly on progress.

Identify several communication approaches you would like to use by answering the questions above. Use the following table to analyze any potential approaches you are considering. For each audience and each communication objective, write the approach and evaluate it against the selection criteria.

Key Approach	Intended Audience	Communication Objective
Criteria	**Meets this Criteria (Y/N)**	
1. Matches the identified motivational barrier.		
2. Is appropriate for the level of complexity of the barrier.		
3. Is appropriate for the level of sensitivity of the barrier.		
4. Matches audience literacy level.		
5. Meets reach requirements for audience.		
6. Is within program budget.		
7. Is an acceptable approach to the intended audience.		
8. Technology and innovation level is appropriate.		

Key Approach Table [(Appendix NN)

SELECTING COMMUNICATION CHANNELS

Once you determine your broad approach, the next step is to select specific communication channels. Channels are the specific set of communication tools you want to use. Generally, channels can be organized into four main categories: interpersonal, community based, mass media and social media. The following table defines the different channels and provides examples of how these channels may be applied in FBP programs.

Channel Types	Definition	Examples
Interpersonal: Counseling, peer to peer, client-provider and supervisor to FBP	The process by which two or more small groups of providers exchange information and ideas through face-to-face interaction.	▪ Site visits with leaders and politicians to advocate for policy change ▪ Peer learning groups ▪ Support supervision visits ▪ Coaching to improve counseling skills and empathy ▪ Provider hotlines
Community Based: Community dialogue, community drama, community radio and community events	A process that engages and motivates a wide range of partners and allies at national and local levels to raise awareness of and demand for a particular objective through dialogue.	▪ Community dialogues surrounding norms and health-seeking behavior ▪ Community-provider coalitions to define quality ▪ Community radio highlighting providers' work
Mass Media: Radio and TV; serial dramas, game shows, websites, newspaper, magazines and posters	Diversified media technologies that are intended to reach large audiences via mass communication including radio, film, and television.	▪ TV soap opera modeling effective client-provider interaction ▪ Billboards or radio spots promoting quality clinics and providers ▪ Websites that connect providers and provide helpful tips for values assessments
Social Media: Facebook, WhatsApp, SMS, blogs and podcasts	Internet services where the online content is generated by users of the services including blogging, social network sites and Wikis, etc.	▪ Facebook page for FBPs ▪ Social media user group among FBPs to share better practices, learnings and new techniques ▪ Blog for FBPs

Channel Types	Definition	Examples
		▪ Motivational videos shared on WhatsApp

Refer to the resources section below for detailed guidance on how to select the best channel.

Once the most appropriate communication approach is determined, work with a creative team to develop messages and materials.

Don't forget to ensure that these materials are pre-tested with your primary FBP audience before being finalized and produced!

Record your selected communication approach(es) and communication channels in the Step 6 section of the **SBCC Strategy Template. (Appendix JJ**)

Resources

- Setting Strategic Approaches
- PSI Coaching Toolkit
- PSI IPC Toolkit – Implementation Chapter
- How to Develop a Channel Mix Plan

Resources for Materials' Development:

- Beyond the Brochure: Alternative Approaches to Effective Health Communication
- Clear and Simple: Developing Effective Print Materials for Low Literate Readers
- Scientific and Technical Information Simply Put
- C-Modules – Module 2
- How to Develop SBCC Creative Materials
- How to Conduct a Pretest

Advocacy

- Smart Chart 3.0
- UNICEF Advocacy Toolkit
- Advocacy: Building Skills for NGO Leaders

Branding

- Branding Part 1
- Branding Part 2
- Branding Part 3

- DELTA Companion (PSI)

mHealth

- mHealth Working Group
- WHO mHealth Toolkit
- Support Supervision

Social Media

- The Health Communicators Social Media Toolkit

Step 7: Match Communication Approach to Identified Motivation Barrier

At this stage, you have identified your key barriers to FBP motivation, identified your intended audience(s), defined your objectives and the general strategic approach you plan to use.

This step pulls together resources, toolkits and guidelines that guide the development of SBCC approaches that will help address the identified barriers to FBP motivation. These can be adapted to your context and intended audience as you see fit.

The tools and resources have been organized around the five main categories of FBP motivation discussed previously:

1. Self-Efficacy
2. Status
3. Social and Gender Norms
4. Rewards
5. Work Environment

Review your findings from your situation, root cause and audience analyses to remind yourself of the motivation barriers your FBP audience faces. Consider the approaches you have chosen to address those barriers. Then, read the relevant sections below and access the resources that will help you in designing your SBCC intervention.

SELF-EFFICACY

To improve FBPs' levels of self-efficacy, SBCC interventions can design activities that address the four sources of self-efficacy:

1. **Mastery experiences**. Provide opportunities for FBPs to successfully perform a task. Since success boosts self-efficacy, allowing providers to practice in a safe environment where success is more likely can be effective.
2. **Vicarious experience**. Provide opportunities for FBPs to observe peers succeeding at a task. Having role models demonstrate success in performing a task can strengthen FBPs' beliefs in their own ability to do the task.
3. **Verbal persuasion**. Offer positive feedback and encouragement to FBPs for work done well. This can help FBPs confirm that they are performing well and that they are able to do what is expected.
4. **Emotional state**. Create a positive work environment where stress and anxiety are reduced and positive feelings are heightened. Positive emotional stimulation can boost FBP performance.

Supervisors and facility management play a key role in providing relevant experiences, giving feedback, and influencing the FBPs' environment. SBCC interventions seeking to impact self-

efficacy may find it useful to place supervisors or management as the audience for the SBCC efforts. SBCC could be used to encourage management to implement any of the following activities or approaches:

- → Deliberately create situations where FBPs can safely practice new skills or behavior change. These situations should be of moderate difficulty so that FBPs are challenged but still have good chances of success.
- → Create behavior change strategies jointly with individual FBPs. These strategies should set specific, short-term goals that are reachable. FBPs can verbalize their plans and provide regular progress updates to supervisors.
- → Learn about what interests individual FBPs and provide opportunities for them to pursue those interests.
- → Create peer learning groups or provide opportunities for observing peers.
- → Give FBPs autonomy in specific areas. Supervisors can identify certain areas where they feel comfortable giving FBPs autonomy to act and make their own choices.
- → Provide specific praise and encouragement when FBPs perform well. The praise must be believable and consistent. Supervisors and management can also help FBPs understand their strengths and emphasize the importance of effort – rather than innate ability – in achieving tasks.
- → Offer prompt, frequent, and specific feedback on tasks. Supervisors can provide specific methods for improvement the next time.
- → Create a positive work environment where collaboration, encouragement, and honesty are emphasized.

There are also many non-supervisory SBCC methods for improving self-efficacy among FBPs. Some examples include:

- → Using Entertainment Education (EE) approaches to model desirable behaviors. Whether through TV or radio soap operas, games, community theater, or music, EE presents relatable role models for FBPs. These role models overcome obstacles, adopt new behaviors, and successfully perform tasks in realistic ways, which can enhance FBPs' feelings of self-efficacy.
- → Using role-play activities to guide reflection and provide opportunities to practice skills. *Forum Theatre* uses a combination of observation and role play to help audiences see the familiar from a different perspective. Participants watch a performance, then analyze the performance and coach actors on new ways of constructing the narrative. This helps participants examine and reflect on the way things are being done. *Rehearse for Reality* allows participants to play themselves but with enhanced abilities and self-efficacy. Participants can practice new skills and see themselves succeeding.
- → Using group discussion or learning groups paired with mass media to encourage reflection, discussion, and practice.
- → Using trainings and job aids to build knowledge and skills. There are several training application approaches that can help bridge the knowledge-practice gap. One example

is the Written Self-Guidance approach where FBPs write a motivational letter to themselves after the training. This self-affirming letter includes the training content that was most relevant to the FBP and encourages the FBP in attaining the goal.

The table below contains examples of programs and guidance for addressing self-efficacy among FBPs.

Motivation Resource Table: Self-Efficacy

	Toolkits	Key Literature
Self-Efficacy	1. Using self-efficacy based interventions to increase employee engagement scores	1. Communication skills training increases self-efficacy of health care professionals. 2. Perioperative Nurse Self-Efficacy and Disruptive Behavior 3. The effect of training in communication skills on medical doctors' and nurses' self-efficacy

PERCEIVED PLACE IN SOCIAL HIERARCHY/STATUS

Cultural power and status relationships typically stem from social norms as well as FBPs' and clients' perceptions of themselves and one another. Thus, tackling status-related challenges requires addressing deeply held values, beliefs, and attitudes – among FBPs *and* clients.

SBCC can create spaces for FBPs and clients to listen to each other, discuss and collaborate. Contact theory suggests that increased contact between groups can help reduce prejudice and conflict. However, effects are not as positive when the groups are of unequal status. In those cases, cooperative learning where members of different groups play essential roles in the process can increase empathy and positive feelings between groups. One strategy is to create opportunities for clients and FBPs to jointly work on projects that both groups view as important. Projects can use a variety of approaches and channels to create working and learning spaces, including community dialogue, mass media with listeners' groups, community mobilization, and project-based learning.

The Puentes project in Peru brought communities and health workers together to create participatory videos that identified barriers to utilization of services. Together, they defined what quality services looked like and came up with an action plan for improvements. Health workers saw issues in a new way and were able to shift attitudes about the services they offered and the community they served.

SBCC can also influence perceptions on what is expected from FBPs and clients. SBCC activities can clearly communicate what is expected of FBPs through support supervision meetings, print reminders on clinic walls or in job aids, trainings, TV or radio ads and programs, coaching, or community theatre. These materials and activities can emphasize the expectation of respectful, non-discriminatory treatment.

Clients can also be sensitized to their role in the client-provider partnership and be encouraged to be an informed client that provides relevant information and asks key questions.

The Smart Patient initiative in Indonesia used client coaching to improve the client-provider interaction. Clients received 20 minutes of coaching on their rights, and how to ask questions, express concerns, and ask for clarification. Client educators would assess clients' needs and skills, seek to understand client motivation, prepare questions and rehearse with the client, and then clients would take action with a provider. Both providers and clients responded positively, and client participation increased.

Both clients and FBPs need positive role models in adopting new beliefs and attitudes. Entertainment Education can be an effective way of presenting role models who demonstrate positive attitudes and behaviors (like trusting health workers, using services, or speaking with respect to clients regardless of status) and change just like the audience needs to.

The Nepal Radio Communication Project implemented two radio serial dramas to address issues of caste, status, and trust in providers. One soap opera, designed for the general public, sought (among other things) to improve perceptions of health workers and to model men and women actively seeking better health conditions. A distance education radio serial for health workers told the story of two health workers who modeled a client-oriented approach, desirable attitudes and behaviors, and strong technical knowledge. Health workers received supporting discussion guides and pre-stamped feedback letters. The program also used radio spots based on the serial dramas, trainings, and print materials to support behavior change.

Changing status-related beliefs and attitudes also requires self-reflection. SBCC can take advantage of values assessments used in facility training or support supervision, reflection journals used with TV/radio serials, or job aids that encourage time to reflect before taking action. It is also important to examine FBPs' workloads, stressors, and contextual factors. Sometimes FBPs treat certain populations poorly as a way to cope with difficulties at work. Helping FBPs obtain and practice effective coping skills can ease status-related tensions.

The table below contains examples of programs and guidance for addressing status among FBPs.

Motivation Resource Table: Hierarchy and Status

	Toolkits	Key Literature
Perceived Place in	1. Smart Patient Coaching in Indonesia 2. NURHI Distance Education videos	1. Exploring Evidence for Disrespect and Abuse in Facility-Based Childbirth

Social Hierarchy/ Status	3. PDQ – "Puentes" in Peru: "Mobilizing Communities to Bridge the Quality of Care Gap" 4. Nepal Radio Communication Project	2. Experiences of and responses to disrespectful maternity care and abuse during childbirth; a qualitative study with women and men in Morogoro Region, Tanzania 3. El enemigo invisible dentro del sistema de salud 4. Client communication behaviors with health care providers in Indonesia 5. Impact of the Integrated Radio Communication Project in Nepal, 1994–1997

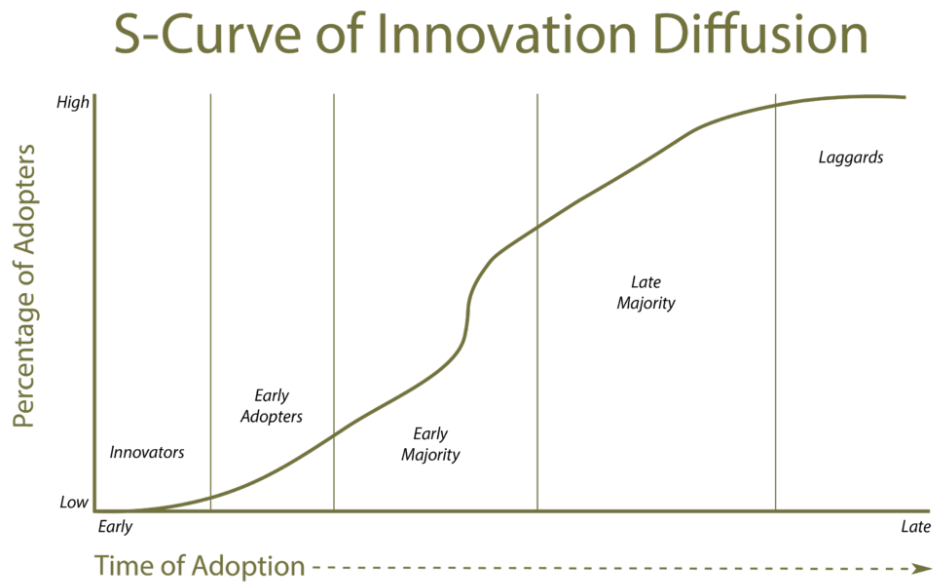
SOCIAL AND GENDER NORMS

There are many social and gender norms that influence how FBPs interact with their clients. You likely uncovered some of those norms through the Situation Analysis. However, you may need to do additional research to understand what local norms are barriers to quality service provision (both among FBPs and clients) and the underlying reasons why they exist. This can be done through key informant interviews, focus group discussions or interactive research techniques.

In Egypt, there were strong norms for conception immediately after marriage. Providers did not feel they could advise their clients to wait to have children because of the strong community norms. Even when they believed it would be best for the family, they did not actively encourage the behavior out of fear of ridicule, rejection, and losing clients' trust.

Once you understand what social and gender norms need to be addressed, you can design focused interventions. Normative change typically requires dialogue – between partners, families and communities. This is especially true when community members incorrectly perceive that their attitudes and behaviors differ from other community members' (pluralistic ignorance). In these cases, a large group of individuals reject a norm privately but participate in it because they believe others support it. Open, honest dialogue about the norm can help community members realize that others do not support the norm and desire change. Even in situations where pluralistic ignorance does not exist, FBPs and community members need to confront their values and openly discuss the impact of those values on their community and the health system. SBCC approaches to encourage this type of discussion include community dialogue, TV/radio listeners' groups, community mobilization, and peer-to-peer approaches.

Social change also requires early adopters that others who are considering change can look to – both in the community and at the health center (see graphic below). SBCC projects can identify FBPs and community members who are already practicing supportive norms or ones who might be willing to make a change (innovators or early adopters). Then, a number of approaches can be used to spread that norm, including positive deviance and peer networks; testimonials on radio, print, or web; or norm champions. Mass media can help create a sense that a certain behavior or attitude is normative, and Entertainment Education can effectively use modeling to show how change could occur.



In designing programs for FBPs that will target gender-related norms, consult the Gender Equality Continuum as a means of evaluating whether your program contributes to gender equity.

The table below contains examples of programs and guidance for addressing social and gender norms among FBPs and community members.

Motivation Resource Table: Social and Gender Norms

	Toolkits	Key Literature
Social and Gender Norms	1. Program H – Working with Young Men 2. An Entertainment-Education Initiative on Television: A Glimpse into the Production Process 3. Healthy Images of Manhood: A Male Engagement Approach for Workplaces	1. Communication for Improving Maternal, Infant and Young Child Nutrition: Developing, Implementing, and Monitoring Social and Behavior Change

	and Community Programs Integrating Gender, Family Planning and HIV/AIDS - A Case Study	Communication Activities for a Five Country Project 2. An Explication of Social Norms

REWARDS

Projects can use SBCC to help FBPs feel rewarded for their work. Advocacy efforts aimed at facility managers and ministry staff can be used to encourage financial rewards and other systemic changes that providers view as rewarding. For example, advocacy campaigns can urge ministry officials to provide more opportunities for learning and training or to create systems for merit-based advancement. It can also encourage local control of incentives to enable facility managers to be creative with rewards. Once rewards systems are in place, SBCC can be used to advertise those rewards and encourage FBP participation through mass media, social and peer networks.

SBCC can be used to recognize FBP contributions and to show appreciation. These recognition campaigns can be done at the facility-level where supervisors and peers recognize efforts and good work. Or they can be done at the general public level where community members or ministries express appreciation for the FBPs. A variety of channels can be used to recognize providers, including TV or radio spots, community events, print materials in clinics, Facebook or WhatsApp groups, closed-network SMS groups, ministry events, or websites.

PSI designed an incentive program to recognize and reward Most Improved and High Performing providers. The program tracked provider performance and improvement related to provision of services and program goals. Motivation among providers increased when improvement was recognized.

Helping FBPs see and believe the importance of their work can also improve motivation and performance. SBCC can be used to design data visualizations that show the impact of FBPs' work, community dramas or TV/radio serials that show the value of FBPs' efforts, or client testimonials that demonstrate how FBPs helped them.

The Women's Health Project helped providers see the benefit of providing IUDs and the ways it could improve clients' lives by producing a cost/time analysis to the providers in their clinics.

The table below summarizes financial and non-financial incentives that can be used to reward FBPs. While SBCC programs do not usually directly provide financial incentives, they can advocate for financial rewards.

Direct Incentives	
Financial Incentives	**Non-Financial Incentives**
Terms and conditions of employment: salary/stipend, promotion, pension, insurance, allowances and leave	*Job satisfaction/work environment*: autonomy, role clarity, supportive/facilitative supervision and manageable workload
Performance payments: performance-linked bonuses or incentives	*Preferential access to services:* health care, housing and education
Other financial support: fellowships, loans and ad hoc	*Professional development:* continued training, effective supervision, study leave, career path that enables promotion and moving into new roles
	Formal recognition: by colleagues, health system, community and wider society
	Informal recognition: T-shirts, name tags, and access to supplies/equipment

Indirect Incentives	
Health System	**Community Level**
Well-functioning health systems: effective management, consistent M&E, prompt monthly payments, safe environment, adequate supplies and working equipment	FBPs witnessing visible improvements in health of clients
Sustainable health systems: sustainable financing, job security	Peer organizations that support FBPs
Responsive health systems: trust, transparency, fairness and consistency	

Motivation Resource Table: Rewards

	Toolkits	Key Literature
Rewards	1. Guidelines: Incentives for Health Professionals. International Council of	1. Health Workers: Building and Motivating the Workforce

	Nurses, International Pharmaceutical Federation, World Dental Federation, World Medical Association, International Hospital Federation, World Confederation for Physical Therapy, 2008 2. Performance Incentives for Global Health: Potential and Pitfalls	2. Improving Health Worker Productivity And Performance In The Context Of Universal Health Coverage: The Roles Of Standards, Quality Improvement, And Regulation 3. Evaluating The Effectiveness Of Non-Financial Incentives To Improve The Delivery Of Health Services In Sierra Leone

WORK ENVIRONMENT

Interventions to improve FBPs' work environment should start with an assessment to understand the work environment, what FBPs need, and what could be done to improve the climate. You may have discovered some of this information during the Situation Analysis. However, you will likely need to do some more research to understand the work environment. This can be done by talking to both clients and FBPs.

Workplace environment interventions require normative change – at the organizational, managerial, and individual provider levels. SBCC interventions need to address the values, assumptions, behavioral norms, and symbols that impact how FBPs interact with each other and clients.

Health facility management plays a key role in creating a positive work environment with norms for teamwork, recognition, civil treatment of clients, equal participation, social sensitivity, and quality work. Managers also need skills in effective management and supervision, leadership, setting a vision, and creating efficient systems. Thus, health facility managers are often a primary audience for SBCC efforts.

Given management's role in the facility, many SBCC interventions to improve the work environment include leadership training. These trainings are aimed at helping facility leadership to set and communicate a strong vision, practice supportive supervision and effective management, improve management systems, and recognize staff accomplishments. Some strategies include:

- → Education and coaching
- → Action-learning workshops
- → Leadership learning modules
- → Simulations and role playing
- → Reflective and visionary practice

FBPs are also a key SBCC audience for workplace environment interventions. Norms need to change across the health facility – not just at leadership levels – and interventions that do not involve employees are rarely successful. Many successful SBCC interventions use FBP change champions supported by leadership and a clear vision for improvement. These change champions help lead the cause in setting and practicing new norms and behaviors, including praising and recognizing colleagues, interacting positively with clients, supporting colleagues emotionally, sharing responsibilities, and promoting teamwork.

Some health facilities have implemented civility interventions to encourage FBPs to treat all people in the workplace civilly and respectfully. These interventions also aim to increase collaboration, teamwork, and engagement through facilitated discussions, role-playing and action plans. Print reminders, civil role models, and closed-network SMS encouragements can support the core activities.

The Civility, Respect, and Engagement at the Workplace (CREW) intervention has been used to increase civil and respectful interactions in health facilities. CREW raises awareness about the importance of civility and helps staff develop a shared understanding of how civility can help them achieve work goals. Trained facilitators meet frequently with specific work groups and facilitate discussions that define civil behaviors and aim to change behaviors, attitudes, and emotions. Facilitators use role-plays and action plans to encourage problem solving and group interaction. Using CREW has helped improve the work environment significantly by increasing civility, trust, respect, and empowerment.

SBCC can also be used to improve teamwork at the facility. These interventions focus on improving teambuilding, group communication, conflict management, and a sense of collaboration. Teamwork interventions often involve teamwork training, problem-based learning teams, simulations, feedback sessions, joint redesign of work practices, change teams, communication shortcuts with mnemonic devices, and informal conversations. Some of the SBCC tools used in teamwork interventions include:

- → Podcasts
- → Bulletins and emails
- → Self-review and communication
- → Facilitator debriefs
- → Checklists

The table below contains examples of programs and guidance for improving the work environment.

Motivation Resource Table: Work Environment

	Toolkits	Key Literature

Work Environment	1. Improving the Work Climate at Rural Facilities in Kenya 2. Peer-driven quality improvement among health workers and traditional birth attendants in Sierra Leone: linkages between providers' organizational skills and relationships 3. The NGO "Healthy Families" Improves Its Work Climate	1. Workplace Culture Improvements: A Review of the Literature 2. Creating a Work Climate That Motivates Staff and Improves Performance

Step 8: Develop an Implementation Plan

At this point, you have completed a situation analysis, identified your intended audience, developed communication objectives framed around the key barriers to FBP motivation, and identified the tools and resources you will either develop or adapt for your intervention. The next step is to determine how, by when and by whom your SBCC intervention will be implemented.

The steps to developing an implementation plan for SBCC that addresses FBPs performance are identical to other types of SBCC interventions and follow these fundamental steps:

1 Determine Partner Roles and Responsibilities

Ask the following key questions:

- → What competencies are needed to implement the strategy?
- → What potential partners have these competencies?
- → How will coordination for implementation be handled?
- → Who will serve as the lead implementer of the communication strategy?
- → Are there any capacity strengthening needs?

2 Outline Activities

Answer the following questions and assign responsibility:

- → What are the activities that need to be implemented?
- → What are the intermediate steps for each activity?
- → What is the necessary sequence?

3 Establish a Timeline

This plan outlines the time schedule for development, implementation and evaluation of activities. It is flexible and should be reviewed periodically.

4 Determine a Budget

This task determines how much funding is needed to implement the communication strategy.

C-Change developed a budget tool (see pg. 14) to guide the outline of the major budgeting categories for SBCC.

Finalize Implementation Plan

This activity summarizes how the SBCC strategy will be implemented answering the *who?, what?, when? and how much?* C-Change developed an implementation plan template (see pg. 3) you can use as a guide.

Record partner roles, activities, timeline and budget in the Step 8 section of the **SBCC Strategy Template: (Appendix JJ).**

Resources

- Designing a Social and Behavior Change Communication Strategy Implementation Kit
- C-Change C-Module 4 – Implementation and Monitoring

Step 9: Monitor and Evaluate

All SBCC programs, including those that focus on FBPs, must include a monitoring and evaluation (M&E) component. While M&E is introduced in Step 9 of this I-kit, it is important to remember that throughout the SBCC design process, you made key decisions that are a key part of M&E. Specifically:

- **Step 1: Situation Analysis/Performance Needs Assessment** – You identified what were the key behavioral problems that needed to be addressed and subsequently measured in your evaluation.
- **Step 2: Identify the Core Problem** – You identified the core problem that needed to be addressed.
- **Step 3: Define Key Audience Segments** – You identified which cadre of FBPs you would focus on in order to change behavior.
- **Step 4: Develop Communication Objectives** – You determined which specific motivational factors you would address and developed SMART objectives to measure them.
- **Step 5: Determine the Key Promise and Support Points** – You developed a promise telling your audience what they would receive by changing their behavior and supported this with evidence.
- **Step 6: Define and Prioritize Communication Approach** – You determined the communication channels you would use throughout implementation, and those you would subsequently track throughout implementation.
- **Step 7: Match Communication Approach to Identified Barrier** – You matched the communication channels to your SMART objectives.
- **Step 8: Develop Implementation Plan** – You developed the overall implementation plan to inform both your monitoring and evaluation activities.

Your M&E efforts help you to compare the effects of your SBCC intervention with your program objectives and identify factors that helped or limited the program's success. Motivation cannot be observed or measured directly and as a result, monitoring and evaluation must measure the key factors of motivation. For FBPs these are defined as: *self-efficacy, perceived place in social hierarchy/status, social and gender norms, rewards,* and *work environment.*

Developing a monitoring and evaluation plan to measure your program's success is important. However, before developing a Monitoring and Evaluation plan for SBCC, it is important to understand the difference between Monitoring and Evaluation and the indicators they measure.

MONITORING

Monitoring tracks and measures program activities. It helps you quantify **what** has been done, **when** it has been done, **how** it has been done and **who** has been reached. Monitoring also

help you identify any problems so that adjustments can be made. The indicators tracked by monitoring are called Process Indicators.

Process Indicators

Process indicators measure the extent to which SBCC activities were implemented as planned. Examples include: the number of community dialogues held, the number of job aids distributed, the number of support supervision visits conducted, the number of peer group sessions conducted, and the number of SMS messages sent to FBPs.

C-Change created guidelines on how to develop an **SBCC monitoring plan** (see pg. 24).

Examples of performance monitoring and routine support supervision tools:

- → **Situation Behavior Impact (SBI)** – An interactive performance monitoring and coaching technique that can be used by FBP supervisors to monitor FBP job performance.
- → **PSI's IPC Toolkit** – Guidelines and resources to monitor IPC activities including routine monitoring for providers.
- → **PSI's Provider Behavior Change Toolkit on Coaching and Feedback** – Tools to provide structured routine support supervision and feedback to FBPs.

EVALUATION

Evaluation is data collected at discrete points in time to systematically investigate whether an SBCC program has brought about the desired change in an intended population or community. Evaluation enables the SBCC program to determine whether the communication strategy and activities were effective.

Evaluation requires a comparison of variables and the measurement of changes in them over time. It measures what has happened among the intended audiences as a result of program activities and allows SBCC practitioners to answer questions like:

- → Were the barriers to improved FBP motivation reduced by our efforts?
- → Did these changes improve our program success?

Evaluation indicators for SBCC typically include *Output, Outcome* and sometimes *Impact* Indicators.

Output Indicators

These indicators will measure:

1. Changes in the key factors of FBP motivation as defined by: levels of self-efficacy, perception in changes of social and gender norms, perception of status, and perceived changes in rewards for work and the work environment.
2. The extent to which these changes correlate with exposure to SBCC activities.

Example: The proportion of FBPs who feel more supported by their colleagues as a result of activities to promote emotional intelligence and peer recognition.

Outcome Indicators

Outcome indicators measure:

1. Changes in audiences' behavior.
2. The extent to which these changes correlate with program exposure.

Example: The proportion of FBPs who participated in positive deviance groups who now provide quality HIV testing and counseling to female sex workers.

Impact Indicators

Impact indicators measure changes in health outcomes.

Example: Percent decrease in malaria cases among children under 5; percent decrease in maternal mortality; percent decrease in HIV incidence

While effective SBCC programs have the potential to contribute to health impact it may not be possible to attribute this impact entirely to SBCC. As a result, while impact indicators are defined above, most SBCC programs – including those that target FBPs – track process, output and outcome indicators.

To increase the utility of M&E data, indicators should be disaggregated to facilitate more in-depth analysis of program performance. It is recommended that indicators are also disaggregated by gender, experience level, geographic location and type of provider, etc.

Because the SBCC component of your program may be part of a larger health systems strengthening or FBP performance improvement plan, if M&E plans already exist, add appropriate outcome or impact indicators and provide input into the existing M&E plan.

C-Change has more guidelines on developing an **SBCC Evaluation Plan and indicators**.

Record your M&E indicators in the Step 9 section of the **SBCC Strategy Template. (Appendix JJ)**

Resources

- Situation Behavior Impact
- IYCF Support Supervision tools
- Coaching (PSI PBC)
- Developing and Strengthening Community Health Worker Programs at Scale
- Community Health Worker Assessment and Improvement Matrix (CHW AIM): A Toolkit for Improving CHW Programs and Services
- How to Develop Monitoring Indicators

- How to Develop Monitoring and Evaluation Plan

Appendices

Appendix A

Performer Analysis Worksheet

Purpose – to clearly define and identify the group of individuals whose needs you would like to assess (generally known as "performers"), including information about how many of these individuals there are, where they work, and the basics of the work they do, when they do it, and how it is measured. Having this information will help clarify the target group for your stakeholder Steering Committee, and provide valuable data as you scope the breadth and depth of the needs analysis.

Performers	Community Health Workers (CHWs)
Who	
Where	
When	
What	
Why	
How	

Tips:

- If there is great variation in the types of practice, locations, or individual characteristics of the performers, you may want to create and describe the major subgroups separately. For example, you may consider CHWs who work in large clinics in central cities and CHWs in small villages as two different groups. Rely on your Steering Committee members to help determine if these subgroups are necessary, especially those committee members who represent the performers themselves
- The better you can define the performers at the start, the easier the steps that follow will be since this information will guide decisions further along in the process
- Any existing measurements of CHW performance you identify now will be helpful in tracking the impact of any change, or intervention, meant to support performance; you should see improvements to these measures once new performance supports are in place or performance barriers are removed.

Example Performer Analysis Worksheet

Here is the Performer Analysis Worksheet prepared by Cecilia, the Facilitator, and a subgroup of the Steering Committee.

	Community Health Workers (CHWs)
Who	Typical CHWs in {name}'s region fall into one of two categories: Village Health Workers (VHWs) are volunteers within their communities. They typically have less than 6 years of formal schooling, but were provided with two weeks of initial training when they took on the role and receive 3-5 days of refresher training each year. They are all women of child bearing age, most with children of their own, who are either from the village they work in or from that immediate area. Many of these volunteer hours take place during the school day, but other local mothers watch VHWs' children when they are too young for school or school is not in session. VHWs make up about 65% of the overall regional health workforce. Senior CHWs (SCHWs) are certified healthcare providers with 18 months of formal training; they delivery services and supervise VHWs in their immediate area who provide counseling and funnel patients to central clinics for complex care. SCHWs are generally located in larger villages or towns. They are usually from that area but not specifically from the town they work in. If patients require more extensive care, they are referred or transferred to the regional hospitals for physician care. SCHWs vary in age from 30 to 60 years old and typically no longer have small children at home. They are often the primary breadwinners in their families. They make up about 25% of the overall regional health workforce.
Where	VHW – volunteer in village settings, usually providing care by visiting the homes of patients SCHW – work in regional health clinics, with clean, reasonably well supplied facilities
When	VHW – volunteer on a part-time basis, usually 10-15 hours per week, year round SCHW – work 30-40 hours per week year round
What	VHW – generally an information and minimal delivery role; visits local homes to provide family planning counseling, including the description of methods and distribution of general medications in support and control of reproductive health (barrier methods, prenatal vitamins, etc.) Usually visits an average of four families during each of her three, 5 hour days. This is typical of VHWs across the region. SCHW – clinical service delivery for family planning, including IUD placement, Depo-Provera injections, vasectomy, and general health testing and prevention visits. Usually sees 12-15 patients during each week day. Services delivered are determined by the clinic Director, who also oversees more critical cases and refers them to regional hospitals for additional treatment when necessary. This is typical of SCHWs in clinics across the region.

Why	VHW – are usually attracted to the role because of their desire to help their villages; they enjoy a raised status among the village population. SCHW – most were drawn to the role because of their interest in medicine or public health, some hope to go on for more advanced training.
How	VHW – performance is tracked by number of patients visited, volume of drugs and resources delivered (submitted monthly), and annual number of unplanned pregnancies in the village; supervised by regional public health officials, generally 1 supervisor to 8 VHWs that connect via text message and twice annual visits to local villages SCHW – supervised by clinic Directors on a daily basis; measures include number of patients seen, number of repeat visits, and number of procedures completed (reported weekly); clinic Directors generally oversee up to three SCHWs in addition to the general clinic staff which number around 15 total.

Stakeholder Analysis Worksheet

Purpose – to identify those groups or individuals that have a vested interest in your needs analysis, and to document the likely concerns, areas of interest, and support they might provide to complete the process. This might include individuals who:

- create healthcare goals for the community
- lead organizations where CHWs work
- lead the communities where CHW's work
- contribute to the procurement, logistics, or quality of the supplies needed for CHWs to conduct their work
- can represent the interests of the patients seen by CHWs
- can represent CHWs supervisors
- can represent CHWs themselves

Major stakeholder(s) or groups	**Point of Contact**	**Their Stake**	**Support**
Describe each major stakeholder or group of stakeholders	*Who can represent the group on a Steering Committee?*	*Describe the values, interests, and likely expectations the stakeholder(s) might have in in addressing causes of poor performance, or in addressing identified needs to improve performance*	*Describe the likely support this stakeholder can provide – access to data, control over resources, public opinion leader, beneficiary of the performance, etc.*

Tips:

- Don't worry about identifying *everyone* who might possibly be involved – a smaller group might be easier to manage, so long as the key groups are effectively represented on the Committee you should be fine
- One identified audience or contact may lead you to another—rely on those you engage to help you clarify who else should be included
- New stakeholders may emerge as you work through the needs analysis process—as they do, invite them to participate on the Steering Committee and catch them up on decisions and perspectives agreed upon thus far

- Be realistic about expectations for the analysis and let the group know the constraints they might face
- Include both those individuals who are likely to be champions of the process and those who might present the biggest roadblocks—better to have them close and their concerns clear right from the start

Example Stakeholder Analysis Worksheet

This is the Worksheet that Cecilia compiled to better understand the key players in the Needs Analysis she is facilitating.

Major stakeholder(s) or groups	Point of Contact	Their Stake	Support
Regional public health officials	the Deputy Regional Minister	Accountable to the national ministry of public health, and anxious to have the region seen as an exemplar within country	Access to limited discretionary budget to support public health initiatives; can provide access to clinical data and health indicators measures
NGO project representatives	Associate Directors for each of 4 major projects in the region that address public health – two address family planning directly, one focuses on Maternal & Child health, one on HIV/AIDS	Interested in CHW performance that contributes to project goals; wants to ensure that any changes to CHW support do not negatively impact ongoing projects or effect project metrics.	Actively collecting data on CHW actions as related to their individual project goals; employ a number of opinion leaders across the community; can provide some financial support if it is an allowable expense and funds are available
NGO M&E representatives	Senior M&E Manager for largest project in region	Wants to ensure valid of needs analysis; concerned project M&E staff will be pressed to support needs analysis that is not an allowable expense	Able to lend personal expertise, but not funding, for sampling, instrument development, data collection, data housing/management, and analysis
Regional Pharmacy Centers	Purchasing Manager, regional pharma distribution center	Wants to ensure that regional stocking/distribution methods are seen as supportive; concerned that poor ordering at clinics that result in stock-outs will be seen as a failure of their systems	Can provide measures of stock and pharma throughput to region, region clinics and local areas
SCHWs	A typical SCHW, and clinic Director	Interested in ensuring work at clinics is seen in a positive light and in improving the funding and support of clinics throughout the region	Can provide unique insights to the work and motivation of SCHWs throughout the area; can pilot data collection instruments and assist in interpretation of comments and data
VHWs	Cecilia, representing the typical VHW within the region; a VHW Supervisor from another area within the region	Wants to represent her local community well, and ensure VHW challenges are identified and addressed; nervous about	Can provide unique insights to the work and motivation of VHWs throughout the area; can pilot data collection instruments and assist in interpretation of comments and data

		working with senior managers and political authorities	
Local government officials	the Assistant Mayor of one the largest towns in the Local Government Area	Want to be sure that their authority on local matters is not ignored, and that regional or NGO group don't interfere with local governance, values, or traditions	Can provide access to local public radio stations, public events and local funding to support health initiatives when they deem them in the public interest; can influence leaders of other towns in the area
Religious leaders	Local Imam, Shaman, and Christian Minister	Concerned that family planning services conflict with religious doctrine	Can influence public opinion about healthcare offerings and practices
Civic society organizations	Member of local Football League Administration; School Board member	Generally concerned about public health, public health education and public well-being	Can influence public opinion, provide venues for public gatherings, and possibly provide additional funding or support to CHWs at regional or local level

Logic Model Worksheet

Purpose –a logic model shows the relationships between the performers and the ultimate goals their work is intended to achieve. It makes the connection between actions and goals clear for all parties. Below is a typical logic model template, with one high-level example for clarity.

Inputs	Activities	Outputs	Outcomes (short and long term)	Impact
The resources available to support the performance or program (people, funding, time, materials, etc.)	*The sequenced actions that performers or programs take with the available resources to achieve the stated goals (offerings, events, products, services, etc.)*	*Direct, tangible accomplishments of the activities with the intended audiences*	*The measurable changes in audience behavior or capability that result from the performance or program*	*Realized changes in the populations, organizations, or systems the performance or program was designed to influence (typically these are community health goals)*

Tips:

- Many people find it easiest to begin with the *Activities*, then describe the *Outputs*, *Outcomes* and *Impact* before returning to identify the *Inputs* required
- Some logic models combine components—especially Activities and Outputs; for a logic model that will guide a needs analysis we want to be as explicit as possible in describing the individual actions of performers with their Outputs and Outcomes since it is the performance behavior of individuals we are most interested in investigating
- Keep your logic model entries at a fairly general level to begin with. You don't have to describe Activities at the granular level (example: CHW asks patient to lie on examination table), unless or until a specific Activity is associated with a performance gap. Then it might be illustrative to consider the sequences of actions that make up Activities to further clarify what is causing or contributing to the gap. You might also revise the Logic Model to reflect changes undertaken to address gaps going forward.

Example Logic Model Worksheet

Here is just a brief portion of the Logic Model prepared by Cecilia and her Steering Committee sub-group.

Inputs	Activities	Outputs	Outcomes (short and long term)	Impact
• Clear expectations • Skills and Knowledge (ability) • Facilities and necessary materials (opportunity) • Motivation of both VHWs and community members to engage in counseling sessions	Family planning counseling sessions delivered by VHWs	Couples understand the options available for family planning and make decisions that support their intentions for reproduction	Short term: increased number of referrals to regional clinics for reproductive health procedures with SCHWs Long term: increased confidence in and adherence to chosen family planning methods	Reduced number of unplanned pregnancies

Question Matrix

		Data Sources				
Investigative Questions	**Sub-Questions; Possible Survey Questions** (reword as appropriate for different audiences)	CHW	Supervisors	Patients	Community	Documents
Expectations Questions						
Is the performance itself clear and unambiguous to performers?	Is it clear what services CHWs will provide?					
	Is it clear what services are not provided by CHWs?					
	Is there consistent definition and understanding of each service offered?					
Are there clear and measurable performance standards?	Are metrics for CHW performance during service collected? Are they shared with the individual performers? With their supervisors?					
	Are metrics for CHW performance collected after service has been completed? Are they shared with the individual performers? With their supervisors?					
Are the standards attainable?	Do performers consider the standards attainable?					
Are good models of behavior available? Do they know what success looks like and what failure looks like?	Is good performance clearly defined?					
	Is poor performance clearly defined?					
Is there sufficient feedback on performance to allow an experienced person to perform well?	Are there accepted standards for CHW performance during service delivery?					
	Is CHW performance observed periodically for immediate feedback?					
Are the objectives of the performance clear?	Are the public health goals affected by CHW delivery of services understood and accepted?					
What are the key gender relations related to setting expectations for CHW performance? What are the gender-based constraints on setting performance expectations?						

If expectations are not clear, why? What might be some of the reasons why expectations are not clear?						
Add any other expectations questions unique to your situation						
Ability Questions						
Are the tasks and procedures that make up the performance understood?	Are the key services provided by CHWs defined?					
	Are the specific actions to accomplish those tasks clear?					
Are they logical?	Does the flow of tasks involved in each service optimize performance?					
Do the performers have the knowledge needed to perform well?	Is it clear what knowledge is needed to provide services?					
	Are CHWs tested on this knowledge? How regularly?					
	Is there an established way for new or updated knowledge to reach CHWs?					
Do performers have the skills to perform well?	Are the skills needed for CHWs to provide services clear?					
	Are CHW skills tested? How regularly?					
	How are new or updated skills acquired by CHWs?					
	Do the policies for recruiting and hiring of CHWs take the needed knowledge and skills into account?					
What are the key gender relations related to skills and knowledge acquisition and maintenance for CHW performance? What are the gender-based constraints on ability issues overall?						
If there is a lack of ability on the part of the CHWs or those who supervise them, what might be contributing to this?						
Add any other ability questions unique to your situation						
Opportunity Questions						
Is it clear what resources are needed, at minimum, to perform as expected?	Is it clear what supplies, equipment, teamwork and circumstances are needed to appropriately deliver services?					

	Is it clear how much time it generally takes to deliver services properly?					
Are these resources regularly available?	Are the supplies needed to deliver services regularly available?					
	Is the equipment needed to deliver services regularly available?					
	Is there sufficient teamwork to allow CHWs to deliver services?					
	Is sufficient time available to deliver services for each patient(s)?					
	Are there reasonable expectations for the number of patients seen in a given workday?					
Are the settings for performance sufficient?	Are the services offered in locations with sufficient space, sanitation, privacy, and convenience to patients?					
Are the performers physically, mentally, and emotionally able to perform as expected?	Do the CHWs have the physical fitness required to delivery services appropriately?					
	Are there any emotional or mental issues inhibiting CHW's abilities to delivery services?					
Are members of the target population aware of the services offered?	Do potential patients know about the services CHWs provide?					
Do members of the target population have the opportunity to obtain services?	Are potential patients able to reach service locations? If not, what barriers do they face?					
What are the key gender relations related to patient access, environmental influences, and resource availability for CHW performance? What are the gender-based constraints on opportunity issues overall?						
If there are environmental, social, or other barriers that keep CHWs or their supervisors from performing as expected, what might be driving these barriers?						
Add any other opportunity questions unique to your situation						

Motivation Questions						
Do the performers understand why good performance is important?	Do CHWs see a directly link between their work and public health goals?					
	Is there understanding and agreement on how the logic of how specific tasks and services that CHWs provide will improve public health?					
	Is the importance of each service (or tasks which make up a service) understood?					
Is there individual motivation to perform? Do the performers get something positive out of their taking action?	Are the motivations that drive CHWs to deliver service understood? What are the tangible motivations? What are the intangible motivations?					
	Do CHWs experience an increase in status as a result of their role?					
	Do the families of CHWs support them in their role?					
	Are their personal needs of CHWs that are fulfilled by service in role?					
Are there rewards in place for good performance?	Are there unique rewards for CHWs who demonstrate good performance?					
Are there consequences for poor performance? Are they meaningful to the performers?	What rewards are forfeit by poor performing CHWs?					
	Does the loss of rewards by poor performers inspire change in their practice or improvement in their future performance?					
	What are the consequences for continued poor performance by individual CHWs?					
Are there environmental or sociocultural influences that might impact performance?	Are there groups or individuals that oppose the services that CHWs typically provide?					
	Are there groups or individuals that oppose CHWs specifically for any reason?					
	Are there legal prohibitions against delivery of any services?					

	Are there any negative consequences to CHWs for providing services?					
	Do values conflict with the delivery of services or the public health consequences of those services?					
Are communities committed to the goals and objectives of service as outlined in the logic model?	Does the community clearly understand the link between CHW services and the health goals of the community?					
Do communities support the activities of CHWs in providing services?	Does the community actively support the public health goals contributed to by the work of CHWs?					
	Do CHWs feel connected to the community they serve?					
What are the key gender relations related to motivation for CHW performance? Both motivation of the CHWs themselves and the motivation of the patients in seeking and receiving healthcare services? What are the gender-based constraints on motivation issues overall?						
If there is a lack of motivation for CHWs to perform, what might be interfering with their motivation?						
Add any other motivation questions unique to your situation						

Example Question Matrix

At one of her first Steering Committee meetings, Cecilia asked the group to split into four teams. Each team was asked to review one of the essential factor sections of the Question Matrix (Expectations, Ability, Opportunity, and Motivation), and adapt or expand upon it to reflect the specific considerations of the Steering Committee for the needs analysis. The Committee then reviewed each adapted section together and made final edits. The result is a list of investigative questions that are most important to the Stakeholder Steering Committee members.

		Data Sources				
Investigative Questions	**Sub-Questions; Possible Survey Questions** (reword as appropriate for different audiences)	CHW	Supervisors	Patients	Community	Documents
Expectations Questions						
Is the performance itself clear and unambiguous to performers?	Can VHWs list and describe the services they are expected to provide within their village? Can SCHWs list and describe each of the services they are expected to deliver at their clinic?					
	Do VHW supervisors provide the same list and description of services? Do SCHW supervisors provide the same list and description of services?					
Are there clear and measurable performance standards?	Are VHWs aware of how their work is tracked and measured? Do they know their most recent measures? Are SCHWs familiar with the metrics that track their work? Can they state their most recent measure and trend?					
	Are supervisors of VHWs and SCHWs familiar with the metrics of those they supervise? How often do they share and discuss these metrics with their reports?					
Is there sufficient feedback on performance to allow an experienced person to perform well?	How do VHWs receive feedback on their counseling services?					
	Is SCHW performance observed periodically for immediate feedback?					

Are the objectives of the performance clear?	Are the public health goals affected by VHW and SCHW delivery of services understood and accepted?					
What are the key gender relations related to setting expectations for CHW performance? What are the gender-based constraints on setting performance expectations?	In what ways to gender relations impact the expectations set for VHW performance? Are there gender relations issues in setting expectations for SCHW clinical services?					
	What kinds of gender issues are involved in expectation setting for service recipients?					
	If expectations are not clear, what are some of the reasons behind this?					
Ability Questions						
Are the tasks and procedures that make up the performance understood?	Do VHWs understand what the major components of a family planning counseling session? Are the specific steps and actions that make up those major components clear?					
	Do SCHWs understand the step by step activities that are contained in the clinical family planning services they provide?					
Do the performers have the knowledge needed to perform well?	Do VHWs have the knowledge and skills needed to deliver a family planning counseling session?					
	Do SCHWs have the knowledge and skills needed to provide clinical family planning services? for all services offered?					
Are supervisors keeping track of skills and knowledge needs?	Do supervisors of VHWs and SCHWs regularly assess the skills and knowledge of their reports?					
What are the key gender relations related to skills and knowledge acquisition and maintenance for CHW performance? What are the gender-based constraints on ability issues overall?	Are there gender relations issues behind the delivery of services? Are there gender relations issues that either inhibit or support the acquisition of skills and knowledge needed for family planning service delivery?					
	If there is a lack of ability on the part of VHWs or SCHWs, or their supervisors, what is contributing to this?					
Opportunity Questions						
Is it clear what resources are needed, at minimum, to perform as expected?	Is it clear what supplies, equipment, teamwork and circumstances are needed to appropriately deliver services?					

Are these resources regularly available?	Are the supplies and equipment needed to deliver services regularly available?					
	Are there reasonable expectations for the number of services to be provided in a given day? given week?					
Are members of the target population aware of the services offered?	Do potential patients know about the services VHWs and SCHWs provide?					
Do members of the target population have the opportunity to obtain services?	Are potential patients able to reach service locations? If not, what barriers do they face?					
What are the key gender relations related to patient access, environmental influences, and resource availability for CHW performance? What are the gender-based constraints on opportunity issues overall?						
	If there are environmental, social, or other barriers that keep CHWs or their supervisors from performing as expected, what might be driving these barriers?					
Motivation Questions						
Do the performers understand why good performance is important?	Do VHWs and SCHWs see a directly link between their work and public health goals?					
Is there individual motivation to perform? Do the performers get something positive out of their taking action?	Are the motivations that drive VHWs and SCHWs to deliver service understood? What are the tangible motivations? What are the intangible motivations?					
	Do CHWs experience an increase in status as a result of their role?					
	Do the families of CHWs support them in their role?					
	Are their personal needs of CHWs that are fulfilled by service in role?					
Are there rewards in place for good performance?	Are there unique rewards for VHWs and SCHWs who demonstrate good performance?					
Are there consequences for poor performance? Are they meaningful to the performers?	What rewards are forfeit by poor performing VHWs and SCHWs?					
	What are the consequences for continued poor performance by individual VHWs and SCHWs?					

Are there environmental or sociocultural influences that might impact performance?	Are there groups or individuals that oppose the services that CHWs typically provide?					
	Are there any negative consequences to CHWs for providing services?					
	Do values conflict with the delivery of services or the public health consequences of those services?					
Are communities committed to the goals and objectives of service as outlined in the logic model?	Does the community clearly understand the link between CHW services and the health goals of the community?					
Do communities support the activities of CHWs in providing services?	Does the community actively support the public health goals contributed to by the work of CHWs?					
	Do CHWs feel connected to the community they serve?					
What are the key gender relations related to motivation for CHW performance? Both motivation of the CHWs themselves and the motivation of the patients in seeking and receiving healthcare services? What are the gender-based constraints on motivation issues overall?	How do gender relations impact the motivation of VHWs to provide family planning counseling in their villages? Are there gender relations issues that impact the clinical services offered by SCHWs?					
	If there are other aspects of motivation lacking for VHWs, SCHWs, or their patients, what might be contributing to it?					

Acceptable Evidence Worksheet

Purpose – to identify what stakeholders will find satisfactory as an answer to each investigative question. Once the data is collected and analyzed, this content will help you know if the answer is "good enough" for Steering Committee members to feel there are no problems or needs associated with that area. It's a good idea to clarify acceptable evidence in advance for three reasons: (1) so your data collection instruments collect data in the level of detail that is needed, and (2) so that the Committee can publically align on minimally acceptable evidence *before* data is in hand and thereby avoid potentially divisive discussions once summarized data is in hand. It's also a terrific final check across all questions and sub-questions before beginning you plan for data collection.

Process – Assign a Steering Committee to champion each of the four performance factor sections of the *Question Matrix*. Committee sub-groups should form and discuss each question, identifying minimally acceptable evidence, based on stated goals and objectives for the performance. Each sub-group shares their worksheet with the larger Committee for consensus and buy-in.

Investigative Questions	**Sub-Questions; Possible Survey Questions** (reword as appropriate for different audiences)	**Acceptable Evidence**
List each major investigative question	*List the sub-questions that support the investigative questions*	*For each question, identify the line between "it's OK" and "this is a gap"*
Are there clear and measurable performance standards?	Are metrics for CHW performance during service collected? Are they shared with individual performers? With their supervisors?	If 90% of CHWs report that performance metrics are collected and are shared with them by their supervisors on a weekly basis, there is no need for intervention. The Steering Committee agrees that if fewer than 90% report this will indicate there is a need to be addressed in this area.

Tips:

- Be sure to note the performance factors that *must* be present in order to allow any level of performance to take place. For example, if the necessary medications are not available, service delivery cannot take place at all. But having the medicines available does not *guarantee* that CHWs will provide good service. Having this notation will be helpful when prioritizing which needs to address first.
- If multiple audiences are involved in determining the answer to a given question, be sure to note if the level of evidence differs from audience to audience. For example, is the Committee

comfortable if only 50% of CHWs feel their performance measures are clear and measurable? Or is the minimally acceptable number closer to 90%?

- The first time you conduct a needs analysis for any group, the minimally acceptable evidence will be harder to pinpoint. In future cycles you will have the previous cycle's data to rely on as a starting point—with the assumption that things should be improving cycle over cycle.

Don't be surprised if data collected from one audience appears to contradict data from another audience. Supervisors of CHWs may have a very different perspective on what constitutes a motivating reward than CHWs themselves. All perspectives are *valid* for that audience—your goal is to identify those which are most *informative* in answering the investigative questions.

Example Acceptable Evidence Worksheet

Here is a cross-section of the Acceptable Evidence Worksheet completed by Cecilia and her Steering Committee sub-team. One question from each of the four essential factors is included.

Investigative Questions	**Sub-Questions; Possible Survey Questions** (reword as appropriate for different audiences)	**Acceptable Evidence**
	List the sub-questions that support the investigative questions	*For each question, identify the line between "it's OK" and "this is a gap"*
Expectation Question : Are there clear and measurable performance standards?	Are VHWs aware of how their work is tracked and measured? Do they know their most recent measures? Are SCHWs familiar with the metrics that track their work? Can they state their most recent measure and trend?	75% of VHWs should be able to describe how their performance is measured and their most recent measurement results. 90% of SCHWs should indicate metrics are collected and shared weekly by their supervisors. If fewer than 90% report this, it will be seen as a need.
Ability Question: What are the key gender relations related to skills and knowledge acquisition and maintenance?	Are there gender relations issues that affect delivery of VHW counseling services or SCHW clinical services? Do these issues impact the ability for these CHWs to provide services?	VHWs and SCHWs report minimal gender relations issues and none that affect their ability to provide services as described. If any gender relations issues are identified that interfere with specific counseling or clinical services, this will be considered an addressable need.
Opportunity Question: Are sufficient resources regularly available?	Are the supplies and equipment needed to deliver services regularly available?	Fewer than 10% of SCHWs and their supervisors report occasional shortages of supplies for clinical service delivery. If shortages are reported that interrupt service delivery in any location for more than one day per month this will be considered an addressable need.
Motivation Question: Are there environmental or sociocultural influences that might impact performance?	Are there any negative consequences to VHWs or SCHWs for providing services?	Fewer than 5% of VHWs and SCHWs indicate that there are negative consequences for their providing services to the community. If more than 5% report negative consequences this will be considered an addressable need.

Sampling Overview

Purpose – to provide a general overview of sampling issues, and support approaches that will ensure the perspectives and opinions you capture from a small number of individuals properly represents the perspectives and opinions of the entire group or population

At this point in the needs analysis, you know what questions you'd like answered and which individuals or groups might have information to answer them. But how do you choose which *individuals* to approach in order to gather your data? Most needs analyses will collect information from a variety of sources using several different methods. This is known as a *mixed methods* approach, and it usually involves more than one approach to selecting samples of individuals to engage with for data collection.

First a *probability sampling* is used to ensure for the group of individuals chosen is representative of the entire group (this is called generalization). This is often supplemented by *purposive sampling,* which is used to gather data for specific investigative questions that require deeper perspective from unique groups of performers or informants. Here is an overview of each type of sampling and when it is typically used:

Types of Probability Sampling	Types of Purposive Sampling
Random Sample: ensures you can confidently generalize results to the larger population in one of two methods: simple - every member of the entire population has an equal chance of being selected; systemic – choose from a randomized population list in a structured way (every 12th person, for example)	Exemplar – sometimes called *success case* study, this method is sometimes associated with a positive focused technique called *appreciative inquiry*, this method involves identification of top performers in order to study what contributes to their success
Stratified – major subgroups within the population are identified first, then random samples are pulled from each in proportion to their size in the general population; this ensures small, geographically dispersed, or key stakeholder groups are sampled in large enough numbers to generalize to their subgroup	Snowball – rely on insider knowledge from the various groups of informants to identify useful cases to include; this method ensures a variety of specific examples will be included but requires strong trust between the data sources and the researchers
Cluster – naturally occurring sub-populations (clinics, families, towns) are identified and a random sample of these groups is chosen; this is useful when travel is difficult or expensive and the sub-group populations are relatively similar	Convenience – selection of individuals who are easily at hand and willing to participate; this is the least desirable method since it is not likely to be as transferrable or representative but is lowest in cost
When to use Probability Sampling	When to use Purposive Sampling
When you want to understand the size or prevalence of an issue or factor that is affecting performance—how widespread is it?	When you have an interest in the perspective of a specific group or category of individuals—what do "XYZs" think?
When you want to know if a problem or need is consistent from place to place and group to group—is it the same everywhere?	When you want to look at extremes to highlight the differences in factors that contribute to their

	differences—who are the best at this and why? Who are the least effective and why?
When the group is large, resources are tight, and you cannot gather data from everyone, but want ensure smaller numbers can represent the perspectives of the entire group—what small group can validly speak for everyone?	When you want to test a hypothesis about what might be happening—data suggest two factors may be related, who can best confirm this?

Tips:

- Ensure you have a realistic perspective on the number of individuals in each group and how likely it is that you will be able to engage with them
- If you have strongly opinioned groups, be sure that they are represented appropriately in proportion to their size—it is easy for small, opinioned groups to dominate the data if you are not careful

Be sure to consider gender, age, ethnicity, or other demographics of note when selecting samples so that disadvantaged groups or those less visible are appropriately included.

Data Collection Considerations

Purpose – to support broad thinking about the data collection process in order to ensure a balanced, valid, and reasonable approach is adopted for your needs analysis

Access – think about how you will reach the individuals you are trying to collect data from. Are they difficult to reach geographically, either because of distance or environmental or situational barriers? How much time are you likely to have with them to answer your questions? What could you do to increase their willingness to participate? Is there anyone who might want to block your access to these individuals? Are there legal, ethical or confidentiality issues that would keep them from talking with you?

Method – it is important to match the type of information you are seeking with a collection method that is suitable to the audiences involved, the geographic area, and your time and cost constraints

Method	Strengths	Weaknesses	Relative Cost	Relative Time
Questionnaires	• Consistent measures • Perceived anonymity encourages honesty • Ease of data analysis • Good validity when tested with target audiences	• Low response rates • Open-ended responses can be unclear • Logistics of distribution of paper versions across large areas can be a challenge • Use of online versions can be a challenge in low resource locations	↓ for large groups	↓ front loaded time investment in creation and piloting of instrument
In-Depth Interviews	• Allows depth through follow-up and probing • clear intent and interpretations • use of phone can limit travel	• open conversation responses can take time to analyze • lack of anonymity • investigator can influence • training investigators can take time	↑ when conducted in person	↑ front loaded time investment in creation and piloting of instrument
Focus Group Discussions	• feedback from larger groups with fewer resources • allows some depth and follow-up • can increase breadth of participation	• Reactions of group can impact responses • lack of anonymity • protocol must be consistently followed across sessions • some individuals can dominate	↓ if group members are co-located	↔ focus group protocol
Documentation/ Existing Data	• allows reliance on trusted resources • allows view across time • avoids issues with access and availability of populations	• available data may not be perfect fit to needs • missing or incomplete data may cause validity issues • data access may be limited or difficult	↓ if data is already in a form that is easily exported and used	↔ if data is not in readily usable, can take time

Tips:

- When there is little known about what may be influencing, it may be best to start with less structured data collection methods—such as interviews and focus groups. The information you gather from these methods can help you identify important barrier to good performance, and develop theories about how and why they exist.
- Ensure that gender issues are managed for each data collection method you propose. If women will speak more freely in focus groups that do not contain men, for example, plan to hold

separate groups. This is also true when considering groups that might mix levels or seniority and age.

Further reading:
How to Conduct Qualitative Formative Research

Data Collection Planning Worksheet

Purpose – to create a clear plan across all data sources and methods that will allow you to ensure balance, use resources wisely, and track progress

Investigative Question	**Sub-Question**	**Data Source(s)** (who or what)	**Sample** (which individuals or records)	**Method** (how)	**Administrator** (who will manage collection)	**Schedule** (by when)
Drawn from the Question Matrix	*Drawn from the Question Matrix*	*Who or what sources can help answer the question?*	*Within those data sources, which individuals or records will you choose?*	*How will you gather the data? questionnaire? survey? focus group? interview?*	*Who is responsible for managing data collection related to this question and gathering it for analysis?*	*What is the timeframe for gathering data?*

Tips:

- Be sure that those investigative questions identified as most important to your Steering Committee and stakeholders are given priority in any funding or time constraints
- Ensure that data from any given source is linked to all of the investigative questions it supports – for example, interviews with the supervisors of CHWs are likely to provide input on many different questions, and on questions that cover all four essential factors (expectations, ability, opportunity, and motivation)
- Be sure that the sample and method you choose will support your *Acceptable Evidence Worksheet* targets for each question—for example, if your acceptable evidence is based on a percentage of CHWs reporting, ensure you either reach that percentage of *all* CHWs or that you pull a representative same so you can generalize with confidence to the larger population
- If a needs analysis loses momentum, it is often in the data collection stage -- ensure Administrators of each data collection method have the resources needed to capture the data, and follow up with them on a regular basis to ensure they stay on schedule

Example Data Collection Planning Worksheet

Here is an excerpt from the Data Collection Planning Worksheet completed by Cecilia and her Steering Committee subgroup:

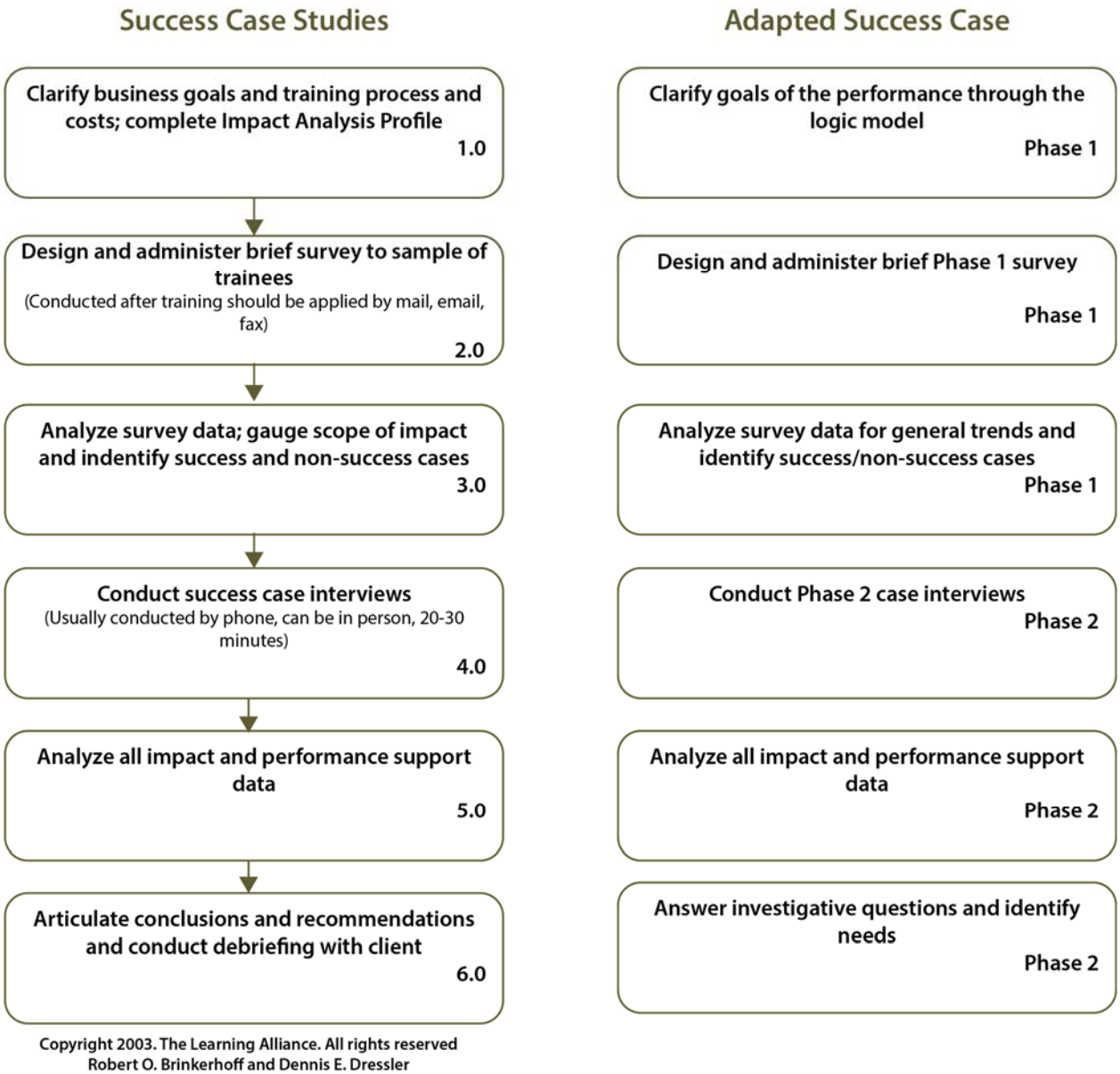
Investigative Question	Sub-Question	Data Source(s)	Sample	Method	Administrator	Schedule
Expectation Question: Are there clear and measurable performance standards?	Are VHWs aware of how their work is tracked and measured? Do they know their most recent measures? Are SCHWs familiar with metrics that track their work? Can they state their most recent results & trend?	VHWs & Supervisors Records of Metrics SCHWs & Supervisors Records of Metrics	Statistically representative sample of VHWs & Supervisors for generalization; Corresponding Records of Metrics Due to smaller numbers, sample all SCHWs, Supervisors; Records of Metrics	Questionnaire, Records Review; Documentation Worksheet Interview, Records Review; Documentation Worksheet	Regional public health official on Steering Committee will access all Records of Metrics Senior M&E Manager on Steering Committee will create Questionnaire and Interview Protocol, manage data collection by NGO project representatives	Records data gathered by Week 2 Questionnaire and Interview Protocol developed/piloted by Week 1; data collected by Week 3
Ability Question: What are the key gender relations related to skills and knowledge acquisition and maintenance?	Are there gender relations issues that affect delivery of VHW counseling services or SCHW clinical services? Do these issues impact the ability for these CHWs to provide services?	VHWs & Supervisors SCHWs & Supervisors Regional public health officials (trainers in particular)	Statistically representative sample of VHWs & Supervisors for generalization Census of SCHWs	Questionnaire Interview	Senior M&E Manager creates, NGO project representatives administer Senior M&E Manager creates, NGO project representatives administer	Questionnaire and Interview Protocol developed and pilots by Week 1; data collected by Week 3
Opportunity Question: Are sufficient resources regularly available?	Are the supplies and equipment needed to deliver services regularly available?	VHWs SCHWs Purchasing Manager of Regional Pharma Center	Representative sample of VHWs, Census of SCHWs All managers in regions under study	Questionnaire & Interview Records Review/ Documentation Worksheet	Senior M&E Manager creates, NGO project representatives administer Purchasing Manager of Regional Pharma Center will access data across all centers in region	Questionnaire and Interview Protocol developed/piloted by Week 1; data collected by Week 3 Records data gathered by Week 2

Motivation Question: Are there environmental or sociocultural influences that might impact performance?	Are there any negative consequences to VHWs or SCHWs for providing services?	VHWs SCHWs Local government officials Potential patients of CHWs	Representative sample of VHWs, Census of SCHWs One government official for each village in region Representative sample of patient population	Questionnaire & Interview Interview Interview	Senior M&E Manager creates, questionnaire and all interview protocols, NGO project representatives administer	Questionnaire and Interview Protocols developed/piloted by Week 1; data collected by Week 3

Adapted Success Case Overview

Purpose – to provide a general overview and best practices for conducting focus groups to collect data

Robert O. Brinkerhoff's Success Case Method was originally designed to provide relatively quick, low resource evaluation of training interventions. However, with some minor adaptations, it can be used as an effective framework for conducting needs analyses in low resource settings. Here is a brief comparison between the Success Case Method and the Adapted Success Case approach:



Adapted Success Case Data Collection Planning Worksheet

Purpose – to provide a general work plan for implementing the Adapted Success Case approach

Ideally, the Facilitator will lead the Steering Committee through the planning process during one of the initial meetings and ask for specific support and resources from each member.

Phase	Action	Resources	Administrator/Contributors	Schedule
Which phase	*Describe action to be taken*	*What time, tools, individuals, materials, etc. are needed and how will they be sourced?*	*Who is the owner of this action and which individuals will support?*	*When does this action begin and end?*

Tips:

- Working through this plan with members of the Steering Committee helps ensure that everyone contributes where they can, and creates a public accountability for promised actions by members
- When planning for data collection, consider any cultural issues around age, class, gender, or ethnicity and arrange interviewers, focus group composition, and method or timing to accommodate
- If there is time and available access, share the data collection plan with members of the target audiences to uncover issues or concerns you may not be aware of
- Remember to think about both sides of the data collection plan—both how you will reach and engage with the individuals you seek and how you will capture and consolidate the resulting data for analysis

Example Adapted Success Case Data Collection Planning Worksheet

Here is an excerpt of the plan that Cecilia and her Steering Committee members put together to drive their data collection process:

Phase	Action	Resources	Administrator/Contributors	Schedule
Phase 1	Identify Phase 1 participants – list all regional VHWs & SCHWs	Employee records of VHWs Employee records of SCHWs	Deputy Regional Minister of Public Health, Regional Clinic Directors	Week 1
	Develop communications about needs analysis and connect with stakeholders for distribution	Communications expertise Time on Task (LOE)	NGO Communications Specialist creates with input and approval from local government officials, religious leaders, and civic society organizations	Early Week 1
	Create Phase 1 Survey questions	Question Matrix Time on Task (LOE)	Senior M&E Manager for largest project in the region	Phase 1 survey created and piloted early Week 1
	Develop survey instruments and collect data	Regional public health ministry will print 65 VHW survey questionnaires (cost of print) The regional pharmacy center will manage distribution and collection from VHWs/supervisors leveraging regular distribution systems To reach SCHWs/supervisors, one of the major NGO projects will create the survey in Google Form since they have internet access and anonymity will be maintained	Facilitator (Cecilia) will coordinate efforts of: Deputy Regional Minister of Public Health Purchasing Manager of Regional Pharmacy Center Associate Director of NGO	Printed and distributed to VHWs/supervisors end Week 1 & collected end Week 2 Google Form created and invitation sent to SCHWs/supervisors end Week 1 with reminder end Week 2
	Consolidate and analyze data	Spreadsheet skills, Knowledge of statistics Time on Task (LOE)	Senior M&E Manager, Associate Director of NGO coordinate staff who consolidate & conduct analysis	Early Week 3
	Choose success and non-success cases for Phase 2	Measures of dispersion, Time on Task(LOE)	Senior M&E Manager	Late Week 3
Phase 2	Create Phase 2 Interview Protocol	Question Matrix, Time on Task (LOE)	Senior M&E Manager	Early Week 2

	Prepare interviewers and data capture tools	Interview protocol, data capture tools, training tools, Time on Task (LOE)	Facilitator (Cecilia) and Associate Director of NGO	Late Week 2 – early Week 3
	Conduct interviews	Interview skills, Time on Task (LOE)	NGO project representatives	Late Week 3 – Week 5
	Consolidate and analyze data	Spreadsheet skills, Knowledge of qualitative and quantitative analysis, Time on Task (LOE)	Senior M&E Manager, Associate Director of NGO coordinate staff who consolidate and conduct analysis	Week 6

Documentation Worksheet

Purpose – to help you effectively leverage existing documents as data sources

When working with existing documentation or records, remember that it's likely the data was gathered for a different purpose than the one you will use it for. In order to ensure you are capturing the data from the existing source in a useful way, you will actually need review the records or documentation to get the answers you are looking for. That is, pull just the answer to your question from each record and capture that answer in a central location along with data from all other records that were reviewed.

Sample when necessary. In the same way that you would sample a large group of human responders to limit cost, you may need to sample from large bodies of documentation too, rather than spend the time and resources to review every document available. The same sampling techniques and best practices apply.

Data capture. Records or documentation review needs as much time and attention as any other form of data collection in order to be effective. Here are the primary steps and considerations:

1. Develop and pilot a protocol—in order to gather the data you need from whatever format it is currently in, you will need to create a guide for reviewers on how to find what is needed. For example, if patient records are a source of data for your needs analysis, the person who will look at dozens—or hundreds!—of records needs clear direction on exactly what to look for, where to find it in each record, and how to capture what is found for later analysis.
2. Develop and pilot a capture instrument—because you want to gather the information across many documents or existing sources into a single location for analysis, you need to provide an instrument to capture it. Typically, document reviewers identify needed information from existing sources and note it on a computer spreadsheet. A well-constructed spreadsheet or capture document is essential to speed this work along. For example, if the data of interest is the variety of services delivered to patients as noted in patient records, creating a drop down list of all the possible services they may have received will allow a quick notation on the spreadsheet for each record reviewed before moving on to the next one.
3. Train reviewers—if at all possible, use actual examples of the documents to be reviewed when training your reviewers. Choose examples that illustrate the full range of document types or possible content. Show reviewers how you expect information to be captured for each type of data noted, and what to do if data is missing, incomplete, or does not fit the expected categories. Time individuals as they reach competency so you can estimate the total amount of time needed to review the sample or total number of available documents.

Tips:

- Document and records review is sometimes a tedious process, so be sure to encourage your data reviewers to take frequent breaks.
- If at all possible, capture the data in electronic format as it is easier to manage and analyze. Be sure to back up all files to ensure the work is not lost if a given piece of equipment breaks down.

Focus Group Worksheet

Purpose – to provide a general overview and best practices for conducting focus groups to collect data

A focus group session is typically held to allow deep discussion and data capture on a few topics by a fairly small group of individuals. Depending on the culture and skill of the facilitator, it is usually advisable to have between 8-12 individuals in a focus group discussion. When planning for your focus groups, be particularly conscious of the differences among participants and consider creating homogenous groups based on any important demographic attributes such as gender, age, political group, or religion. That will improve the comfort of your participants and allow for more open sharing and conversation.

The focus group facilitator plays a truly essential role in ensuring that everyone participates, that no one individual dominates, and that everyone remains on topic. This can be a challenge over the course of the hour or two that the discussion lasts, and so it's advisable to have a second individual taking notes so the facilitator can give total attention to the group. If it's possible and all participants agree, you can also audio tape the discussion—but be aware that this might lead some to be less forthcoming for fear of reprisals about statements they may make. In many countries, there are legal issues about recording, so be sure to check on any restrictions or requirements in your location.

Number and Composition of Groups	Protocol Topics	Facilitator	Data Capture
What are the key demographic distinctions to consider? How many individual groups will be needed to accommodate them?	*What issues or topics would you like the group to discuss? Will these be the same for all groups? or vary group by group?*	*Who will facilitate the discussion for each group? are they a good match to the demographics of their participants?*	*How will you capture data from the discussion for use in answering the investigative questions? What format does the data need to be in for analyses?*
Group 1	*Group 1 topics*	*Group 1 Facilitator*	*Group 1 Note Taker*
Group 2	*Group 2 topics*	*Group 2 Facilitator*	*Group 2 Note Taker*

Tips:

- Establishing "ground rules" at the start of the discussion is often helpful in creating group norms; if you say up front that you want to hear from everyone, it's easier to interrupt someone who is dominating the conversation by saying you want to ensure everyone's opinion is heard.
- If the groups goes off topic in a directly that is not informative to your investigative questions, continue to bring them gently back to topic by saying, "Can you help me understand how that impacts *(topic)*?" If they continue to drift off topic, assume they have exhausted that topic and move on to the next one
- It's a good idea to create a general protocol for the facilitator, listing the topics their specific group of participants is expected to discuss. If a second individual is capturing notes, be sure to share the protocol in advance so note taking is a bit easier. In most cases, notes will have to be reviewed and edited before submission for analysis—be sure both the note taker and the facilitator agree the data captures is a valid representation of the session before submitting.

Interview Worksheet

Purpose – to provide a general overview of best practices for conducting interviews to collect data

Interviews are often the most expensive method for collecting data, but they also allow the greatest flexibility for responses from people who are providing data to answer your investigative questions. The formality of an interview can vary widely, from a conversational interview which is a fully unstructured discussion, to a guided interview where topics are identified on a protocol but can be covered in any sequence with no standardized wording, to a formal, standardized open-ended interview where question wording and order are the same for all individuals. Here are key questions to ask yourself when planning for interviews as a data collection method:

Number of Interviews – how many individuals, from which sub-groups, will be interviewed? are you striving for representation (how common is an issue or opinion in the larger group) or striving for discovery (identify anything that might impact performance)?

Interview Protocol – how formal will the interview be? who will create the protocol? do you need the same questions answered by all individuals? or are some questions specific to some groups or demographic targets?

Interviewers – who will conduct the interviews? how will they be trained? how will they be matched to the key demographics of their interviewees? will the interview be conducted in person? on phone? via the internet?

Data Capture—how will notes be captured during the interview for the purposes of data analysis? Typically, there is not a separate note taker during a one-to-one interview, so who will create either the paper or electronic template to facilitate note capture?

Tips:

- Be sensitive to the genders, status, and ethnicity of both the interviewee and interviewer, and ensure they are paired as equally as possible on all relevant attributes.
- If cultural, gender, age, or ethnicity issues are anticipated, consider the less structured interview approaches as they are more likely to surface issues you cannot foresee from across boundaries.
- In general, the more structured the interview the less extensive the training needed for those conducting the interview.

Questionnaire Development Worksheet

Purpose – to provide a general overview and best practices for developing questionnaires to collect data

Questionnaires allow you to collect a lot of data across a large population relatively quickly and inexpensively. However, for the data to be useful, your respondents need to answer the exact question you are asking. Because it's essential that all instructions and questions are clear, it is absolutely essential that you pilot any instrument with members of the target population.

Guidelines for Questionnaire Development

- begin with the full number of topics you would like to explore with the targeted responders
- keep your respondents in mind at all times and write from *their* perspective not your own
- ensure each question is exploring only a *single* topic or issue
- consider using multiple questions for topics that are more complex or abstract—it's ok to break down questions into individual components to improve clarity
- ensure forced choice options are mutually exclusive
- avoid leading questions that hint at an acceptable response or otherwise influence responders
- mix up the question formats, if possible, to keep respondents engaged
- pilot both the questionnaire and its directions - ask a member of the respondent group to complete the questionnaire in a single sitting; then have them go through the questionnaire with you and describe, in their own words, what each question was asking and how they answered
- note how much time it takes for respondents to complete the questionnaire during the pilot and include that in the directions so respondents can plan accordingly

Tips:

- When piloting your instrument with a member of the target group, ask them to "think out loud" so you can understand what they believe each question is asking, and how they are forming their reply; note where you intent and the responder's intent do not match and adjust the question to fit the responder's perspective
- consider actively seeking instrument pilots based on sex, age groupings, class, or ethnicity where appropriate – to ensure the questions are sensitive to issues of importance to these groups and
- You can maximize space by covering more than one aspect of an issue on a single line with multiple scales:

	how often?	how useful?
Feedback from my supervisor	1 2 3 4	1 2 3 4

Appendix V

Adapted Success Case Phase 1 Survey Questionnaire

Purpose – to collect Phase 1 data for the Adapted Success Case approach

Phase 1 of the process consists of getting a general "pulse" of the experience CHWs in their daily work lives. It also helps you identify specific cases at both ends of the performance spectrum for further study. These cases will be samples from among top performers, on the high end of the scale, and challenged performers, those on the low end of the scale. It can also include randomly selected members of any specific subgroup that is of particular interest due to characteristics like geography, demographics, or professional attributes.

Key Information Needed	Draft Question
Quality	*Question should capture if workers feel they have the opportunity to give their best every day*
Expectation	*Question should measure knowledge of performance expectations*
Ability	*Question should measure skills and knowledge to perform the job*
Opportunity	*Question should measure barriers such as lack of resources or environmental challenges*
Motivation	*Question should measure intrinsic drivers to perform and resulting rewards or consequences*
Impact	*Question should measure perception of how their work makes a difference*

Tips:

- Keep the survey short – get the data you need in as few questions are possible.
- Use a response scale that will allow differentiation among performers. A simple yes-no will not get the level of detail you need to choose cases for Phase 2.
- Phrase the questions in a way that reduce concerns that respondents might have about their answers. For example, few people will say they aren't able to do their job. Instead of asking it outright, one strategy is to ask "how often" they face challenges that would keep them from doing their job.
- If there are key challenges that have already been identified, use one of the questions to determine how prevalent that challenge is across the population.
- Try and change the direction of the questions at least once, so that all responses perceived to be positive are not at the same end of the scale.

Example Phase 1 Survey Questionnaire

This is the Phase 1 Survey Questionnaire Cecilia and her Steering Committee created to capture data across all CHWs in their region. The same questions were used on the self-administered paper questionnaire for the VHWs and their supervisors and the online version for SCHWs and their supervisors. The data was used to identify top success and non-success cases for Phase 2.

Worker

Instructions: please read each question on the left and choose the response that best matches your experience as a community health worker on the right.

Draft Question	**Response**			
	Never	*Sometimes*	*Often*	*Always*
Given the variety of patients and issues you face, how often do you feel you know what is expected of you as a community health worker?				
How often do you feel you are able to do your best work?				
How often do you feel you lack some specific skills or knowledge to do your job well?				
How often do you encounter challenges that keep you from providing services to patients?				
How often do you feel fully motivated to provide services to patients?				
How often do you feel supported in your work?				
How often do you experience negative consequences for serving patients?				
How often do you feel your work is making a difference in the lives of your patients?				
Is there anything else you would like us to know about the challenges you face as a Community Health Worker?				
Would you be willing to discuss your work in greater detail with us during a 15 to 20 minute interview? If so, please provide your name and contact information and will follow up shortly.	*Name:* *Best way to contact you:*			

Supervisor

Instructions: please read each question on the left and choose the response that best matches your experience with direct reports on the right.

Draft Question	**Response**			
	Never	*Sometimes*	*Often*	*Always*
Given the variety of patients and issues your CHWs face, how often do you feel they know what is expected of them as a community health worker?				
How often do you feel they are able to do your best work?				
How often do you feel they lack some specific skills or knowledge to do their job well?				
How often do they encounter challenges that keep them from providing services to patients?				

How often do they feel fully motivated to provide services to patients?				
How often do they feel supported in your work?				
How often do they experience negative consequences for serving patients?				
How often do they feel their work is making a difference in the lives of patients?				
Is there anything else you would like us to know about the challenges you face as a Community Health Worker?				
Would you be willing to discuss the work of CHWs in greater detail with us during a 15 to 20 minute interview? If so, please provide your name and contact information and we will follow up shortly.	*Name:* *Best way to contact you:*			

Adapted Success Case Phase 2 Interview Protocol

Purpose – to structure the discussion you will have with success case and non-success case performers that will uncover areas of need. The Phase 2 Interview should probe more deeply on the issues factors addressed in Phase 1, and touch upon those items in the Question Matrix that do not come up naturally in the course of conversation.

Protocol

Introduction – *greet your interviewee, provide a high level description of why the interview is taking place, describe how the data will be used, reiterate promise of anonymity (where appropriate), and ask if there are any questions before getting started.*

Expectations - In the initial survey, you said you always (never) feel you know what is expected of you as a community health worker. Can you tell me more about this? What contributes to your feeling this way? *(Follow along with Expectations Questions in the Question Matrix, and include any that are not covered in the open discussion)*

Quality - You also said you always (never) feel as though you have the opportunity to give your best every day as a community health worker. Can you tell me more about this? What contributes to this feeling (gets in the way of your feeling) this way?

Ability – You indicated that there are (are not) specific skills or knowledge that you feel you need to do your job well. Can you tell me about how you conduct your work, and where the skills or knowledge are most needed (are not available) to perform well? *(Follow along with Ability Questions in the Question Matrix, and include any that are not covered in the open discussion)*

Opportunity – You said that you always (never) encounter challenges that keep you from providing services to patients. Can you tell me more about this? How do you avoid challenges (what kinds of challenges come up)? *(Follow along with Opportunity Questions in the Question Matrix, and include any that are not covered in the open discussion)*

Motivation – You indicated that you always (never) feel fully motivated to provide services, that you always (never) feel supported in your work, and that you always (never) experience negative consequences for serving patients. Can you tell me more about what contributes to these feelings? *(Follow along with Motivation Questions in the Question Matrix, and include any that are not covered in the open discussion)*

Tips:

- As with all data collection instruments, you must pilot with actual members of the target population to ensure validity. Consider actively seeking instrument pilots based on sex, age groupings, class, or ethnicity where appropriate – to ensure the questions are clear and are sensitive to issues of importance to these groups.

Ensure your interviewers have sufficient practice in advance of the actual interviews, and where possible try to minimize the effect of the interviewer by having each person trained capture data from both success and non-success cases.

Example Phase 2 Interview Protocol

VHW Phase 2 Interview Protocol

Directions to Interviewers ***– All text in italics contains directions for you—do not read italic text!***
Please read or paraphrase the Introduction text as you begin the interview. Then, for each section please read the ***main question*** *(in bold typeface) and use the sub-questions below to draw out information on any aspect that did not come up naturally during the initial response.*

Introduction

Hello and thank you for taking the time to talk with me today. As you may know, we are talking to community health workers across the region to find ways to support them in their work. A few weeks ago, you answered a short questionnaire and said you would be willing to discuss your work in greater detail. That is our purpose here today. Our conversation will be combined with those of others across the region, and analyzed to identify needs that we can try to address. Do you have any questions or concerns you'd like to raise before we begin?

Quality (5-7 minutes)

In the initial survey you said you always (never) feel as though you have the opportunity to give your best every day as a community health worker. Can you tell me more about this? What contributes to this feeling (gets in the way of your feeling) this way? *Capture the main issues the interviewee raises that support or hinder their work as a VHW. Prompt only for further understanding—this should be a list entirely generated by the VHW with no influence from your input.*

Expectations (3-5 minutes)

In the survey, you also indicated that you always (never) feel you know what is expected of you as a community health worker. Can you tell me more about this? What contributes to your feeling this way? *Ask the following optional questions as prompts, if the topics are not raised naturally in the discussion:*

- what services do you provide in the village?
- how is your work tracked and measured? what are your most recent measurements?
- how do you get feedback on the services you provide?
- what public health goals does your work strive to achieve?

Ability (3-5 minutes)

You indicated that there are (are not) specific skills or knowledge that you feel you need to do your job well. Can you tell me about how you conduct your work, and where the skills or knowledge are most needed (are not available) to perform well? *Ask the following optional questions as prompts, if the topics are not raised naturally in the discussion:*

- what happens during a typical family planning session?
- how were you initially trained?
- how do you maintain your skills and keep up with new knowledge?
- do you feel there are any specific challenges for women (men) to gain the needed skills and knowledge?

Opportunity (3-5 minutes)

You said that you always (never) encounter challenges that keep you from providing services to patients. Can you tell me more about this? How do you avoid challenges (what kinds of challenges come up)? *Ask the following optional questions as prompts, if the topics are not raised naturally in the discussion:*

- on average, how many people do you provide services for on a weekly or monthly basis? *(capture number of people, not number of couples)*
- is it easy for patients to reach you? or you them?
- what resources do you use to deliver services? are they regularly available?
- do people in the village who might benefit from your services understand what you provide?
- are there any other issues that make it difficult for you to provide services?

Motivation (3-5 minutes)

You indicated that you always (never) feel fully motivated to provide services, that you always (never) feel supported in your work, and that you always (never) experience negative consequences for serving patients. Can you tell me more about what contributes to these feelings? *Ask the following optional questions as prompts, if the topics are not raised naturally in the discussion:*

- why do you choose to do this work?
- are there rewards for providing good services as a VHW? what are the consequences for VHWs who are not doing well in their role?
- how has life changed for you since beginning this work?
- does your family support you in your role?
- does the community support you in your role? *(note how connected VHW feels to community in this answer)*
- are there groups or individuals who oppose your work?
- are there any gender issues that impact your motivation to do this work?

Provider Behavior Change Implementation Kit

Example SCHW Phase 2 Interview Protocol

Directions to Interviewers ***– All text in italics contains directions for you—do not read italic text!***
Please read or paraphrase the Introduction text as you begin the interview. Then, for each section please read the ***main question*** *(in bold typeface) and use the sub-questions below to draw out information on any aspect that did not come up naturally during the initial response.*

Introduction
Hello and thank you for taking the time to talk with me today. As you may know, we are talking to community health workers across the region to find ways to support them in their work. A few weeks ago, you answered a short questionnaire and said you would be willing to discuss your work in greater detail. That is our purpose here today. Our conversation will be combined with those of others across the region, and analyzed to identify needs that we can try to address. Do you have any questions or concerns you'd like to raise before we begin?

Quality (5-7 minutes)
In the initial survey you said you always (never) feel as though you have the opportunity to give your best every day as a community health worker. Can you tell me more about this? What contributes to this feeling (gets in the way of your feeling) this way? *Capture the main issues the interviewee raises that support or hinder their work as a SCHW. Prompt only for further understanding—this should be a list entirely generated by the SCHW with no influence from your input.*

Expectations (3-5 minutes)
In the survey, you also indicated that you always (never) feel you know what is expected of you as a community health worker. Can you tell me more about this? What contributes to your feeling this way? *Ask the following optional questions as prompts, if the topics are not raised naturally in the discussion:*

- what services do you provide in the clinic?
- how is your work overseen or supervised?
- how is your work tracked and measured? what are your most recent metrics?
- how do you get feedback on the services you provide?
- what public health goals does your work strive to achieve?

Ability (3-5 minutes)
You indicated that there are (are not) specific skills or knowledge that you feel you need to do your job well. Can you tell me about how you conduct your work, and where the skills or knowledge are most needed (are not available) to perform well? *Ask the following optional questions as prompts, if the topics are not raised naturally in the discussion:*

- what happens during a typical clinical session?
- how were you initially trained?
- how do you maintain your skills and keep up with new knowledge?
- do you feel there are any specific challenges for women (men) to gain the needed skills and knowledge?

Opportunity (3-5 minutes)

You said that you always (never) encounter challenges that keep you from providing services to patients. Can you tell me more about this? How do you avoid challenges (what kinds of challenges come up)? *Ask the following optional questions as prompts, if the topics are not raised naturally in the discussion:*

- on average, how many people do you provide services for on a weekly or monthly basis? *(capture number of people, not number of couples)*
- do patients have any difficulty getting to the clinic?
- what resources do you use to deliver services? are they regularly available?
- do people in the area understand what kind of service you provide at the clinic?
- are there any other issues that make it difficult for you to provide services?

Motivation (3-5 minutes)

You indicated that you always (never) feel fully motivated to provide services, that you always (never) feel supported in your work, and that you always (never) experience negative consequences for serving patients. Can you tell me more about what contributes to these feelings? *Ask the following optional questions as prompts, if the topics are not raised naturally in the discussion:*

- why do you choose to do this work?
- are there rewards for providing good services as a SCHW? what are the consequences for SCHWs who are not doing well in their role?
- how has life changed for you since beginning this work?
- does your family support you in your role?
- does the community support you in your role? *(note how connected VHW feels to community in this answer)*
- are there groups or individuals who oppose your work?
- are there any gender issues that impact your motivation to do this work?

Appendix Z

Data Collection Tracking Tool

Purpose – to help you manage the process of data collection, particularly if the effort is large or complex

The methods are known, the instruments are tested, and the individuals who will actually capture the data are ready to get going. How best to keep track of who is collecting what data, by when, and know that the work has been completed? Each Administrator should create a version of this Tracking Tool and share it regularly with the Facilitator, who can combine and track from the overall project perspective.

Method (how)	**Data Source(s)** (who or what)	**Sample** (which individuals or records)	**Collector**	**Schedule** (by when)	**Submitted** (complete)	**Prepared** (in format needed for analysis)	**Validated** (reviewed/approved)
How is the data being collected?	*Who or what is the source of the data?*	*What portion of the target group will you engage?*	*Who will be doing the actual data collection work (if self-administered questionnaires, list the person who creates them online or prints and distributes them physically)*	*Start and end dates*	*Yes/no and give date*	*What format is it submitted in?*	*Who will check final submission for errors?*

Appendix AA

Example Data Collection Tracking Tool

Purpose – to help you manage the process of data collection, particularly if the effort is large or complex

The methods are known, the instruments are tested, and the individuals who will actually capture the data are ready to get going. How best to keep track of who is collecting what data, by when, and know that the work has been completed? Each Administrator should create a version of this Tracking Tool and share it regularly with the Facilitator, who can combine and track from the overall project perspective. Below is a sample from Cecilia's overall Tracking Tool, with content from one Administrator, the Regional Public Health official, included.

Method	Data Source(s)	Sample	Collector	Schedule	Submitted	Prepared	Validated
Records Review	VHW Records of Metrics	Representative sample	Regional Public Health Official	Begin Week 1 Finished Week 2	Yes, Feb 24th	Yes – spreadsheet capture of data found on records	Cecilia
Records Review	SCHW Records of Metrics	Census	Regional Public Health Official	Begin Week 1 Finished Week 2	Yes, Mar 3	Yes – spreadsheet capture of data found on records	Cecilia

Adapted Success Case Phase 2 Case Selection Worksheet

Purpose – to provide guidance on selection of success case and non-success case performers to include in the Phase 2 data collection

The easiest way to identify cases for Phase 2 is to use the spreadsheet housing the Phase 1 data and conduct a few simple analyses:

1. For each individual case, or row on the spreadsheet, calculate the arithmetic average, or mean, of their responses across all questions using a formula and place the mean in the far right column.
2. Next, sort that new column so that the highest and lowest means are at the top and bottom rows of data.
3. Look for an obvious "cut off" line to separate highest and lowest groups from the bulk of the other cases. You may see a natural break in the continuum of means, or you can simply choose a large enough number on either end to reach the 8 to 10 individuals needed to kick off Phase 2 interviews.

Example. Your spreadsheet might look similar to the one below. Individual cases are placed in rows, with their numeric answers to each question placed in Columns B through G. If you are using a four-point scale, just change the words of the scale to numbers (1=never, 2=sometimes, 3=often, 4=always). The formula for mean in this case would be 2B+2C+2D+2E+2F+2G/6 and you would put that formula into the cell 2H and copy and paste it to all spreadsheet rows.

	A	B	C	D	E	F	G	H
1	Individual Case	Response to Q1	Response to Q2	Response to Q3	Response to Q4	Response to Q5	Response to Q6	Mean
2	*name or other identifier*	#	#	#	#	#	#	x̄
3								
4								

If you have important demographic factors you wish to consider, like gender, you can include them as their own column in the spreadsheet and sort by them first. Then sort within each group for highest and lowest means to represent success and non-success cases within that group. In the example below, sort by Column B and then highlight just the cases within each gender group and sort by Column I.

	A	B	C	D	E	F	G	H	I
1	Individual Case	Gender	Response to Q1	Response to Q2	Response to Q3	Response to Q4	Response to Q5	Response to Q6	Mean
2	*name or other identifier*		#	#	#	#	#	#	x̄
3									
4									

Example Adapted Success Case Phase 2 Case Selection Worksheet

Here is an excerpt from the spreadsheet used by Cecilia to identify cases for Phase 2 data collection. Their spreadsheet included a column for gender and role because they wanted to be able to examine data and select cases based on these categories in order to ensure these perspectives were captured. They pulled the data for these columns based on content originally provided from the employee records the Regional Public Health Official supplied to identify the Phase 1 participants.

Individual Case	Gender	Role	Response to Q1	Response to Q2	Response to Q3	Response to Q4	Response to Q5	Response to Q6	Mean
subject 100	F	SCHW	3	4	3	4	4	3	3.50
subject 101	M	VHW	2	4	1	3	4	4	3.00
subject 102	M	VHW	3	2	2	4	2	4	2.83
subject 103	F	VHW	3	3	1	3	1	2	2.17
subject 104	F	VHW	2	1	3	2	1	2	1.83
subject 105	F	VHW	3	2	4	1	3	3	2.67
subject 106	M	SCHW	3	2	3	2	4	3	2.83
subject 107	F	VHW	2	2	1	3	4	2	2.33
subject 108	M	VHW	4	2	2	4	2	4	3.00
subject 109	F	VHW	4	3	4	4	2	4	3.50
subject 110	F	VHW	2	4	3	2	4	4	3.17
subject 111	F	VHW	1	3	4	4	4	4	3.33
subject 112	F	SCHW	3	3	1	3	3	1	2.33
subject 113	F	VHW	1	3	3	3	3	4	2.83
subject 114	M	VHW	4	4	4	2	3	4	3.50
subject 115	F	VHW	2	2	2	3	3	2	2.33
subject 116	F	VHW	4	3	4	4	2	4	3.50
subject 117	M	VHW	3	4	1	3	1	2	2.33
subject 118	F	VHW	2	4	4	2	4	2	3.00
subject 119	F	VHW	4	3	4	4	3	4	3.67
subject 120	F	VHW	1	2	4	2	3	1	2.17
subject 121	F	VHW	4	4	1	3	4	4	3.33

Because she and her Steering Committee were particularly concerned about gender differences, they sorted by first by gender, then by role, and finally they chose the highest and lowest means from each of the resulting groups to be success and non-success cases:

Individual Case	Gender	Role	Response to Q1	Response to Q2	Response to Q3	Response to Q4	Response to Q5	Response to Q6	Mean
subject 100	F	SCHW	3	4	3	4	4	3	3.50
subject 112	F	SCHW	3	3	1	3	3	1	2.33
subject 119	F	VHW	4	3	4	4	3	4	3.67
subject 109	F	VHW	4	3	4	4	2	4	3.50
subject 116	F	VHW	4	3	4	4	2	4	3.50
subject 111	F	VHW	1	3	4	4	4	4	3.33
subject 121	F	VHW	4	4	1	3	4	4	3.33
subject 110	F	VHW	2	4	3	2	4	4	3.17
subject 118	F	VHW	2	4	4	2	4	2	3.00
subject 113	F	VHW	1	3	3	3	3	4	2.83
subject 105	F	VHW	3	2	4	1	3	3	2.67
subject 107	F	VHW	2	2	1	3	4	2	2.33
subject 115	F	VHW	2	2	2	3	3	2	2.33
subject 103	F	VHW	3	3	1	3	1	2	2.17
subject 120	F	VHW	1	2	4	2	3	1	2.17
subject 104	F	VHW	2	1	3	2	1	2	1.83
subject 106	M	SCHW	3	2	3	2	4	3	2.83
subject 114	M	VHW	4	4	4	2	3	4	3.50
subject 101	M	VHW	2	4	1	3	4	4	3.00
subject 108	M	VHW	4	2	2	4	2	4	3.00
subject 102	M	VHW	3	2	2	4	2	4	2.83
subject 117	M	VHW	3	4	1	3	1	2	2.33

Success cases for female VHWs are subjects 119, 109, and 116. Success cases for male VHWs are subjects 114 and 101.
Non-success cases for female VHWs are subjects 104, 120, and 103. Non-success cases for male VHWs are subjects 117 and 102.

Phase 2 Interview Data Capture Tool

Purpose – for ease of recording important data that result from Phase 2 interviews

Because interviewers need to attend fully to the conversation, it's best to provide them with a simple tool for use in capturing the data from their discussion. The easiest approach is to create a table with questions and a space for responses to each. Encourage interviewers to capture key phrases rather than try to take verbatim notes—even if they are doing so on a computer. This makes it easier to synthesize data when it is combined. If you are using printed capture tools, provide more space for notes than you would on the electronic version, which will expand the cell as needed while the interviewer types.

The basic capture tool could be structured in the format below, which is just a fragment of a full interview tool:

Question	Responses and notes
Quality (5-7 minutes) **In the initial survey you said you always (never) feel as though you have the opportunity to give your best every day as a community health worker. Can you tell me more about this? What contributes to this feeling (gets in the way of your feeling) this way?**	
Expectations (3-5 minutes) **In the survey, you also indicated that you always (never) feel you know what is expected of you as a community health worker. Can you tell me more about this? What contributes to your feeling this way?**	
what services do you provide in the village?	
how is your work tracked and measured? what are your most recent measurements?	
how do you get feedback on the services you provide?	
what public health goals does your work strive to achieve?	

Example Phase 2 Interview Data Capture Tool

This is the Phase 2 Interview Data Capture Tool used by Cecilia and her trained interviewers to capture data while they were conducting interviews with success and non-success case subjects.

Instructions: All questions in **bold** should be asked directly, and regular typeface follow-on questions included as appropriate. Capture the key ideas and issues raised in subject responses in the space to the left of the appropriate question. You may add observations of your own by notating with your initials and parenthesis, like this-- (*AB: this is a personal note)*

Question	Responses and notes
Quality (5-7 minutes) **In the initial survey you said you always (never) feel as though you have the opportunity to give your best every day as a community health worker. Can you tell me more about this? What contributes to this feeling (gets in the way of your feeling) this way?**	I look forward to coming to work each day. The couples I counsel have better lives and so do their children.
Expectations (3-5 minutes) **In the survey, you also indicated that you always (never) feel you know what is expected of you as a community health worker. Can you tell me more about this? What contributes to your feeling this way?** • What services do you provide in the village? • How is your work tracked and measured? What are your most recent measurements? • How do you get feedback on the services you provide? • What public health goals does your work strive to achieve?	Sometimes patients don't know what their options are, and it is my job to present the options and let them decide what works best for them. The goal is to reduce unplanned pregnancies, and we track this by patient feedback on follow-up visits. This past year we had 15 fewer unplanned pregnancies in the village. *(GS: very proud of the good results)*
Ability (3-5 minutes) **In your responses to the survey, you indicated that you always (never) lack the skills or knowledge to do your job well. Can you tell me what training you have (have not) received?** • Can you describe the major components of a family planning counseling session for me? • How are your skills and abilities kept current? Do you have regular	During a family planning session, I begin by getting basic health information and then ask about the patients' thoughts on the size of family they would like. I then present the options for controlling fertility and give them time to consider which would be best for them. We are given 4 days of annual training to learn what is new and to review what is already known.

refresher training? Are your skills measured or tracked?	
Opportunity (3-5 minutes) **You also said that you always (never) encounter challenges that keep you from providing services to patients. Can you tell me about these challenges?** • Are the nature of these challenges personal? professional? both? • In what ways have you tried to overcome these challenges? • Does this tie in with how supported you feel (do not feel) in your work?	Some patients are concerned that the methods used to postpone pregnancy will be permanent and they will not be able to have children at a later time. I tell them about the many couples I have worked with who later have healthy babies and gives them confidence.
Motivation (3-5 minutes) **On the survey you indicated that you always (never) feel motivated to provide services to patients. Can you tell me why that is, or what influences your motivation?** • What are the social or environmental influences that impact your work? o are you proud of what you do? o does the community value your work? do they support it? • Are there any negative consequences for providing services? From your family? Your peers? The community? o do you feel you are treated differently in the community because of your work?	Some people in our village do not feel that controlling fertility is right—that God makes the decision to give the gift of a baby and we interfere with this. I am not worried about these people, because I can see the difference in the lives of the couples I help. They have good jobs and enough money to feed their children and send them to school. For some women too many children is a health risk—and I see them live longer, healthier lives by limiting the size of their family. My family is supportive, and my patients are grateful for the work I do. It's enough to overlook those who do not agree.
Are there any gender related issues that impact your ability, opportunity, or motivation to do work?	For some couples, it is difficult to bring the husband to the clinic. The wife may be willing but the husband resists. Men are worried about seeing a woman to talk about such topics. But once they understand the benefits they are

	usually willing to come. Sometimes a woman will come alone. *(GS: seems unwilling to talk more about the women who come alone).*
Closing (2-3 minutes) **Are there any other issues or aspects of your work that you feel make a big contribution to your success (lack of success) on the job?**	My supervisor is very supportive and listens when I talk to him about special cases or challenges. We have good levels of supply, and that makes everything work well.

Needs Summary Table

Purpose – to help you summarize identified needs by category, and not their relationships to one another (if any)

Essential Factor	Identified Needs	Need Interactions
Expectation	*Needs uncovered related to issues of ability*	*Note if any need has a relationship to others in the table—either direct (it appears or increases when another need is present) or indirect (it is absent or decreases when another need is present)*
Ability	*Needs uncovered related to issues of ability*	
Opportunity	*Needs uncovered related to issues of opportunity*	
Motivation	*Needs uncovered related to issues of motivation*	
Other		
Needs uncovered that are not related to the investigative questions, or that are beyond the CHW needs scope but have an impact on their work		

Example Needs Summary Table

Purpose – to help you summarize identified needs by category, and not their relationships to one another (if any)

Essential Factor	Identified Needs	Need Interactions
Expectation	Gap exists between what supervisors believe is expected of CHWs and what the CHWs believe they are expected to do	Possible link to motivation issue around self-efficacy
	Supervisors of CHWs expect a very large number of patients to be seen each week, and logistics make it very difficult for each CHW to carry that level of patient load	
Ability	CHWs are not aware of new contraceptive alternatives that are available—they continue to describe and promote established methods	
Opportunity	In some communities, patients do not want the CHW to come to their home for consultation because of the social stigma	
	Lack of supplies hinders the ability of CHWs to provide the full variety of contraceptives to patients	
Motivation	CHWs are demotivated by perceived lack of self-efficacy in the job	Possible link to expectation differences—they may not feel effective in the role if they believe they are doing what is expected but are measured on something different
Other		
Drought is making local water sources less reliable	No immediate need but could affect personal hygiene if the drought continues or intensifies	

Prioritization Matrix and Action Tracker

Purpose – to help you build upon the *Needs Summary Table* by setting priorities as a group and identifying those who will be held accountable for addressing the needs

Essential Factor	Identified Needs	Need Interactions	Priority	Action Owner and Review Date
Expectation	*Needs uncovered related to setting of expectations*	*Note if any need has a relationship to others in the table—either direct (it appears or increases when another need is present) or indirect (it is absent or decreases when another need is present)*	*Rank order those needs considered top priorities*	*Identify a Steering Committee owner for addressing each prioritized need and a date by which the Committee will be updated on progress*
Ability	*Needs uncovered related to issues of ability*			
Opportunity	*Needs uncovered related to issues of opportunity*			
Motivation	*Needs uncovered related to issues of motivation*			
Other				
Needs uncovered that are not related to the investigative questions, or that are beyond the CHW needs scope but have an impact on their work				

Example Prioritization Matrix and Action Tracker

Purpose – to help you build upon the *Needs Summary Table* by setting priorities as a group and identifying those who will be held accountable for addressing the needs

Essential Factor	Identified Needs	Need Interactions	Priority	Action Owner and Review Date
Expectation	Gap exists between what supervisors believe is expected of CHWs and what the CHWs believe they are expected to do	Possible link to motivation issue around self-efficacy	1	
	Supervisors of CHWs expect a very large number of patients to be seen each week, and logistics make it very difficult for each CHW to carry that level of patient load		3	
Ability	CHWs are not aware of new contraceptive alternatives that are available—they continue to describe and promote established methods		2	
Opportunity	In some communities, patients do not want the CHW to come to their home for consultation because of the social stigma		5	
	Lack of supplies hinders the ability of CHWs to provide the full variety of contraceptives to patients		4	
Motivation	CHWs are demotivated by perceived lack of self-efficacy in the job	Possible link to expectation differences—they may not feel effective in the role if they believe they are doing what is expected but are measured on something different	1 (related)	
Other				
Drought is making local water sources less reliable	No immediate need but could affect personal hygiene if the drought continues or intensifies	Possible hygiene issues for population if drought becomes severe.		

Social and Behavior Change Communication Strategy Worksheet

Purpose – The purpose of this template is to compile all the information from each step to create an overarching communication strategy for provider behavior change.

Directions – As you complete each step, fill out the relevant section of this template. Once you have finished filling out Step 9, this template will contain all the information you need to write your provider behavior change SBCC strategy.

1. Problem Statement, Shared Vision, Problem Scope, Affected Population, Context, Provider Barriers and Needs, Motivational Barriers, Communication Landscape and Other Efforts
2. Core Problem
3. Primary Audience, Influencing Audiences, Audience Segments, Primary Audience Profile and Influencing Audience Profile
4. Communication Objectives
5. Key Promise and Supporting Points
6. Communication Approach and Communication Channels
7. Ideas for Adaptation
8. Partner Roles, Activities and Budget
9. Monitoring and Evaluation Indicators

Step 1

Problem Statement
What is the provider behavioral problem you need to address?

Shared Vision
What is your vision for provider behavior and service provision? What will the future look like thanks to your SBCC intervention?

Problem Scope
How big or widespread is the problem? How severe is it and what are its causes?

Affected Population
Who is affected by the problem (provider types, values, demographics, psychographics, location, motivations and education level)?

Context
What is the broad context in which the problem exists (policy, environment and social)?

Provider Barriers and Needs
What inhibits and facilitates provider behavior change (in each category)?
Expectation

Ability

Opportunity

Motivation

Motivational Barriers
What specific motivational factors (social norms, status, lack of rewards or lack of recognition, etc.) are barriers to provider behavior change and quality service provision?

Communication Landscape
What communication channels are available? What are the preferred sources of information and channels? Who uses which channels?

Other Efforts
What are other programs doing to address the identified problem? How do you plan to work with them to reach the shared vision?

Step 2

Core Problem
What is the core problem your intervention needs to address?

Step 3

Primary Audience
Who is the broad primary audience for your intervention? Whose behavior needs to change?

Influencing Audiences
Who are the key influencing audiences for your intervention? Who influences your primary audience?

Audience Segments
What audience segments will your intervention focus on?

Primary Audience Profile(s)
What is your primary audience segment like (demographics, psychographics, geographic location and behaviors)?

Influencing Audience Profile(s)
What is your influencing audience segment like (demographics, psychographics, geographic location and behaviors)?

Step 4

Communication Objectives
What objectives do you hope your SBCC intervention will achieve? What change do you desire, how much, and by when?

Step 5

Key Promise and Support Points
What promise are you offering each audience if it makes the desired behavior change? What evidence do you have to back up that promise?

Step 6

Communication Approach
What communication approach(es) will you use to achieve your objectives?

Communication Channels
What specific communication channels will you use for which audience segments? Which channel will be your primary channel and which are supporting?

Step 7

Ideas for Adaptation
How could you adapt or use the ideas and project examples presented?

Step 8

Partner Roles
What role will each partner play in implementing the SBCC intervention?

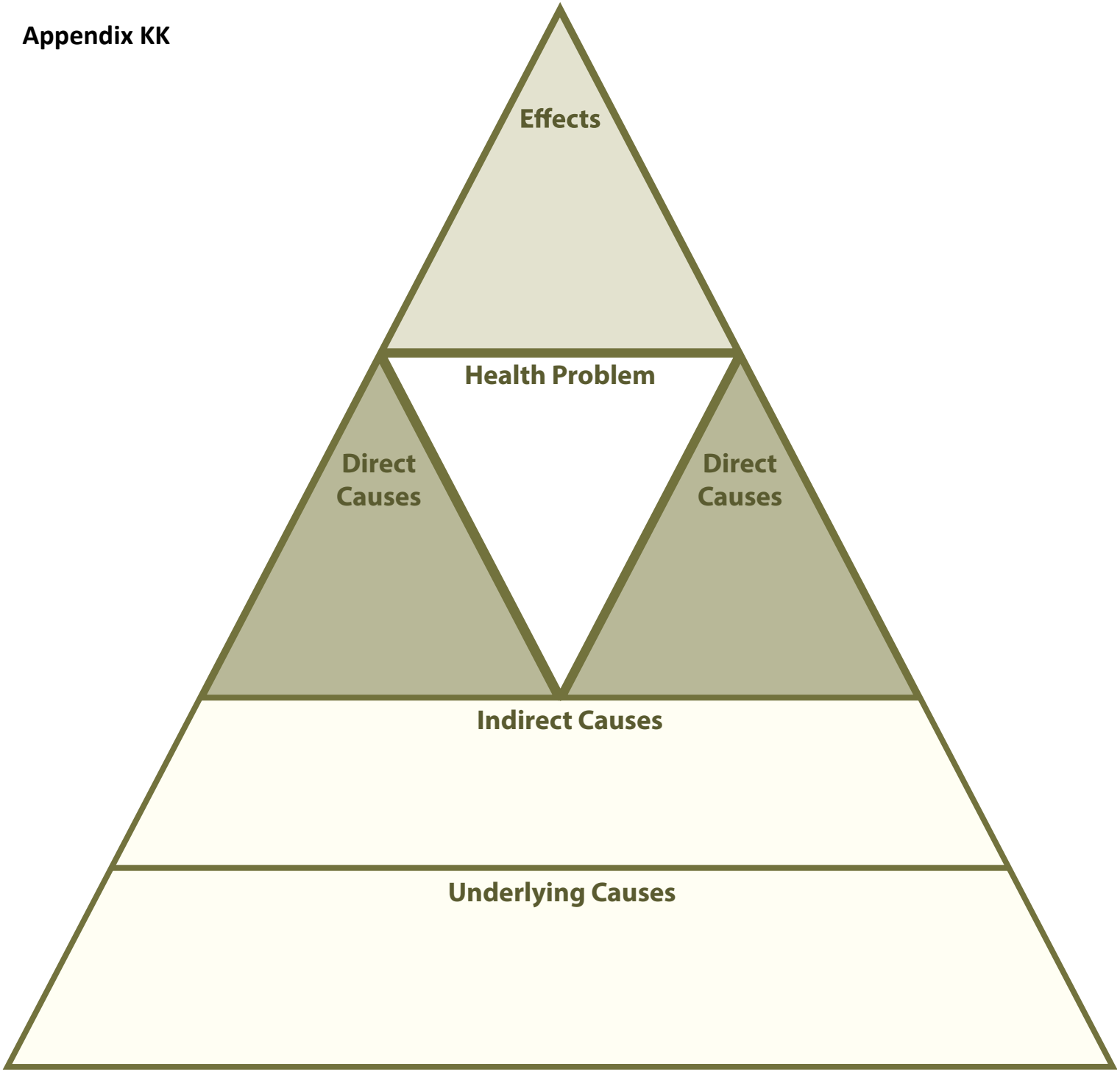
Activities
What activities will you and your partners carry out to achieve your objectives, based on the selected approach and channels? What is the timeline for activities?

Budget
What is your budget for your intervention? (This is best done in a spreadsheet but can be summarized here.)

Step 9

M&E Indicators
What indicators will you use to measure success, including process, output, outcome and impact indicators?

Appendix KK


Effects
Health Problem
Direct Causes
Direct Causes
Indirect Causes
Underlying Causes

Segmentation Table

Potential Audiences	Potential Primary Audiences	Potential Influencing Audiences
Demographic Characteristics Age, gender, years of training and years as CHW		
Geographic Characteristics Region, urban or rural, and area of conflict		
Socio-Cultural Characteristics Language, culture, place in society, religion and ethnicity		
Behavioral Characteristics Behaviors that affect or impact the challenge		
Psychographic Characteristics Personality, values, attitudes, interests, lifestyle and reasons for wanting to be a CHW		
Ideational Characteristics May include knowledge, beliefs and attitudes about CHW work, expectations and attitudes about clients served, perceived risk, self-efficacy, social support and influence, environmental supports and constraints, emotions, norms and self-image		

Final Communication Objectives Table

Audience Segment	Desired Change	How Much Change	Barriers to Change	Timeframe
Example: CHWs working 1-5 years (working in peri-urban areas) serving FP clients with high client loads	*Example: To increase the number of FP referrals made to the health clinic*			

Key Approach Table

Key Approach:	Intended Audience	Communication Objective
Criteria	**Meets this Criteria (Y/N)**	
1. Matches the identified motivational barrier		
2. Is appropriate for the level of complexity of the barrier		
3. Is appropriate for the level of sensitivity of the barrier		
4. Matches audience literacy level		
5. Meets reach requirements for Audience		
6. Is within program budget		
7. Is an acceptable approach to the intended audience		
8. Technology and innovation level is appropriate		

Appendix OO: Other Resources

The following is a collection of recent tools, resources, articles and literature you may consider as you design provider behavior change interventions to address *Expectation, Ability* and/or *Opportunity* barriers. Often, these challenges cannot be addressed solely through SBCC. However, using SBCC to complement the interventions can help make them more successful.

For example, a program that seeks to address *Ability*-related gaps through trainings providers in HIV counseling skills could develop complementary SBCC activities to build demand for HIV counseling and testing.

SBCC could complement *Expectation*-related challenges where FBPs do not understand quality standards or what is expected of them through community mobilization.

Opportunity-related challenges could be complemented by community advocacy to enable resources and health system support for improved CHW integration into the health system.

	Toolkits/Guidance Documents	Key Background Literature
Expectation	1. UNICEF—Community Based Infant and Young Child Feeding, 2010. Support Supervision Module 2. IPC Toolkit, PSI, Implementation module: Quality Assurance Chapter and Cost Effectiveness Chapter 3. PSI Provider Behavior Change Toolkit: Support Supervision Tools and Coaching Basics Handbook	
Ability	1. Developing and Strengthening Community Health Worker Programs at Scale: A Reference Guide for Program Managers and Policy Makers, MCHIP, 2013 2. IPC Toolkit, PSI, Implementation module 3. Social and Behavior Change Communication for Frontline Health Workers, C-Change, 2012 4. The Balance Counseling Strategy: A Toolkit for Family Planning Providers, Population Council 5. Provider Behavior Change Communication Toolkit. PSI, 2012: Guidelines for identifying provider needs and creating value propositions (communications and materials development) and Objection handling guidance (communication and materials development) 6. Supporting Orphans and other Vulnerable Children Through Communication and Basic	1. Meeting the Health Information Needs of Health Workers: What have we learned? M. D'Adamo, et al. Journal of Health Communication: International Perspectives, 17:sup2, 23-29

	Toolkits/Guidance Documents	Key Background Literature
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