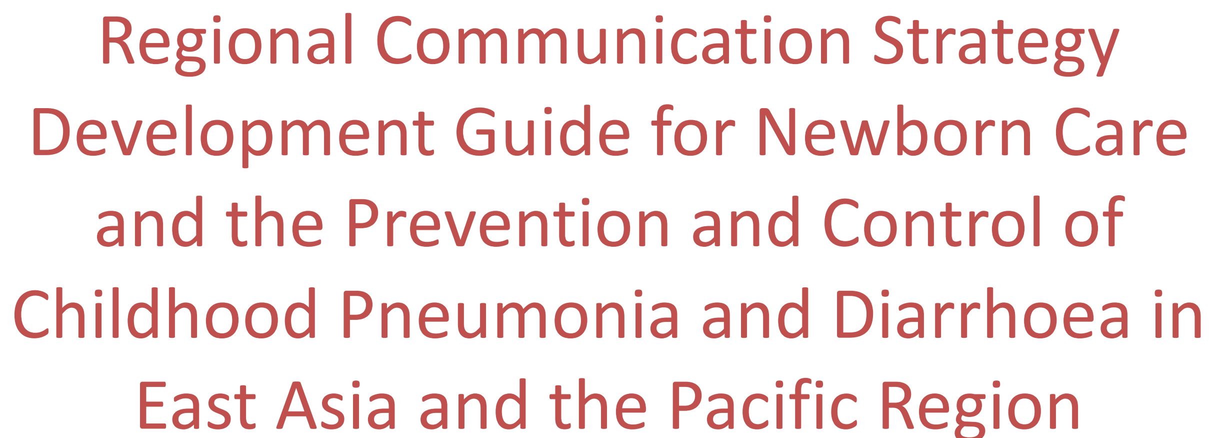
Module 1 Unit 3

This is a **REQUIRED READING: SITUATION ANALYSIS**

UNICEF. 2013. Regional Communication Strategy Development Guide for Newborn Care and the Prevention and Control of Childhood Pneumonia and Diarrhoea in East Asia and the Pacific Region. Pp. 29-36 and 74-75.



Regional Communication Strategy Development Guide for Newborn Care and the Prevention and Control of Childhood Pneumonia and Diarrhoea in East Asia and the Pacific Region

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March 29, 2013

A Guide Commissioned by UNICEF/NYHQ

Acronyms

BCC	Behavior Change Communication
C4D	Communication for Development
CFC	Communication for change
DHS	Demographic and Health Survey
EAPRO	East Asia and the Pacific Regional Office
EU	European Union
HMIS	Health Management Information System
IMCI	Integrated Management of Childhood Illness
IPC	Interpersonal Communication
INGO	International Non-Governmental Organization
MICS	Multiple Indicator Cluster Survey
MNCH	Maternal, Neonatal, and Child Health
MOH	Ministry of Health
MoRES	Monitoring Results for Equity System
NGO	Non-governmental Organization
RM&E	Research, Monitoring & Evaluation
SWOT	Strengths, Weaknesses, Opportunities, and Threats
WASH	Water, Sanitation, and Hygiene
UNICEF	United Nations Children’s Fund (formerly United Nations International Children’s Emergency Fund)

Glossary of Terms

ADVOCACY

Advocacy is an organized effort to inform and motivate leadership to create an enabling environment for achieving program objectives and development goals. The purpose for advocacy is (1) to change governmental or organizational laws, policies or rules, (2) to redefine public perceptions, social norms and procedures, (3) to support protocols that benefit specific populations[1] affected by existing legislation, norms and procedures, and/or (4) to influence funding decisions for specific initiatives. Advocacy includes motivating different levels of decision makers (e.g. politicians, policymakers) to publically discuss important issues, defend new ideas or policies, and commit resources to action. The advocacy process requires continuous efforts to translate relevant information into cogent arguments or justifications and to communicate the arguments in an appropriate manner to decision makers.

BEHAVIOR CHANGE COMMUNICATION

Behavior change communication (BCC) is commonly defined as a research-based interactive process to develop tailored messages and approaches, using a variety of population-appropriate communication channels to motivate sustained individual- and community- level changes in knowledge, attitudes, and behaviors. The process involves using formative research to understand current levels of knowledge, attitudes, and behaviors among individuals in order to develop communication programs that move individuals along a continuum of change (or through stages of change) toward the desired positive behavior(s). Various population-appropriate communication channels are used to provide populations with relevant information to motivate them to change, including interpersonal, group and mass/social media channels and participatory methods.

COMMUNICATION FOR DEVELOPMENT (C4D)

Communication for development (C4D) is a systematic, evidence-based, and strategic process to promote positive and measurable change at the individual, family, community, social and policy levels of a society. C4D aims to promote dialogue within communities and with decision-makers at local, national, and regional levels for the purpose of promoting, developing, and implementing policies and programs that drive positive and healthy behavior and social change. The approaches that make up the C4D strategy are: (1) Behavior change communication (BCC); (2) social change communication; (3) social mobilization, and (4) advocacy.

COMMUNITY MOBILIZATION

Community mobilization (CM) brings together community members, leaders and institutions at various levels to work together to identify and solve problems. CM is a process for facilitating collective action through a participatory process. CM helps communities collectively identify prioritize problems and decide on courses of action to address the problems. Communication

[1] Note that the use of the words "population(s)" and "participant group(s)" are used interchangeably throughout this document and refer to groups of individuals that are identified for, and involved in, a specific behavior and social change program.

practitioners usually act as catalysts in this process, providing new information as appropriate and establishing or facilitating forums for discussion. The aim is for communities to develop community-owned action plans and sustainable solutions to the identified problems.

SOCIAL CHANGE COMMUNICATION

Social change communication (also called communication for social change) is a purposeful and iterative process of public and private dialogue that allows groups of individuals or communities to define their needs and collaborate to transform the way their social system is organized, including the way power is distributed within social and political institutions. This process is intended to be participatory and provide space for exercising human rights. Dialogue is meant to contribute to behavior change on a large scale, to eliminate harmful cultural practices, and change societal norms and structural inequalities. Behavior change communication (including interpersonal, mass media, information communication technologies) is used to effect change, and are often combined with advocacy.

SOCIAL ECOLOGICAL MODEL

The Social Ecological Model (SEM) is a framework for understanding the multifaceted and interactive effects of personal and environmental factors that determine behaviors, and for identifying behavioral and organizational leverage points and intermediaries for health promotion within organizations. There are five nested, hierarchical levels of the SEM: Individual, interpersonal, community, organizational, and policy/societal (Figure 1). The most effective approach to public health prevention and control uses a combination of interventions at all levels of the model.

SOCIAL MARKETING

Social marketing is the systematic application of traditional commercial marketing to achieve specific behavioral goals and positive social change. Social marketing seeks to influence social behaviors to benefit the intended population and the general society. A social marketing strategy involves selling a “product” while focusing on the social value of these behaviors and products when they are made widely available to low income populations in resource-poor settings that would otherwise not have access to them. The social marketing "product" is not necessarily a tangible object. A continuum of products exists, ranging from high-quality, low-cost tangible products (e.g., ORT packets, water purification tablets), to services (e.g., community health worker postnatal home visits), practices (e.g., exclusive breastfeeding) and finally, more intangible ideas (e.g., child survival). A key step in the social marketing process is to discover the consumers' perceptions of the problem and the product, and to determine how important they feel it is to take action against the problem.

SOCIAL MOBILIZATION

Social mobilization is a process that engages and motivates various partners at national and local levels to raise awareness of and demand for a particular development objective. These partners may include decision and policy makers, opinion leaders, professional groups, religious associations, communities and individuals. Engagement is usually through face-to-face dialogue among partners with interrelated and complementary goals to change social norms and accountability mechanisms,

and provide sustainable, multi-faceted solutions to broad social problems. Channels and activities for social mobilization may include mass media to promote child survival, advocacy with community leaders to increase their commitment to the issue, and activities that promote broad social dialogue about the issues, such as talk shows on national television and radio, or community dialogue via local councils and committees. The outcomes are usually oriented toward developing a supportive framework for decision-making and resource allocation to empower communities to act at the grassroots level.

SOCIAL NORM

Social norms are beliefs or informal understandings that a group of people maintains about how members of their social system should behave. These norms generally govern a society's behavior, promote social control, and can be enforced formally or informally through sanctions or non-verbal cues. Social norms allow us to assess what behaviors a group deems important to its existence or survival.

STAKEHOLDERS

Stakeholders are people who have an interest in, who stand to benefit from, or who may be affected by, the outcome of a program. Stakeholders may include:

- **Decision makers**: People who make the final choices, usually at the political or administrative levels.
- **Gatekeepers**: People who control access to something, who can permit something to happen or prevent something from happening.
- **Opinion leaders (also called Influentials)**: People who can influence the behavior and/or opinions of large numbers of people.
- **Policy makers**: People in charge of making official policy.
- **Program participants**: Parents, caregivers, children, community representatives, and members of focal participant groups, especially those from marginalized and socially excluded groups.

STRATEGIC BEHAVIORAL AND SOCIAL COMMUNCIATION

Strategic behavioral and social communication is an interactive process with individuals and communities to develop tailored communication strategies, messages and approaches using a mix of communication channels and interventions to promote healthy behaviors/practices and support individual-, community-, and societal- level behavior change. Strategic behavioral and social communication provides a framework for delivering consistent messages through an array of approaches and channels for maximum effectiveness.

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PREFACE

Growing evidence shows that strategic health communication can influence health behaviors and change health-related social norms. It is important to create an environment that encourages individuals, families, and communities to act positively for their health and to access and advocate quality health services. The purpose for this *Regional Communication Guide for Newborn Care and the Prevention and Control of Childhood Pneumonia and Diarrhoea in East Asia and the Pacific Region* is to provide practical guidance for designing communication for development (C4D) strategic program plans whose implementation will result in direct positive changes in child survival and achieve the Millennium Development Goals (MDGs) for 2015 and beyond.

This Guide provides practical steps for developing evidence-based C4D programs that address multiple levels of the Social Ecological Model (SEM) in order to move beyond one-time or repeated individual-oriented behavior change communication (BCC) campaigns toward more holistic programs aimed at changing health-related social norms and social systems. This Guide is based on evidence from effective child survival programs around the world, and on communication theories and frameworks that address knowledge, attitude, behavioral, and social change.

Users of the Guide

The primary users of this Guide will be program managers, program planners, and communication specialists that work in the area of child survival in East Asia and the Pacific region and have some background in child survival (particularly newborn care, and childhood pneumonia and diarrhoea prevention and control programs) and communication for development approaches. Program managers and program planners should use the Guide to ensure that their child survival programs use various communication approaches to strategically address the necessary levels of the social ecological model and eliminate bottlenecks that may impede progress toward the MDGs. This Guide can also be used to build capacity among partner agencies toward improving child survival program planning, implementation and outcomes. The principles presented in this Guide can be used to develop strategic communication programs for other areas of public health and in other geographical regions.

Scope of the Guide

This Guide is designed to assist program managers and program planners to determine the social and communication context for C4D child survival programs and to follow strategic program

planning steps to develop evidence-based, equity-focused, multi-level, culturally- and population-appropriate, and coordinated communication activities. There are many program planning models used for designing public health program interventions. The planning model used in this Guide is the P-process developed by the Johns Hopkins University Center for Communication Programs. Each of the steps in the process is explained in the context of C4D for newborn care and the prevention and control of childhood pneumonia and diarrhoea. All the steps for strategy development in this guide are meant to be participatory and capacity building, that is, to include a variety of stakeholders, program staff, local organizations, and community members as partners in the design process.

Content of the Guide

This Guide is divided into three parts: Part I provides a brief overview of newborn care and childhood pneumonia and diarrhoea prevention and control interventions and the importance of understanding the context in which child survival programs are implemented. Part II describes the key C4D approaches. Part III provides practical descriptions for each step of the C4D strategic program planning process (analysis, strategic design, development and testing, implementation and monitoring, and evaluation and re-planning), illustrating how C4D interventions can strengthen and improve the outcomes and impacts of child survival programs.

Maintaining an Equity-Focused Lens

Deprivations of children's rights are disproportionately concentrated among the poorest and most marginalized populations within countries. UNICEF's central mission is to reach the most deprived and most vulnerable children. The conventional wisdom in health communication in the past has been to concentrate efforts on the "low-hanging" fruit (i.e., those populations that are easy-to-reach using conventional interventions) and not on the poorest children who are the most hard-to-reach, usually at a high cost. New evidence suggests that child survival programs should take into account that the poorest populations tend to have the largest proportion of vulnerable children with the poorest intervention coverage; these children are usually at the highest risk for stunting, underweight prevalence, and dying before the age of five years. Focusing attention on this segment of a population has the potential to accelerate progress toward your C4D program's goal and objectives, and ultimately toward achieving the MDGs. As you read through and use this Guide to develop your C4D strategic plan, you can re-focus your attention on equity in your commitment to reach the MDGs.

PART I: OVERVIEW

INTRODUCTION

Despite an established evidence base of simple, affordable, and low-cost interventions to avert neonatal deaths and improve child survival, global progress in reducing neonatal mortality has stagnated in recent years. Pneumonia and diarrhoea are the leading causes of death for more than two million children under age five (29 percent) worldwide. These diseases are related to poverty status and closely associated with malnutrition, poor sanitation in the home, and limited access to healthcare services. Some 90 percent of these deaths occur in Asia and sub-Saharan Africa.

Deaths due to childhood pneumonia and diarrhoea[2] are preventable through appropriate measures, including newborn care protocols, adequate nutrition, vaccinations, proper hygiene and sanitation, and access to safe drinking water. These diseases can be treated with such cost-effective interventions as antibiotics for bacterial pneumonia and oral rehydration salts (ORS) for diarrhoea. Several approaches to deliver newborn care and childhood pneumonia and diarrhoea prevention and control interventions have been shown to substantially improve the health of a child and his/her chances of survival, namely health facility-based care, Integrated Management of Childhood Illness (IMCI), and the education of mothers by frontline healthcare workers about the essential care of their babies, in household and community group settings.

UNICEF estimates that more than two million child deaths attributed to pneumonia and diarrhoea could be averted if national coverage of cost-effective interventions were raised to the level of the richest 20 percent in the highest mortality countries (Johansson et al., 2012). In June 2012, the Governments of Ethiopia, India and the United States, in collaboration with UNICEF, convened over 700 government, civil society and private sector participants from more than 80 countries to renew

[2] Childhood pneumonia is a severe form of acute lower respiratory infection that specifically affects the lungs. Most acute respiratory infections result in mild illness (e.g., the common cold), but may lead to pneumonia in vulnerable children, especially when it coincides with diarrhoea and other illnesses. Childhood diarrhoea is the occurrence of loose or watery stools at least three times per day or more frequently than normal for any individual. In general, most episodes of childhood diarrhoea are mild, acute cases can lead to significant fluid loss and dehydration, which, if not treated in a timely manner, may lead to severe illness and even death. Diarrhoea is a common symptom of gastrointestinal infection, most commonly caused by bacteria, viruses and protozoa. Rotavirus is the leading cause of acute diarrhoea. Children with poor nutritional status and health are most susceptible to severe diarrhoea and dehydration than healthy children.

the global commitment to child survival. The *Call to Action* at this summit provided evidence that all countries can lower child mortality rates to 20 or fewer deaths per 1,000 live births by 2035 by intensifying efforts to reach the most underserved population groups. More than ninety governments and many dozens of non-governmental organizations signed a pledge vowing to strengthen their efforts to improve maternal, newborn and child survival by focusing on the hardest-to-reach children in every country.

Communication strategies to increase knowledge, and to change attitudes, behaviors, and norms at the individual, community, and societal levels are essential to decreasing the risk and incidence of, and mortality due to, childhood pneumonia and diarrhoea. Development efforts of the past decade focused on individual- and household- level behavior change in specific populations, using strategies that produced small-scale, fragmented, short-term behavior changes. The emphasis of child survival development programs was on supplying information about wellness and life-saving practices (e.g., exclusive breastfeeding, resuscitation, care-seeking), biomedical interventions (e.g., vaccines, antibiotics), treatments (e.g., ORS, zinc supplements, water purification solutions), and/or technological innovations (e.g., VIP latrines), without much attention to creating demand for the interventions using evidence-based communication strategies (Shefner-Rogers, 2013).

Communication for Development (C4D) is a systematic, planned, and evidence-based approach to promote positive and measurable behavioral and social change. C4D is both a strategy and an approach to engage communities and decision-makers at local, national, and regional levels, in dialogue toward promoting, developing, and implementing policies and programs that enhance the quality of life for all (McCall, 2011). The approaches that make up the C4D strategy include: (1) Behavior change communication (BCC); (2) social mobilization (including strengthening an enabling media and communication environment); (3) social change communication; and (4) advocacy. A central tenet of UNICEF is that C4D is most effective when combined with changes in the social-ecological environment within which children and families live.

This Guide provides the rationale and steps for developing evidence-based, equity-focused, and research-driven C4D child survival programs using a social ecological perspective. The aim is to take a leap forward from the previous focus on behavior change at the individual and household levels of a social system, toward a more comprehensive, multi-level approach that uses communication to create synergies among interventions and create an enabling environment in which behavior and social change can be sustained.

Newborn Care and Childhood Pneumonia and Diarrhoea Prevention and Control

Children in low-income countries have several risk factors for mortality due to pneumonia or diarrhoea, such as malnutrition and limited access to timely treatment. These children are often less likely to be reached by routine vaccination. Development practitioners in the area of child survival rely on a package of interventions that are known to work in resource-poor settings. The *Global Action Plan for the Prevention and Control of Pneumonia* was launched in 2009 by WHO and UNICEF, with the goal of reducing mortality due to pneumonia in children under age 5 by 65 per cent by 2015 compared with 2000 levels (WHO and UNICEF, 2009a). Three targets are to be reached by the end of 2015: (1) 90 percent coverage of each relevant vaccine (with 80 per cent coverage in every district), (2) 90 percent access to appropriate pneumonia case management, and (3) 90 percent coverage of exclusive breastfeeding during the first six months of life. The UNICEF and WHO report, *Diarrhoea: Why Children Are Still Dying and What Can Be Done* (UNICEF and WHO 2009b) provided an action plan for comprehensive diarrhoea control, focusing on fluid replacement to prevent dehydration and zinc treatment.

Prevention and Control Interventions That Work

Table 1 shows the key evidence-based interventions for newborn care, pneumonia and diarrhoea prevention and control promoted by UNICEF and WHO. Most newborn (neonatal) deaths can be prevented with behaviors to improve nutrition and hygiene that do not depend on highly trained providers, biomedical interventions, or technical equipment, for example, keeping a baby warm, maintaining a clean umbilical cord, exclusive breastfeeding, and identifying low-weight babies that require special attention.

Vaccines against leading pneumonia-causing pathogens (*Streptococcus pneumoniae and Haemophilus influenzae* type b [Hib]) and rotavirus vaccine for diarrhoea, as well as vaccines that prevent infections that lead to pneumonia or diarrhoea as a complication (such as pertussis for pneumonia and measles for both pneumonia and diarrhoea) are known to prevent children from dying. WHO recommends that all countries include Hib vaccine, PCV, and RV in their immunization programs (WHO 2006; WHO 2007; WHO 2009).

A clean home environment is critical for reducing the transmission of pathogens that cause pneumonia and diarrhoea. Improvements in household air pollution and access to safe water and adequate sanitation, along with the promotion of good hygiene practices such as hand washing with soap, safe disposal of human feces, and treating household water and storing it safely, can help prevent childhood pneumonia and diarrhoea.

Table 1. Key Newborn Care, Pneumonia and Diarrhoea Prevention and Control Interventions.

Newborn Care	Childhood Pneumonia and Diarrhoea Prevention	Childhood Pneumonia and Diarrhoea Control
• Exclusive breastfeeding • Thermal protection • Resuscitation • Infection prevention (hygiene, cord care) • Immunization • Management of newborn illnesses • Weighing newborns • Skin-to-skin contact • Identification of high-risk, low- weight babies • Support and follow-up	• Vaccination (*Streptococcus pneumoniae* and *Haemophilus influenzae* type b [Hib]), Rotavirus, pertussis, measles) • Water, sanitation and hygiene (WASH) (safe drinking water, safe disposal of human feces, hand washing with soap, household air pollution, household overcrowding) • Exclusive breastfeeding (promotion and support) • Nutrition • Micronutrient supplementation (Vitamin A, zinc) • Reducing/eliminating co-morbidities such as HIV infection	• Antibiotics • ORS • Knowledge of danger signs • Care-seeking behavior • Access to healthcare services • Community case management

Children who are malnourished are at greater risk of death and severe illness due to pneumonia and diarrhoea than well-nourished children. Breastfeeding (especially exclusive breastfeeding for the first six months) reduces the risk of morbidity and mortality due to pneumonia and diarrhoea for infants. Evidence also shows that micronutrient supplementation, including zinc and vitamin A, is critical for normal growth and can reduce diarrhoea- and pneumonia- related risk and mortality in children.

Integrated community case management of childhood diseases at the community and health facility levels is a treatment intervention that increases the efficiency, cost-effectiveness, and quality of care for sick children. It can be delivered by trained community health workers or higher level health professionals and reduce mistreatment of illnesses due to symptom overlap and co-morbidities. On the demand-side, it is important for caregivers to know when and where to seek appropriate care and seek appropriate care for sick children when necessary.

Achieving the goals for decreasing morbidity and mortality from childhood pneumonia and diarrhoea requires communication inputs to raise awareness, increase knowledge, and encourage positive attitudes about pneumonia and diarrhoea prevention and control, and to motivate individuals, families, communities, social systems to adopt the interventions and create norms

around the healthy child survival behaviors.

The Importance of Program Context

The context in which a C4D program is implemented determines the approaches that can and should be used to change health behaviors, social norms, and harmful practices (e.g., gender discrimination or prejudicial treatment of members from specific religious or tribal groups) that endanger mother and/or child and prevent her from seeking healthcare when necessary. The countries of East Asia and the Pacific represent an array of political, economic, environmental, geographical, and social contexts with varying degrees of local, regional, and national capacities, political will, and commitment to implementing single-focused health programs (e.g., a water, sanitation, and hygiene (WASH) program) or integrated child health programs. For example, in one country, a program may not be able to engage in community empowerment because the idea of empowerment is a challenge in that political context, while in another country community engagement is an acceptable and usual approach. These variations demand tailored country-level strategies for utilizing C4D approaches for child survival development programs. The strategy development process therefore begins with extensive formative research to understand the current state of the intended population for the program and their social ecological context in order to know how to motivate changes in health behaviors and health-related social norms.

Assessing the specific strengths, weaknesses, opportunities, and threats (SWOT)[3] of the C4D program implementing institution and partner agencies is an important initial step in the program planning process. The purpose for conducting a SWOT analysis is to identify the positive areas and gaps in capacity that may facilitate or impede strategic planning and decision-making processes for child survival programs. The facilitating factors and bottlenecks for any program can occur at several levels of the social ecological system (e.g., political, organizational, community, individual). SWOT analyses can point to recommendations for leveraging internal strengths, improving internal weaknesses, exploiting external opportunities, and minimizing external threats that help program-planners influence how, and how well, C4D child health interventions are designed, received, adopted, and supported by individuals, groups, communities, organizations, donors, and policymakers. Understanding the SWOT for each program, coupled with formative research (the

[3] The acronym SWOT refers to Strengths, Weaknesses, Opportunities, and Threats. A SWOT analysis is a structured planning method used to evaluate the **s**trengths, **w**eaknesses, **o**pportunities, and **t**hreats for any type of venture, including a program/project. Albert Humphrey developed this method in the 1960s at the Stanford Research Institute. Strengths are characteristics of the program that give it an advantage over others. Weaknesses are characteristics that place the program team at a disadvantage relative to others. Opportunities are elements that the program could exploit to its advantage. Threats are elements in the environment that could present a problem for implementing a program. Strengths and weakness are internal to an organization developing the program, while opportunities and threats are external to the organization developing the program. For more information on conducting a SWOT analysis, see http://ctb.ku.edu/en/tablecontents/sub_section_main_1049.aspx.

first step in the program planning process), will help determine where change is possible and how to move forward with your strategic program design.

PART II: COMMUNICATION FOR DEVELOPMENT (C4D) APPROACHES

UNICEF's Communication for Development (C4D) Program mission is to "harness the power of communication and social networks to make a positive difference in the lives of children, their families and communities" (UNICEF, December 10, 2012). Communication for development (C4D) is a systematic, theory-driven, evidence- based, and strategic process to promote positive and measurable change at the individual, family, community, social and policy levels of a society. C4D aims to promote dialogue within communities and with decision-makers at local, national, and regional levels for the purpose of promoting, developing, and implementing policies and programs that drive positive and healthy behavior change.

A central tenet of UNICEF is that C4D is more likely to be effective when combined with changes in the social ecological environment within which children and families live. The C4D process is interactive and applies a holistic view of a social system, referred to as the social ecological model (SEM), to identify individual- and group- level knowledge, attitudes, beliefs, efficacy (individual and collective), motivations, behaviors, social and cultural norms, infrastructure, and policies that contribute to an environment that allows for, encourages, and sustains positive health behaviors (Figure 1).

C4D uses four key strategies or approaches to engage participants in change: (1) Advocacy, to mobilize resources, support, and leadership commitment to development goals and actions, (2) social mobilization, to enlist wider participation and ownership of programs within a community, (3) social change communication (SCC) to create public spaces for individuals and groups to make their voices heard and exercise their rights, and to change normative and value-laden practices, and (4) behavior change communication (BCC), to change individual knowledge, attitudes, and practices among the members of a social system. Figure 1 presents the Social Ecological Model (SEM) and the corresponding C4D approaches appropriate to each level of the SEM.

The Social Ecological Model (SEM)

The Social Ecological Model (SEM) is a framework for understanding the multifaceted and interactive effects of personal and environmental factors that determine behaviors, and for identifying

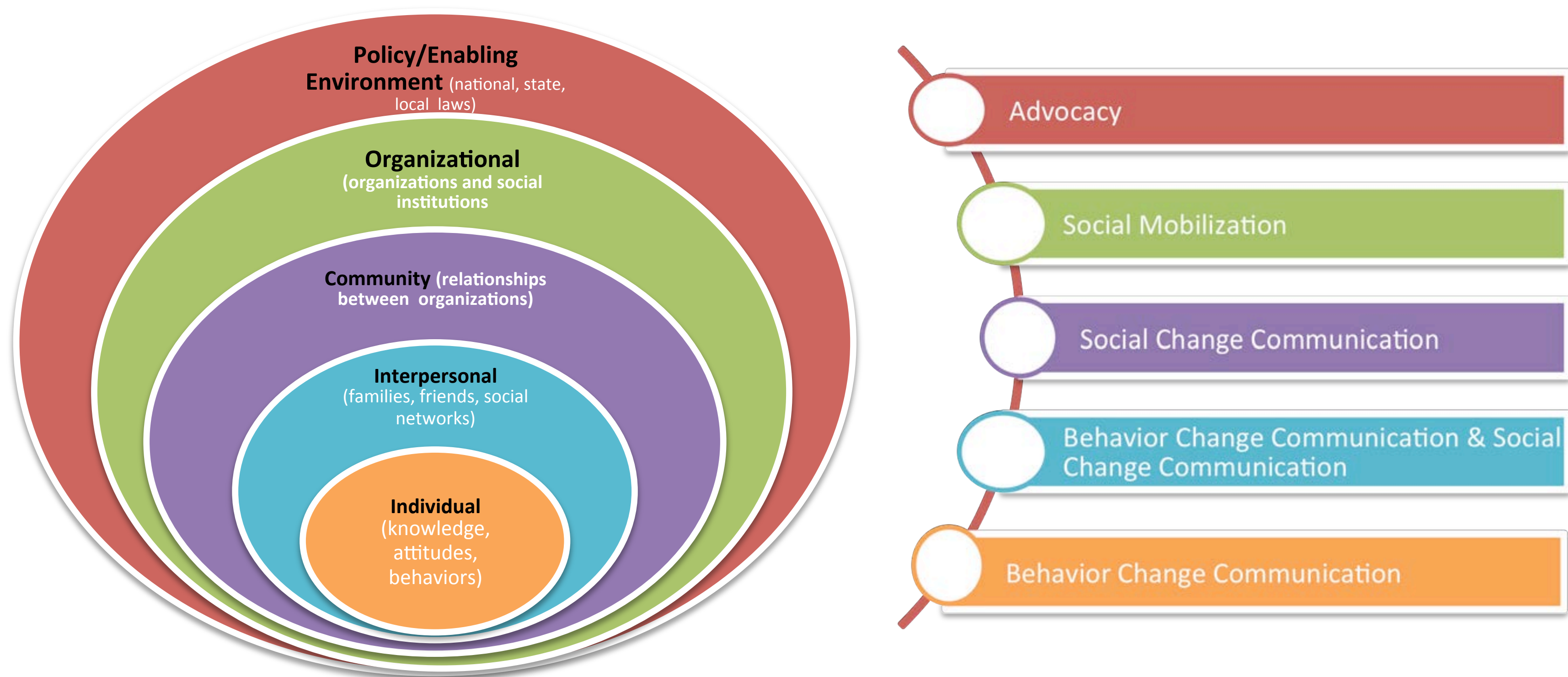

Figure 1. The Social Ecological Model (left side) and Corresponding C4D Approaches (right side).

behavioral and organizational leverage points and intermediaries for health promotion within organizations. By identifying these leverage points, program planners can influence how, and how well, C4D child health interventions are designed, received, adopted, and supported by individuals, groups, communities, organizations, donors, and policymakers.

Table 2 provides a summary of the communication approaches (advocacy, social mobilization, social change communication, and behavior change communication), their key features, and the usual intended participant groups for each approach. The C4D approaches are interrelated and interactive and using them in a well-planned program produces a synergistic effect. Simple preventive actions by the individual, family and community, stimulated by behavior change communication (BCC), are the most immediate means for improving newborn care and reducing child mortality rates from pneumonia and diarrhoea. Advocacy strategies can pave the way for new laws or change a policy that may be impeding change. Multi-level approaches help shift community and organizational norms to ensure that behavior changes are sustained over time. Below is a description of each of the C4D approaches.

Advocacy

The policy/enabling environment level of the SEM consists of policy, legislation, politics and other areas of leadership that influence health and development. A strategy used to address this level of the social system is advocacy. Advocacy is an organized effort to inform and motivate leadership to create an enabling environment for achieving program objectives and development goals. The purpose for advocacy is (1) to change governmental or organizational laws, policies or rules, (2) to redefine public perceptions, social norms and procedures, (3) to support protocols that benefit specific populations affected by existing legislation, norms and procedures, and/or (4) to influence funding decisions for specific initiatives. Advocacy includes motivating different levels of decision makers (e.g. politicians, policymakers) to publically discuss important issues, defend new ideas or policies, and commit resources to action. The advocacy process requires continuous efforts to translate relevant information into cogent arguments or justifications and to communicate the arguments in an appropriate manner to decision makers.

There are three common types of advocacy:

1. Policy advocacy, to influence policymakers and decision makers to change legislative, social, or infrastructural elements of the environment, including the development of equity-focused programs and corresponding budget allocations;
2. Community advocacy, to empower communities to demand policy, social, or

infrastructural change in their environment, and

3. Media advocacy, to enlist the mass media to push policymakers and decision makers toward changing the environment.

Table 2. Summary of Key Features and Participant Groups for the C4D Approaches.

C4D Approach	Key Features	Participant Groups
Advocacy	• Focuses on policy environment and seeks to develop or change laws, policies, and administrative practices • Works through coalition-building, community mobilization, and communication of evidence-based justifications for programs	• Policymakers and decision-makers • Program planners • Program implementers • Community leaders
Social Mobilization	• Focuses on uniting partners at the national and community levels for a common purpose • Emphasizes collective efficacy and empowerment to create an enabling environment • Works through dialogue, coalition-building, group/organizational activities	• National and community leaders • Community groups/organizations • Public and private partners
Social Change Communication	• Focuses on enabling groups of individuals to engage in a participatory process to define their needs, demand their rights, and collaborate to transform their social system • Emphasizes public and private dialogue to change behavior on a large scale, including norms and structural inequalities • Works through interpersonal communication, community dialogue, mass/social media	• Groups of individuals in communities
Behavior Change Communication	• Focuses on individual knowledge, attitudes, motivations, self-efficacy, skills building, and behavior change • Works through interpersonal communication, mass/social media campaigns	• Individuals • Families/households • Small groups

The most common barriers to influencing leadership toward creating an enabling environment for newborn care and childhood pneumonia and diarrhoea prevention and control include (1) political or institutional instability (e.g., high turnover of leadership and re-structuring) or lack of political will, (2) a lack of local evidence on overall program cost and cost effectiveness, (3) a lack of reliable data about the efficacy, effectiveness, or value of a program, (4) dissension among the leadership between health divisions of a government, (5) tensions or low capacity with regard to the use of various levels of health workers, (6) resistance from professional

and/or regulatory bodies, (7) systems requirements (e.g., human resources, commodities), (8) contradictory policies, (9) culturally ingrained practices, social norms, and resistance to change, and (10) a lack of social accountability by policymakers. The challenge is to address whichever barriers may be affecting your participant group(s) (e.g., mothers' or caregivers' access to immunizations). It is important to first understand who the leaders are that you would like to reach, to define specifically what you want them to do for your cause, and to determine what concerns they may have about the issue or program you are presenting. Then, you can begin to plan the types of activities and tools that you will use to gain their support. **Appendix 1** provides a table of the key elements to think about prior to developing an advocacy strategy for different decision-makers, and examples of the concerns, activities and tools that suit these particular intended populations.

Developing an Advocacy Strategy

Once you know the population for your advocacy approach, an advocacy strategy can be developed to address the advocacy component of a newborn care and childhood pneumonia and diarrhoea prevention and control program (Box 1).

BOX 1: AN ADVOCACY STRATEGY DEVELOPMENT CHECKLIST

1. Establish a working group to develop your advocacy strategy.
2. Collect data and information on the advocacy issue (e.g., review current practices and policies, inventory current programs/activities, and understand the context in which programs and policies are implemented). You should write a justification for why your issue is important and how it fills a practical need.
3. Identify your primary and secondary participant groups (i.e., make a list of key individuals, groups, stakeholders, decision-makers, that can help you move your issue forward, and a list of the opponents, and identify each person or group's current position/perceptions and concerns about the issue).
4. Identify the information sources that each individual or group uses/relies on/trusts the most.
5. Define your advocacy objectives and develop an implementation plan for advocacy activities (including team/partner responsibilities, timeline, and monitoring tools).
6. Identify the resources needed for advocacy activities (e.g., human resources, time, money) and create a budget.
7. Develop and pretest advocacy tools.
8. Develop an evaluation plan for advocacy activities and document changes based on the established advocacy objectives.

You may want to advocate for:

- Dedicated C4D program funds
- National, sub-national, and local C4D supportive structures
- Research support
- Media support

- Standardized monitoring systems
- Building capacity among community health workers
- Raising the issue of child survival on the policy agenda
- Community ownership and support for local C4D program activities

Because it is possible (and often desirable) to integrate newborn care and childhood pneumonia and diarrhoea prevention and control activities with existing child survival programs, there may only be a need to conduct advocacy to increase resources for communication activities. Whatever the advocacy intent, it requires a continuous process of collecting data and information about the problem and related issues, and translating that information into a justifiable argument that can be communicated through various interpersonal and media channels in order to amass resources or gain political and social leadership support for a specific C4D program.

Advocacy messages are a critical element of an advocacy strategy. The policymakers/decision makers you intend to reach have limited time to spend on your issue alone so it is important to craft clear, concise and compelling messages (i.e., what you are proposing, why it is important, the benefits and positive impacts of addressing the issue, and your specific request for action), deliver messages effectively (i.e., the messages should be easy to understand and stand out from competing messages), and reinforce messages to ensure that your issues remains on the leadership's agenda. All advocacy messages and tools should be pretested and all advocacy efforts should be monitored and evaluated for impacts and outcomes.

Social Mobilization

Social mobilization (SM) is a continuous process that engages and motivates various inter-sectoral partners at national and local levels to raise awareness of, and demand for, a particular development objective. These partners may include government policy makers and decision-makers, community opinion leaders, bureaucrats and technocrats, professional groups, religious associations, non-governmental organizations, private sector entities, communities, and individuals. This communication approach focuses on people and communities as agents of their own change, emphasizes community empowerment, and creates an enabling environment for change and helps build the capacity of the groups in the process, so that they are able to mobilize resources and plan, implement and monitor activities with the community.

Engagement is usually through interpersonal communication (i.e., face-to-face dialogue) among partners toward changing social norms and accountability structures, providing sustainable, multifaceted solutions to broad social problems, and creating demand and utilization of quality

services. Other channels and activities for SM may include mass media awareness-raising campaigns, advocacy with community leaders to increase their commitment to the issue, and activities that promote broad social dialogue about the issues, such as talk shows on national television and radio, community meetings, traditional participatory theater performances, home visits, and leaflets. The outcomes are usually oriented toward developing a supportive environment for decision-making and resource allocation to empower communities to act at the grassroots level. The social mobilization process typically involves the following five phases:

1. Building rapport and sharing knowledge: Partners organize meetings and activities to understand one another, determine commonalities, and share knowledge and perspectives with regard to the problem that will be addressed.
2. Problem analysis and action plan: Partners conduct exercises to analyze the nature of the problem, identify and prioritize needs, develop a common problem statement, goals and objectives, and draft an action plan.
3. Organization building: Partners develop a participatory, self-governing, self-managing, and self-sustaining committee, coalition, or working group through which resources and actions are organized.
4. Capacity building: Partners may identify weakness in their ability to take action and engage experts or experienced individuals or groups to build the capacity of the committee or coalition to help them achieve their goals and objectives.
5. Action and sustainability: Partners must be involved consistently through all phases of the action plan. It is important that there is shared recognition for implementation and success, transparency, equity, and joint decision-making.

Social mobilization recognizes that sustainable social and behavior change requires collaboration at multiple levels, from individual to community to policy and legislative action, and that partnerships and coordination yield stronger impacts than isolated efforts. Key strategies of social mobilization include using advocacy to mobilize resources and change inhibiting policies, media and special events to raise public awareness and create public spheres for debate, building and strengthening partnership and networks, and motivating community participation.

Social Change Communication (also called Communication for Social Change)

Social change communication (SCC) is a purposeful and iterative process of public and private dialogue, debate, and negotiation that allows groups of individuals or communities to define their needs, identify their rights, and collaborate to transform the way their social system is

organized, including the way power is distributed within social and political institutions. This process is usually participatory and is meant to change behaviors on a large scale, eliminate harmful social and cultural practices, and change social norms and structural inequalities.

While social mobilization focuses on creating and sustaining action-oriented partnerships to create an enabling environment for positive health, SCC focuses on creating ownership of the process of change among individuals and communities. The emphasis of SCC is on creating empowered communities that know and claim their rights and become their own agents for changing social norms, policies, culture and environment (e.g., healthcare delivery infrastructure).

Multi-faceted communication interventions (e.g., using mass-, social-, and traditional media) aimed at changing individual behavior play an important role as a foundation for SCC, with an emphasis on using local communication content that is socially and culturally appropriate to the community. Community members control the tools of communication directly, allowing for suitably tailored messages. Such interventions, however, must be reinforced by activities that encourage dialogue within the community to motivate people to shift toward desirable social/community beliefs, norms, and practices, and are often combined with advocacy.

Community dialogue for social change generally follows a pattern. The dialogue usually begins with a catalyst for change. The catalyst may be an individual within the community, a change agent working for a health organization who introduces a new vaccine, or a mass media message heard by individuals in the community. For example, a mother might talk to another mother about how many infants in the community have severe coughs and how many have died as a result of pneumonia (the mothers may or may not know it as "pneumonia"). The mothers might talk to, and ask questions of, others in their family and social networks about the problem, which may prompt someone to identify an opinion leader or potential champion (e.g., a community health worker) that can help to address the problem. Usually the person who takes up the cause calls a meeting to discuss the issues related to the problem and to achieve consensus about how to address the problem.

Collective action by the community to address the problem requires:

- Clearly assessing the current status of the problem and developing a shared vision of what the community would like to achieve (e.g., increased access to vaccines)
- Developing specific and measurable objectives that reflect the community's expectations for addressing the problem (e.g., To increase by X percent the number of children under five years that are vaccinated by December 2014.)

- Deciding upon appropriate and reasonable activities to motivate change (e.g., interactive street theater performance to raise awareness about the problem; health fairs or immunization days sponsored by the community)
- Developing an action plan and resources (human and financial) to implement activities
- Assigning responsibilities to community participants (and/or organizations within the community) for specific tasks
- Implementing the activities in the action plan
- Monitoring the inputs (e.g., resources) and activities to ensure that the activities are being implemented as planned
- Evaluating the outcomes to determine if the actions achieved the specified objectives (the evaluation should be participatory and involve the community members)
- Dialoguing about the outcomes and lessons learned (collective evaluation) and planning further action as appropriate

Communities that engage in this collective process of social change communication are likely to gain a sense of collective efficacy, feel a greater sense of ownership for their actions and outcomes, and believe in their capacity to engage in similar projects in the future.

Behavior Change Communication

Behavior change communication (BCC) is the strategic use of communication to promote positive health outcomes. BCC is a theory-based, research-based, interactive process to develop tailored messages and approaches, using a variety of population-appropriate communication channels, to motivate sustained individual- and community- level changes in knowledge, attitudes, and behaviors. Formative research is used to understand current levels of knowledge, attitudes, and behaviors among individuals in a specified population in order to develop communication programs that move those individuals along a continuum of change (or through stages of change) toward the desired positive behavior(s).

Using the BCC approach can help to:

1. Stimulate community dialogue and raise awareness about the problem
2. Increase knowledge, for example, about the importance of exclusive breastfeeding or hand washing with soap
3. Promote attitude change, for example, about the risks associated with not vaccinating a child against pneumonia
4. Reduce stigma, for example, around exclusive breastfeeding
5. Create demand for information and services
6. Advocate with policymakers and opinion leaders toward effective approaches to reducing deaths from childhood pneumonia and diarrhoea
7. Promote services for prevention and control

8. Improve skills and the sense of self-efficacy, for example, by teaching mothers how to keep their baby's umbilical cord clean or when to seek care for dehydration due to diarrhoea

BCC is an essential part of comprehensive prevention and control programs that include both services (e.g., health, medical) and commodities (e.g., vaccines, oral rehydration packets, VIP latrines). Before individuals and communities can reduce their level of risk or change their behaviors, they must first understand basic facts about newborn care and childhood pneumonia and diarrhoea, adopt key attitudes, learn a set of skills (e.g., exclusive breastfeeding, care-seeking at appropriate times, hand washing with soap) and be given access to appropriate products and services. They must also perceive their environment as supporting behavior change and the maintenance of safe behaviors, as well as supportive of seeking appropriate prevention, treatment and support.

The above four approaches (advocacy, social mobilization, social change communication, and behavior change communication) are interrelated and interactive. When strategically combined, they produce a synergistic effect, that is, an increased intensity or effect with more efficient use of resources. BCC programs stimulate the most immediate preventive actions among individuals, families and communities for decreasing childhood pneumonia and diarrhoea. Advocacy strategies can be used to create new laws or change existing policies to facilitate change. Multi-level approaches that help to change social, cultural, or institutional norms and enable behavior change are most likely to result in sustained behavior change over time.

How to Use the Social Ecological Model for Planning a Strategic C4D Child Survival Program

Many factors contribute to childhood pneumonia and diarrhoea, and to newborn and under-five mortality. Some of these factors are modifiable individual-level behaviors. Since individuals exist in a social ecological system, changing individual-level behaviors and creating new social norms requires creating an enabling environment, that is, facilitating change and removing bottlenecks that inhibit change at the household, community, organizational, and policy levels. For example, if a program's goal is to increase the number of children that are immunized, then (1) parents and caregivers must understand why it is important to have their child immunized and be motivated to seek and demand immunization for their child, (2) parents and caregivers must have easy access to immunizations for their child in their locale, (3) health facilities and/or community health workers must be trained and equipped to provide

immunizations, and (4) communities must embrace and own the importance of child survival, demand immunization, and create a social norm around immunization.

Program managers and program planners should use the SEM (1) to understand the complexity of, and possible avenues for addressing, the health problem, and (2) to prioritize resources and interventions that address the multiple facets of the problem, remove bottlenecks, and create an enabling environment for sustained behavior and social change. As described above, a preliminary tool that some program managers and program planners use to help them assess the social ecological landscape prior to developing a strategic program plan is the SWOT analysis. A SWOT analysis is one element of a strategic plan. The SWOT analyses is an inventory of resources and usually focuses on four key program management areas: (1) Partnerships, (2) capacity development, (3) research, monitoring and evaluation, and (4) resource mobilization.

The SWOT analyses will highlight internal organizational strengths, internal weaknesses, external opportunities, and external threats or barriers to achieving your program's goal and objectives. Understanding the SWOT analysis will help to determine how to focus on high-priority vulnerable, marginalized, and hard-to-reach populations, where change is possible, and provide opportunities to change course or revise priorities as appropriate in order to reach your program goals. For example, an assessment of resources for a strategic C4D program with a goal of increasing immunization may allow (1) for advocacy activities toward a policy that assures that every child is immunized, (2) for organizational capacity-building to develop a cadre of trained healthcare providers and promoters at the local level, (3) for community engagement activities to create demand for quality healthcare services where immunizations can be obtained at a reasonable cost, and (4) for a campaign to promote the importance, availability, skilled providers, and points-of-access for immunizations in an underserved community.

Partnerships, Collaborations, and Ownership

Strong partnerships and collaborations are at the core of effective C4D programs. When partners take ownership of a program, it is more likely to succeed. A strong communication program should engage multiple partners at the national and local levels in a participatory manner; no single entity can achieve the results produced through multi-partner collaborations. Partners can provide program support through expertise, capacity building, and resource mobilization, can broaden the reach and profile of the program through network affiliations, and can help to avoid duplication of efforts.

A key strategy for developing and administering C4D programs is to create an infrastructure or centralized mechanism for engaging partners in a participatory process to manage the program (e.g., C4D Coordinating Committee). Such centralized mechanisms are more successful when partners create the mechanism together. The process for developing such a mechanism, and the ground rules by which it will operate, helps to create the culture of the partnership and develop working relationships.

The key to high-performance partnerships is continuous and open information sharing. There should be a mechanism for sharing information and communicating about the activities of the group and the program. For newly formed groups, it is useful to begin by clarifying a shared vision to help partners focus on the path to achieving success and brainstorming about the limitations and challenges to realizing the vision and how the team of partners can overcome the limitations or challenges. The partners should also develop a common goal and objectives for the partnership and discuss the potential contributions of each individual, group, or organizational partner. Meetings should be held on a regular basis to share information, assess progress, re-visit program objectives and activities, and discuss next steps in the program steering process.

Steps in Developing a C4D Strategy

Developing a C4D strategy to influence or reinforce behavior and social change is a step-wise process that begins with a solid understanding of the problem and population of interest in order to ensure more efficient use of resources and greater behavior change impact. Each step of the process should include consultation with, and the participation of, partners (e.g., policymakers, technical experts, local change agents, and media specialists) and members of the intended participant groups that can impact and are affected by child survival issues. The next section of this Guide (Part III), will take you through the steps for developing a C4D strategy.

PART III: STEPS FOR DEVELOPING A SRATEGIC C4D PROGRAM PLAN

Part III of this guide presents the steps in the C4D program planning process. There are various program planning models that can be used to guide your program planning process, for example, COMBI, ACADA, the Health Communication Program Cycle, and the SCALE process.[4] There are many similarities in the various planning processes or models, namely a series of steps to follow, suggesting that there are certain basic components to consider when developing a C4D program. Here we use the P-process as a guide for developing a strategic C4D program plan. The P-Process is a well-tested and widely used framework with the five steps that are essential to building a strong and effective C4D program. Whichever planning model you use, you should be sure to:

- Rely on evidence relevant to your context
- Consider all levels of the Social Ecological Model and the participants' perspectives at each level
- Foster community participation
- Develop a program that is culturally sensitive and relevant
- Not make assumptions about the populations/participant groups

THE P-PROCESS

The P-Process is a step-by-step road map that leads communication professionals from the conceptual stages of behavior change to a strategic and structured program with a measurable impact on the intended population (Figure 2). The steps include, (1) analysis, (2) strategic design, (3) development and testing of messages and materials, (4) implementation and monitoring, and (5) evaluation and re-planning. The process is intended to be iterative over time, that is, step 5, evaluation and re-planning, should feed into the design of subsequent programs. Participation of stakeholders and recipient populations, program management and capacity building are essential components that are inferred in all steps of the program process and that help to improve the efficiency and effectiveness of each program, and increase the

[4] Follow the hyperlinks to learn more about COMBI (http://www.who.int/ihr/publications/combi_toolkit_fieldwkbk_outbreaks/en/index.html), UNICEF ACADA (http://www.academia.edu/1741673/ACADA_Model), the Health Communication Program Cycle (http://www.cancer.gov/cancertopics/cancerlibrary/pinkbook/page4), and the SCALE process http://www.globalfishalliance.org/ourapproach.html).

sustainability.

At every stage of the P-Process, the following basic principles should be included:

- Identify communication as a core, continuous, and influential component of the program
- Build support among national and local leaders throughout the life of the program, keep them informed about program activities and successes, and allow them to share credit for program accomplishments
- Encourage your intended population(s) to be actively involved at every stage of the P-Process
- Invite people from different disciplines and backgrounds (e.g., doctors, media experts, social scientists) to share their skills and expertise and build a stronger program
- Ensure that service facilities have trained staff and adequate capacity to serve your intended population (especially if you are promoting those services through your program)
- Build partnerships among government agencies, NGOs, and the private/commercial sector to reinforce communication messages, avoid duplication of efforts, and to share resources
- Provide continuous training, support, and supervision for program staff, stakeholders, and partners, and build institutional capacities to carry out an effective program.

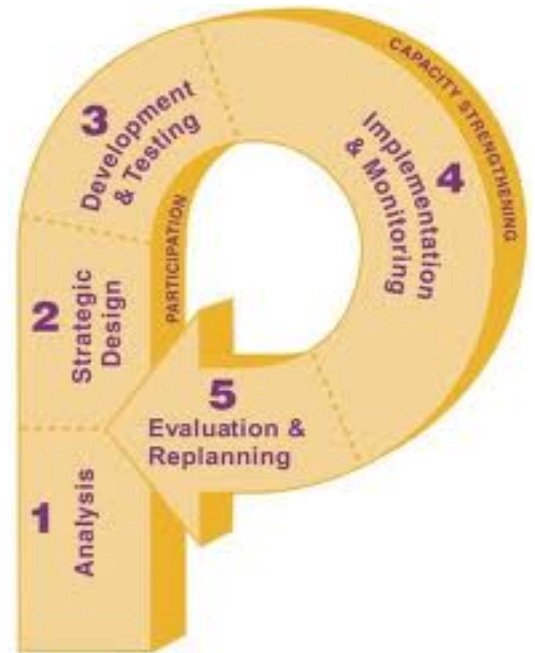

Figure 2. The P-Process.
Source: Johns Hopkins Center for Communication Programs (http://www.jhuccp.org/sites/all/files/The%20New%20P-Process.pdf).

The following pages provide a description of each of the five steps of the P-process, and a checklist (as an Appendix) for each step to guide your development process.

STEP 1: CONDUCTING THE SITUATION ANALYSIS

The C4D approach demands an in-depth understanding of the problem, of your specific population(s) (e.g., mothers, families, healthcare providers), and of the people and environmental factors that influence their decision-making around child health and child survival (policymakers, pharmacists, traditional medical practitioners, family members, services, access to services). The analysis phase, also referred to as formative research, helps you (1) to organize your thinking around the problem, (2) to understand the issues associated with your populations' adoption of appropriate newborn care and childhood pneumonia and diarrhoea prevention and control interventions (e.g., mothers doubts or questions about such interventions as vaccines, ORT, zinc, and such practices as exclusive child feeding), and (3) to fill in any gaps in information you may have about the problem, the context, or your intended population(s). Programs that will be built on existing initiatives will require less intensive analysis if program staff can access all relevant resources. BOX 2 outlines the steps for making a situation analysis/formative research plan prior to beginning any data collection and analyses.

BOX 2: STEPS IN MAKING A FORMATIVE RESEARCH PLAN

1. Define the need and purpose for conducting formative research.
2. Identify the intended populations of interest (this will be refined once the formative research has been completed).
3. Define the research objectives and questions that will guide the formative research process.
4. Determine whether you will out-source all or some of the research.
5. Determine the sources for secondary data.
6. Determine the sources for primary data
    a. Define your study population and participants.
    b. Develop an approach/design for conducting the formative research (e.g., qualitative, quantitative, mixed methods).
    c. Identify your groups/study sites for data collection.
    d. Develop the data collection protocols and instruments (e.g., literature review protocol, focus group discussion guide, survey questionnaire).
    e. Pretest the protocols and instruments.
7. Develop a research implementation plan (including timeline, persons responsible for specific tasks, and budget).
8. Collect the data from all sources.
9. Analyze the data from all sources.
10. Write a report that summarizes the key findings and points to evidence for implementing a specific program or set of activities.

Following is a description of the key information that should be collected for the situation analysis. For each of the key areas, you should determine:

- What you already know (from existing data)
- What you do not know (information gaps)
- What information you need to fill the gaps

Collect Key Information:

1. Determine the scope, severity, and cause(s) of the problem.
    - Review current literature to understand the etiology and epidemiology of the problem (special studies may be warranted if the literature is dated or inadequate in your topic area)
    - Review existing health and demographic data, survey results, study findings, and any other information (published or unpublished) available on the problem
    - Identify which risk practices are most widespread
    - Develop a clear and concise problem statement

2. Understand the needs, perceptions, knowledge, attitudes, behaviors, terminology, and priorities of the intended population(s).
   You may have multiple intended population groups depending upon which level(s) of the social ecological model you will address (e.g., policymakers, government officials, donors, community leaders, pharmacists, healthcare providers, religious leaders, parents), and should develop separate data collection instruments for each group (**Appendix 2 and Appendix 3**). You should use a combination of quantitative (e.g., KAP survey) and qualitative (e.g., community or social mapping) methods to capture this data. This data will help you to understand how ready the majority of your intended population is to change their behavior. The results of this analysis can constitute your baseline research, that is, the benchmark against which to measure the program's progress and final impact:

    - Identify the basic social, cultural, normative, geographical, literacy, and economic challenges related to the problem facing the people the program would like to reach
    - Identify factors inhibiting or facilitating desired changes (e.g., access to health care)
    - Identify current awareness, knowledge, attitudes, beliefs (especially related to rumors about interventions), norms, level of efficacy, aspirations for their children, perceptions (e.g., perceived susceptibility of a child to pneumonia), motivations, and behaviors (e.g., how do mothers currently address severe coughs and persistent

loose stools in their children? What treatments do they use? Where do they get those treatments?). Analyze these factors by age, gender, literacy levels, location and other socio-demographic variables to help segment your population as necessary and tailor the interventions

- Identify where in their list of priorities your intended population puts child survival, newborn care, childhood pneumonia and diarrhoea prevention and control
- Identify the words/language that your intended population uses to talk about newborn care, childhood pneumonia and diarrhoea, prevention and control, and related topics
- Determine what your population of interest may want to know about, for example, vaccines, ORS, exclusive breastfeeding
- Understand your intended population's social networks and patterns for information sharing
- Understand the community dynamics (e.g., who are the opinion leaders for specific issues)
- Determine your intended population's (mass and social) media use and access
- Identify the key communication sources (where or from whom) your intended population prefers to receive information related to the problem

3. Review existing programs and policies.
    - Inventory the programs that have been implemented or are currently being implemented to address newborn care and childhood pneumonia and diarrhoea prevention and control in your population (or a similar population). Learn what programs/activities were effective in changing the intended population, what did not work, and why the program/activities did or did not work
    - Inventory related programs, for example, maternal and child health programs that may have included newborn care and pneumonia and diarrhoea prevention components. Make a list of partners and potential partners with whom to share resources
    - Inventory existing policies in order to identify the parameters for your program and to determine which policies you may wish to change, or policies that you may want to create anew

4. Determine communication capacity.
    - Determine the reach and accessibility of key communication channels (e.g., television, radio, mobile phones, Internet) that are used by your intended population(s)
    - Understand how traditional media is currently used (e.g., puppet theater, street theater, storytelling)
    - Determine the capacities of local media and what might be required to strengthen their capacity
    - Determine the capacity of agencies that can develop communication materials and what might be required to strengthen their capacity
    - Determine the capacity/skills level for interpersonal communication and counseling

5. Identify potential partners.

    Working with partners is a way to avoid duplication of efforts and increase the cost-effectiveness of your program. Partnerships should add value to your program efforts by providing access to expertise and data, by sharing resources, and by increasing your access to your intended population. Select partners that are trusted by, and have credibility with, your intended population.

    - Identify partners and allies at the national level that will help with policy level changes to create an enabling environment for your program (e.g., Ministerial level champions, NGOs, INGOs)
    - Identify partners and allies at the local level that will help to develop and implement your program (e.g., media outlets, private retailers, religious leaders, community groups, health workers).
    - Identify partners in the environment that will help to distribute commodities (e.g., pharmacists)
    - Identify opportunities for active collaboration among partners (e.g., Global Hand Washing Day, World Pneumonia Day)
    - Meet regularly with partners to discuss coordination of activities

How Do You Gather This Information?

The information needed may be available in the form of *secondary* data, that is, in existing documents and databases within your organization, or from other organizations and sources. When secondary data are either not recent or incomplete, it is important to obtain data from *primary* sources. Primary research is information obtained directly from the

source, such as a survey of households or communities, focus group discussion with community health workers, in-depth interviews with pharmacists, shopkeepers that sell diarrhoea remedies, and media personnel. Table 3 provides a list of common primary and secondary sources of data.

Table 3. Common Primary and Secondary Sources of Situation Analysis Data.

Primary Sources	Secondary Sources
• SWOT analysis • Household/organization survey • In-depth interviews • Focus group discussions • Direct observation • Community mapping/Social mapping • Card matching exercises • Word association/Sentence completion • Content analysis • Expert opinion/Key informant interviews	• Literature review/meta-analysis • Reports (government and non-government) • Community records • Census data/national health data/donor country reports • Tracking reports (e.g., media reach analyses) • Audit (e.g. of medical records) • Meeting notes

When collecting data from primary sources, it is useful to use both quantitative and qualitative approaches (also referred to as a *mixed methods* approach). Surveys are effective tools when you already have some knowledge about the research area and are designed to provide valid and reliable representations of for a specific population (**Appendix 4**). They usually have mostly close-ended questions that inhibit the ability to record respondents' elaborations or explanations of their answers. Qualitative research, for example, focus group discussions (**Appendix 5**) and in-depth interviews, community mapping (**Appendix 6**), and social mapping (**Appendix 7**), have formats that encourage respondents to express their ideas and opinions and are useful for exploring a problem, and for understanding your intended populations' ideas and concerns. Qualitative research can be used to (1) develop or broader your understanding of the problem, (2) understand how people feel about the problem, (3) understand various perspectives between different groups of representative samples of your intended population, (4) explore motivations and underlying factors related to the problem, (5) understand decision-making processes, (6) provide information to help you design a quantitative study, and (7) explain findings from a quantitative study.

When deciding whether to use focus group discussions or in-depth interviews it is useful

to consider the topic of discussion, the logistics for arranging the meetings, and the influence of group dynamics. More sensitive or taboo topics are more easily discussed in one-to-one in-depth interviews. In-depth interviews are generally easier to arrange, especially when interviewees are geographically dispersed, compared to assembling a group of individuals at one time in one location. Focus group discussions elicit different perspectives and the group dynamics usually illuminate conflicting opinions. You should conduct enough focus group discussions and in-depth interviews until the information obtained is no longer new. In general, primary data collection should be conducted with representative samples of your intended population.

Once the information gathering is complete, you should revise your problem statement as necessary. This statement will be the foundation for your program goal. The data gathered from the situation analysis will help you to create messages that are scientifically correct, research based, and speak to your intended population in terms that are familiar to them.

Appendix 8 provides a checklist for Step 1: Situation Analysis.

ADDITIONAL RESOURCES

1. de Negri, B., Thomas, E. (2003). Making sense of focus group findings: A systematic participatory analysis approach. Washington, DC: AED (http://www.rhrc.org/resources/general_fieldtools/toolkit/otherResources/AED_MakingSenseOfFocusGroupFindings2003.pdf)
2. Debus, M. (2000). A handbook for excellence in focus group research. Washington, DC: Academy for Educational Development.
3. Patton, Michael Quinn (1978). *Utilization-Focused Evaluation.* Beverly Hills, CA: Sage Publications.

STEP 2: STRATEGIC DESIGN

The C4D strategy is the overall approach the program takes to achieve the goal and objectives. This strategic design step is the point at which (1) the information from the analyses (Step 1) is translated into SMART objectives, (2) appropriate communication approaches are decided upon, (3) communication channels are selected, (4) an implementation plan is developed, and (5) the monitoring and evaluation plan for the program is written.

Establish the Program Goal

The program goal is a general statement that describes the *overall* health improvement that you strive to achieve for your intended population, for example, "To reduce child mortality" (Millennium Development Goal 4). Each goal will have one or more objectives that describe more specifically what the outcomes of the program will be.

Establish Communication Objectives

Communication objectives are the specific communication outcomes you aim to produce in support of your overall goal for the program. Objectives must be **s**pecific, **m**easurable, **a**chievable, **r**ealistic/relevant, and **t**ime-bound, or SMART. Each objective should include the following:

1. A = Audience (the group or population whose behavior you are aiming to change)
2. B = Behavior (the intended performance outcome)
3. C = Conditions (the place and timeframe for change)
4. D = Degree or criteria of success (how much change you expect to see within a specific timeframe)

An example of a clearly stated SMART objective is:

> To increase by [X] percent the number of Cambodian mothers that complete all scheduled immunizations for their child(ren) under one year old by December 2015.
>
> A = Cambodian mothers with children under one year old
> B = Complete all scheduled immunizations
> C = Cambodia, by December 2015
> D = Increase by X percent

There is no need to include a "condition" at the end of your objective (usually indicated using the word "by" followed by a description of HOW the objective will be achieved), for example "To increase by X percent…**by** educating mothers during home visits." Anything after the word "by" is usually an activity and will be included in your C4D program plan once you spell out your approaches and implementation plan. Keep the objective simple and include only the A,B,C, and D.

You may consider various types of objectives to achieve your goal, for example: (1) Institutional capacity-building objectives (e.g., to improve skills for implementing a program or specific component of a program such as evaluation), (2) communication objectives (e.g., to change knowledge, attitudes, skills, behaviors, and social norms), and/or (3) advocacy objectives (e.g., to change policies). Each objective will require a series of activities (e.g., training CHWs, conducting mobile theater events, immunization days). Each objective that you write will be translated into program indicators and used to evaluate the progress of the program from the baseline research to the endline or final impact research (Figure 3). It is wise to focus the objectives for your C4D program so that the activities that help you achieve each objective, and the number of evaluation indicators (which are based on each objective), will be manageable.

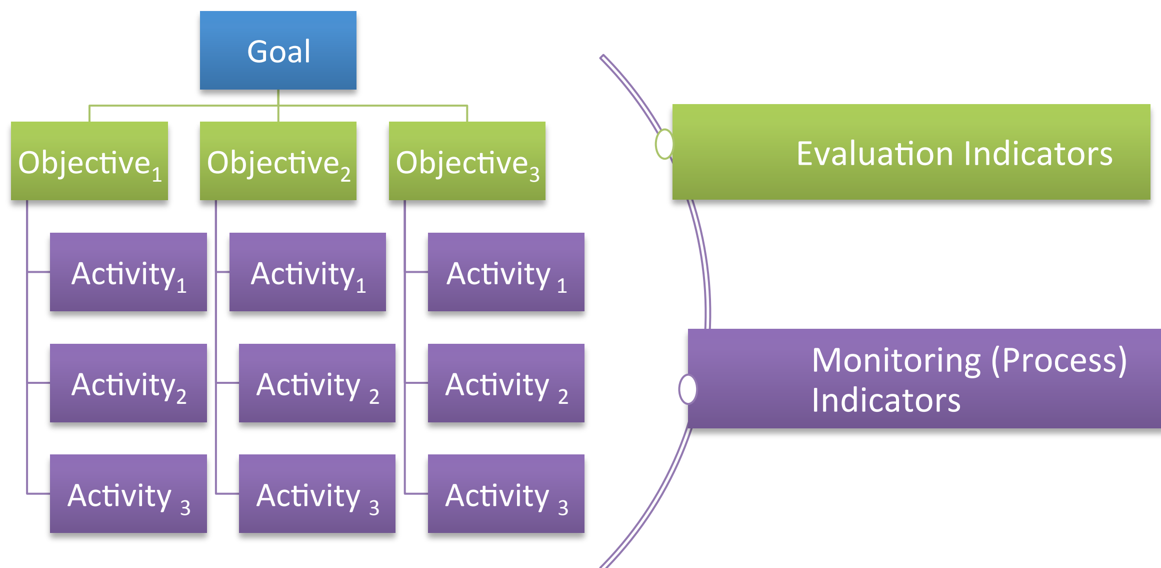

Figure 3. The Relationship of Objectives and Activities to Evaluation and Monitoring Indicators.

Develop Program Approaches

All effective C4D strategies are based on communication theories and models that explain or represent the behavior change process. A theory is a set of interrelated concepts and constructs that present a *systematic* view of relationships between variables in order to *explain* or *predict* outcomes, and are generalizable across populations. Models, like the Social Ecological Model (SEM), are a subclass of theory that *represents* (but does not explain) behavior and social change processes. In general, theories are *tested* and models are not.

Each of the levels of the SEM has a set of corresponding communication theories that should be considered when designing your program intervention. Figure 4 shows the SEM and examples of corresponding communication theories or models.

It is important to use theories and models to explicitly state the assumptions underlying your program approach, that is, to explain WHY and HOW the program approach is expected to change the behaviors identified in your objectives. It is helpful to diagram these assumptions; the diagrams can be used in your advocacy efforts to help show leaders the essence of your C4D program and how it can lead to the desired changes.

Table 4 provides examples of program approaches for community-based, interpersonal or group communication, and strategic-level communication interventions.

Table 4. Examples of Program Approaches for Community-Based, Interpersonal or Group Communication, and Strategic-Level Communication Interventions.

Community-Based Approaches	Interpersonal or Group Communication Approaches	Strategic Communication Approaches
• Community mobilization • Community engagement • Community outreach • Community intervention • Social mobilization • Empowerment	• Home visits • Community Health Workers (CHWs)/Lay Health Workers (LHWs)/Frontline workers/Health agents • Counseling/Peer counseling or education • Faith-based mobilization • Support groups • Social networks • Mobile clinic • School-based	• Advocacy (policy, media, agenda-setting) • Mass media • Community media • Information & Communication Technologies (ICTs)/Social media • Social marketing • Positive deviance • National events (e.g., Immunization Days, festivals)

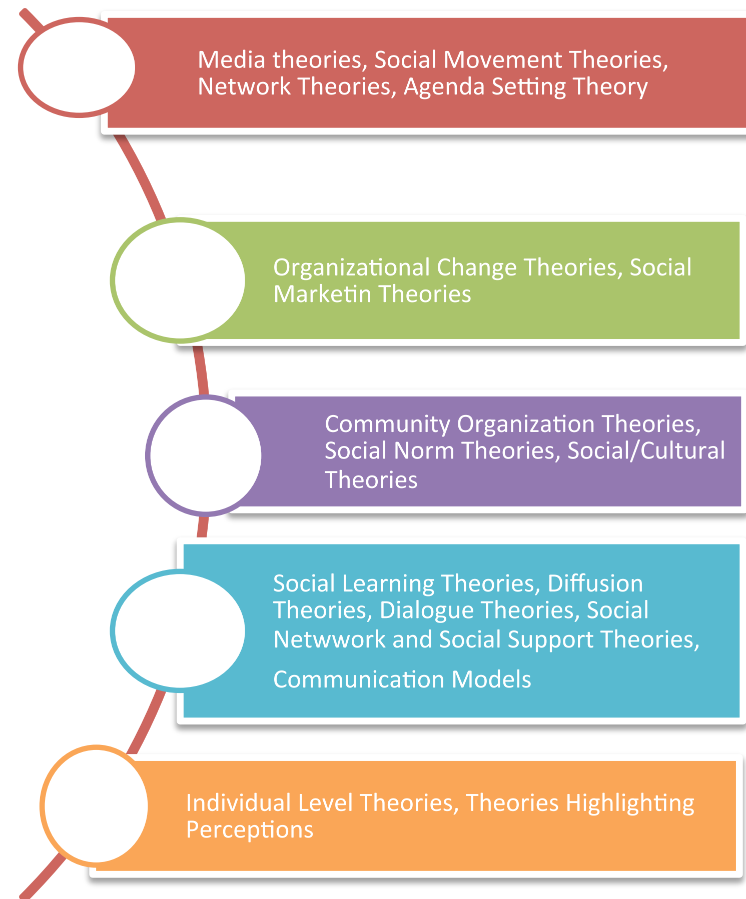

Figure 4. The Social Ecological Model (SEM) and Corresponding Communication Theories and Models

In general, community-based and interpersonal or group approaches produce smaller, localized changes in behavior unless they are scaled up to a larger population base, and tend to achieve more short-term or temporary changes, without necessarily affecting social norms, than strategic communication approaches that have greater breadth and reach larger populations.

Determine Channels

The effectiveness of a communication channel (e.g., interpersonal communication, mass media, community dialogue) should be measured by its ability to deliver the right type of information to the intended population, to get people to remember the information, to motivate people to talk to others about this information, and to change their behavior and, in turn, the behavior of others in their social system, based on the information. Mass or social media messages alone will have limited effects on behavior change, but mass or social media that stimulate dialogue and are combined with interpersonal communication will create synergies that increase the likelihood for sustainable behavior change. A communication channel should provide information in a timely manner, be cost-effective for reaching the intended population, and stimulate meaningful interactions within the population.

Each communication channel has a set of characteristics that make it more or less appropriate for specific population groups and for achieving specific outcomes. Communication channels should be selected to fit the communication task.

Match the Channel to the Task

Different channels play different roles, for example, television and radio spot advertisements work well to raise awareness about an issue, while newspaper articles can provide more in-depth information about a topic. Information and communication technologies (ICTs), including social media, are effective for spreading messages in real-time to members of the population that have access to the means for receiving social media messages, for reinforcing messages, for enhancing service delivery, and for building social networks that can be activated to mobilize communities.

Each type of communication channel has benefits and drawbacks for conveying certain types of messages to specified populations. It is important to consider:

1. The intended population you want to reach:
    a. Does your intended population have access to the channel?
    b. Will the channel reach your intended population?

    c. Does the channel allow for feedback from the population?
    d. Are the channels perceived as trusted sources of information about your issue?
2. The message(s) you want to deliver:
    a. Is the channel appropriate for the type of message you want to deliver (e.g., visual, oral, simple, complex)?
3. The channel reach:
    a. Does the channel cover enough area to expose your intended population to the messages?
4. Timeliness of the channel:
    a. Does the channel allow the intended population to receive the messages whenever they want (e.g., via text message or a Web site) or on a set schedule (e.g., a radio advertisement)?
5. Cost of using the channel:
    a. Does the C4D program have the resources to utilize certain channels?
    b. What is the cost-effectiveness of the channel(s) being considered?
6. Synergies with other program activities:
    a. Does the channel reinforce messages for other program activities?
    b. Does the channel encourage the population to engage in dialogue?
    c. Do the messages motivate the population to seek/demand rights and services?

Appendix 9 provides a summary of the most common communication channels used in C4D programs, the message reach, the suitability for the level of message complexity and audience engagement, and the relative cost.

Match the Channel to the Intended Population

Communication channels should be selected to fit the population and the message delivery task. It is important to select channels that reflect the patterns of use of the intended population group and that reach the group with the greatest degree of frequency, effectiveness and credibility. For example, radio messages should be scheduled at the times that your intended population is listening to the radio; print messages should be tailored to literate segments of your intended population, and visual materials for those who have low literacy or are illiterate. You should know your intended population's preferred channels and media use, as well as their capacity for passing on information within their social networks, from your population analysis in Step 1 of the P-process.

Use Multiple Channels

Using several channels at the same time reinforces and increases the impact of communication

messages. It is especially important to combine media channels with interactive and interpersonal communication activities in order to stimulate dialogue among your intended population. For example, television serial dramas can raise awareness and promote positive social norms for newborn care and child survival and pneumonia and diarrhoea prevention and control through positive and negative role-modeling using characters in serial dramas. Viewers can be invited to respond to the serial drama through viewer groups that meet at designated times to watch the drama and discuss the issues and events of the drama. Supporting media (for example, radio testimonials, billboard advertisements, posters) can be used to reinforce key messages from the television drama. Community health workers and volunteers could use visual materials that reflect the messages of the serial drama during home information visits.

When dealing with more sensitive issues, folk theatre groups can tailor interactive dramatizations (or humorous sketches) in local languages/dialects for issues that the intended population is apprehensive to discuss directly. Performers can elicit feedback from the audience during the performance and request input to the performance. Performances can be followed by group discussions, contests, and demonstrations that invite the audience to participate and discuss the issues.

Develop an Implementation Plan

Once the strategic design elements (e.g., goal, objectives, approaches, communication channels, and activities) are decided, they should be spelled out in a concise strategic design document that includes an implementation plan. The implementation plan should have a work schedule for the activities with benchmarks to monitor progress, and a description of the management tasks for the program (including partners' roles and responsibilities). A line-item budget should also be prepared.

Develop a Monitoring and Evaluation Plan

Monitoring and evaluation should be planned as soon as you have identified the objectives for your C4D program. The indicators for measuring the progress and success of your program are tied to the objectives that you developed in this step of the P-process. Before you move to Step 3, you should develop indicators and identify data sources for monitoring the implementation of your program (process indicators) and for recording reactions to the messages and feedback from your intended populations (see Step 4, page 49 and Appendix 10). You should decide on the study design you will use to measure process outcomes and changes in your intended populations.

Appendix 10 provides a checklist for Step 2: Strategic Design.

ADDITIONAL RESOURCES:

Edberg (2007). *Essentials of health behavior: Social and behavioral theory in public health.* Boston, MA: Jones and Bartlett.

Rice, RE and Atkin, CK (Eds.)(2013). *Public communication campaigns, 4th Edition.* Thousand Oaks, CA: Sage.

U.S. National Institutes of Health (2005). *Theory at a glance: A guide for health promotion practice, 2nd Edition*. (http://www.cancer.gov/cancertopics/cancerlibrary/theory.pdf)

STEP 3: DEVELOPMENT AND TESTING

Step 3 of the P-Process requires translating the situation analysis (Step 1) and strategic plan (Step 2) into the communication interventions/activities, including messages and materials that will be used to reach and engage your intended populations. The interventions/activities and messages should relate to each of your program objectives and should be created with participation from key stakeholders, including partners, community health workers, media experts and others).

Message and Materials Development

There are a number of factors to consider when developing C4D program messages:

1. Tone of the message (e.g., formal, informal, active, authoritative)
2. Type of appeal (e.g., positive emotional, fear, humor, persuasive one-sided vs. two-sided)
3. Language (e.g., dominant language, local dialect)
4. Clarity (e.g., easy to understand as intended)
5. Sensitivity to cultural and religious norms

Effective messages create interest (intellectual and emotional) in the topic so that members of the intended population are motivated to discuss the messages with others and act on the messages.

Following are the steps to developing messages and materials:

1. Review existing materials to determine whether there are suitable materials already in existence that can be used (or possibly adapted) for your program. The existing messages should be accurate and socially- and culturally- relevant for your intended population.
2. Assemble a team of creative professionals, health professionals, market research professionals and others to develop the messages. Make sure that the team has a clear understanding of the population, the context, and the goal and objectives before you brainstorm about the messages. If you are considering using an advertising or marketing agency, review their portfolio of work to make sure their style fits with your needs, and provide them with your communication strategy to help them understand your goal and objectives.
3. Develop the key messages, including the key promise (i.e., the most important benefit that you want your message to convey), what you are promoting, why you are promoting it, who you want to reach, and the specific cues-to-action that you want your intended population to follow (BOX 3). The messages should be clear, concise, consistent, create an emotional

BOX 3: CREATING A MESSAGE BRIEF

A *Message Brief* is a document that helps you to convey to media development professionals the communication intentions of your program. These creative professionals will use the Message Brief to develop the concepts, craft the messages, and create materials for your program. The message should eliminate the problem the intended population has with idea or product and reinforce the benefits of the action or behavior. The situation analysis in **Step 1** of the P-Process will provide the information that you can use to develop the Message Brief. Here is an example of a Message Brief for exclusive breastfeeding messages:

Message Brief Component	Explanation of the Component	Example
1. **The Key Issue or Fact**	The most important statement you want to make about the problem, and what you want the message to address	Mothers are not aware immunizing their child is a safe way to protect the child against infectious disease
2. **The Promise**	A persuasive statement that conveys the most important benefit of the action and that will motivate your intended population to complete the action. State one key promise; more than one benefit may reduce the impact of the message	• Immunizing your child will help her to stay healthy and grow strong, OR • Immunizing your child shows your family that you are a good parent
3. **The Support**	A brief statement about WHY the intended population should believe the promise. This statement can be factual or emotional (depending on what your research suggested is most persuasive for your intended population) and express why the promise outweighs any barriers to completing the action. The information can come from testimonials, expert endorsements	• Factual: Children who are not immunized are X-times more likely to get sick with or die from an pneumonia or diarrhoea than children who are immunized. • Factual: A child that is immunized is less likely to get sick and will save you the time and cost of seeking treatment • Emotional: When your child is immunized you will worry less about him/her getting sick
4. **The Competition**	Messages in the intended population's environment that contradict your message or make it difficult for your intended population members to believe your message or adopt the idea or behavior you are promoting	• Statements by community members about the dangers of vaccines • Statements from mothers that immunization did not help to prevent pneumonia in their children
5. **The Statement of Ultimate and Lasting Impressions**	The belief or feeling that the intended population will have following exposure the message	My child's health is important and immunizing my child is a safe way to protect him/her from sickness
6. **The Desired Audience Member Profile**	How the intended population perceives someone who adopts the idea or behavior being promoted	• Mothers that love and care about the health of their children
7. **The Key Message Points**	The key information that will be included in all communication materials for the C4D program (you can include information that will counteract the most common misperceptions or misinformation)	• Vaccines are safe • Vaccine side effects are minor • Healthcare providers in your area are trained to deliver vaccines to your child

Source: Adapted from O'Sullivan, G.A., Yonkler, J.A., Morgan, W., and Merritt, A.P. A Field Guide to Design- ing a Health Communication Strategy, Baltimore, MD: Johns Hopkins Bloomberg School of Public Health/Center for Communication Programs, March 2003.

connection with the intended population, be consistent, and should always include a cue-to-action (i.e. tell the intended population exactly what you want them to do as a result of being exposed to the message).

4. Develop appropriate materials, for example, CHW visual aids, TV or radio storyboards or scripts, posters, *fotonovelas* or comic books, Web sites, leaflets, PowerPoint presentations.
5. Consider branding the materials (e.g., create a label or logo, theme song, slogan) to facilitate recognition for the program by the population and to create an emotional link to the program.
6. Consider including "evaluation markers" in the materials. BOX 4 provides an example of using an evaluation marker in a television soap opera in South Africa.
7. Pretest all messages and materials with *representative samples* of your intended population (**Appendix 11**) to ensure:
    a. Appeal: Does the intended population find the message attractive, attention grabbing? Do they like the colors, photos, and language?
    b. Relevance: Do they feel that the message is aimed at them or a different audience?
    c. Comprehension: Is the message clearly understood?
    d. Acceptability: Does the message contain anything that is offensive, distasteful, annoying, or untrue in the eyes of the intended population? Do they believe the message? Is the source trustworthy and credible?

BOX 4: POT BANGING FOR VIOLENCE PREVENTION IN SOUTH AFRICA

The Soul City 4 television series, broadcast in 1999, highlighted the issue of violence against women in Southern Africa. The TV series was part of a media and mobilization campaign that included a daily radio drama, booklets, an advertising/publicity campaign, and advocacy and social mobilization activities, to increase knowledge and change attitudes and practices regarding gender-based violence (GBV), and to encourage individuals and communities to take action to stop abuse.

The TV series role-modeled a community's shift from silent inaction regarding domestic violence, to active participation in decreasing the incidence of GBV. Community members were shown standing outside the home of a couple where the husband was verbally and/or physically abusing his wife, with pots and wooden spoons in hand, banging loudly until the husband was forced to come to the front door and the community members could make him stop the abuse. Pot banging was not previously known in South Africa; it was created specifically as a method for embarrassing the abuser, using items that even the poorest families would have in their home.

The Soul City 4 program increased participation in community action. Reports of pot banging (and a variation of bottle-banging) were recorded during the evaluation of this intervention, linking this activity directly to the TV series.

Source: The Communication Initiative Network: Soul City 4 (February 15, 2005): http://www.comminit.com/content/soul-city-4.

e. Persuasion: Does the message motivate the intended population to (want to) change their behavior?
f. Recall: Can the intended population members identify the cue-to-action? Do they recognize the benefit(s) being offered?

8. Revise the messages and materials based on the pretesting results and re-test as necessary before finalizing and producing the materials.

Despite careful message and materials development efforts, sometimes messages are misconstrued or used to support an alternative agenda. BOX 5 provides a description of how to develop a crisis management plan to dispel rumors and misinformation, and re-direct protests and reactions to unintended consequences from program messages, activities or interventions.

BOX 5: DEVELOPING A CRISIS MANAGEMENT PLAN

Rumors, misinformation, protests, and rare medical reactions to interventions (e.g., an allergic reaction to a vaccine) can derail any C4D program. It is important to have a crisis plan in place to be able to respond rapidly and positively to adverse events. Following are actions that should be taken prior to implementing your C4D program:

1. Convene a C4D Crisis Committee at the national and local levels.
2. Develop a set of communication messages to address unintended consequences of your C4D childhood pneumonia and diarrhoea prevention program. These messages can be quickly refined to address the specific threat(s) or unintended consequences. Once the messages are finalized, ensure that they are a standardized response to the issue(s).
3. Identify respected spokespersons to deliver the standardized messages to your population(s) of interest.
4. Conduct briefings with media personnel to ensure that the standardized messages have maximum reach.
5. Conduct briefings with all stakeholders to explain any adverse effects or negative circumstances and to assure them of the overall safety and effectiveness of your C4D program.
6. Engage local opinion leaders (i.e., credible and trustworthy sources of information in the communities where your C4D program is being implemented) to address the issue(s) in a culturally and socially appropriate manner.
7. Conduct briefings with local healthcare providers (e.g., community health workers/volunteers) to explain the issue(s) and to give them “talking points” to help them explain the issue(s) to the mothers, families, and other community members.
8. Monitor and measure the response to the crisis to understand how to make the crisis management plan more efficient and effective.

Appendix 12 provides a worksheet for charting the development and testing of the activities to meet your program objectives.

ADDITIONAL RESOURCES

O'Sullivan, GA Yonkler, JA., Morgan, W., and Merritt, AP (2003). *A Field Guide to Designing a Health Communication Strategy*. Baltimore, MD: Johns Hopkins Bloomberg School of Public Health/Center for Communication Programs.

STEP 4: IMPLEMENTATION AND MONITORING

A good implementation plan includes a clear description of the message and materials to be developed, of any training that is necessary, of the roles and responsibilities of the partners involved, a realistic timeline, a realistic budget, and a description of monitoring tasks. Keep the management tasks simple and ensure that the management activities support the program objectives.

Produce Materials and Develop a Dissemination Plan

Once you have finalized the program messages and materials, interventions and activities (Step 3), you should determine when and how, and/or how often materials and activities will be produced and disseminated or implemented. If you intended to conduct community meetings, advocacy events, or other participatory or interactive activities, you will need to plan for, and develop a schedule for, each event/activity. Your dissemination plan should include a description of the distribution channels or event locations (including dates and times), a promotion plan, the identification of who is responsible for ensuring that the materials are disseminated, and a plan for how you will monitor the distribution or placement of materials. Communicate this plan will all partners and stakeholders.

Plan and Conduct Training

Make a plan to train individuals or groups that require skills-building support to manage and implement the program, including program managers, staff, and field workers/community health workers. For example, if you are promoting the services of local health clinics to treat childhood pneumonia, it is essential that clinic staff are properly trained to address the child's illness and the parents' concerns regarding the illness. Conduct the training in a timely manner prior to the start of program activities.

Manage and Monitor the Program

C4D program managers need reliable and timely information about program activities. Monitoring, also referred to as process evaluation, is the routine (day-to-day) tracking of activities and deliverables to ensure that materials are being distributed to the right people in the right quantities, messages are being delivered, partners are involved, and the program is proceeding as planned, on schedule, and within budget. Program monitoring alerts managers to problems or deviations from the program plan in a timely manner, provides information for improved decision-making, ensures more efficient use of resources, and strengthens accountability of the program. Monitoring can also help you to measure the intended populations' reactions to program interventions in a timely manner so that adjustments to messages, materials, or activities can be made in a timely manner.

Monitoring information can be collected through various sources (Table 5). Rapid appraisal methods are quick, low-cost ways to gather the views and feedback of intended participant group members and other program participants. The feedback can be quickly analyzed to determine whether any of the program elements require changes. The findings, however, are usually related to specific communities and not necessarily generalizable to all communities in the program. Community group interviews involve a series of questions and facilitated discussions in a meeting open to all community members. The use of mystery clients is primarily for monitoring the quality of services at health facilities and/or the state of the health facility.

Table 5. Examples of Quantitative and Qualitative Monitoring Methods.

Quantitative Methods	Qualitative Methods
• Rapid appraisal survey or rapid audience assessment • Pre-post surveys for trainings • Audits (e.g., of medical records) • Tracking logs • Content analysis (e.g., of media coverage)	• Focus group discussions • Community group interviews • Key informant interviews • In-depth interviews • Direct observation (field visits) • Mystery client

Whenever possible, utilize a mixed methods approach, that is, incorporate both quantitative and qualitative methods to obtain a more comprehensive perspective of program processes and activities.

Figure 5 shows the sequence of events for a C4D program using a simplified Logic Model.[5] There are four key components to the model:

1. Inputs: The resources that go into the program (e.g., staff, volunteers, time, money, equipment, materials)
2. Outputs: The activities, services, events, and products that reach your intended populations

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[5] A Logic Model is a graphic depiction of the logical relationships between program inputs (resources), activities, outputs, and outcomes of a program. This Model can be used as a planning tool for the monitoring and evaluation stages of a program. The Kellogg Foundation Logic Model Development Guide can be found at http://www.wkkf.org/knowledge-center/resources/2006/02/wk-kellogg-foundation-logic-model-development-guide.aspx.

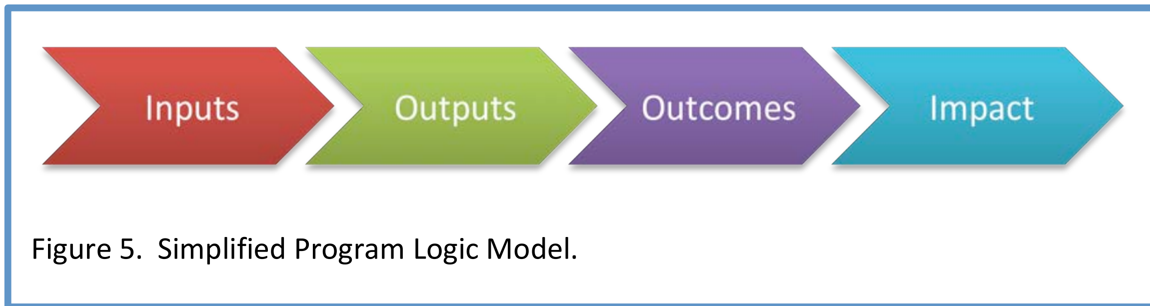

Figure 5. Simplified Program Logic Model.

3. Outcomes: The short- and medium- term results or changes in your intended populations as a result of exposure to the program activities
4. Impact: The long-term, sustainable changes in health status, and in organizations, communities, or social systems that occur as a result of program activities

Monitoring pertains to measuring the communication inputs and outputs, and can be used to assess the early outcomes in your intended population members (Figure 6). What you monitor

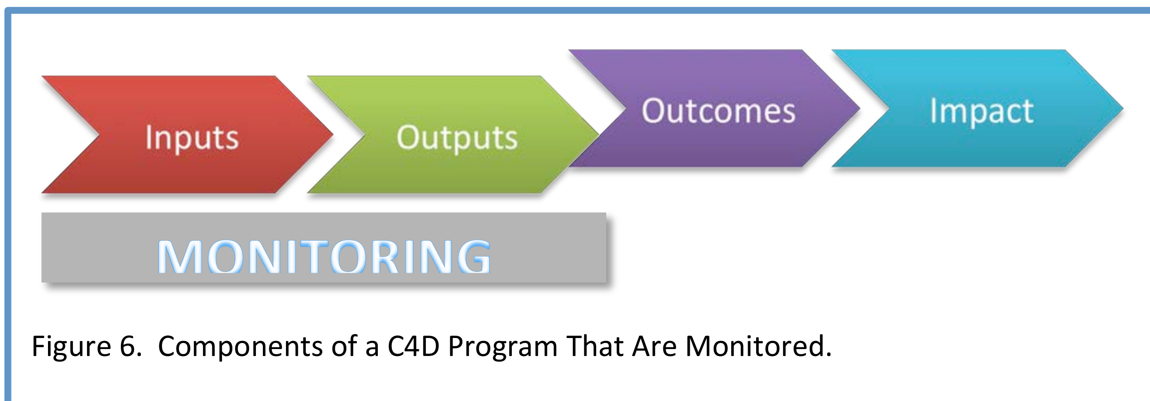

Figure 6. Components of a C4D Program That Are Monitored.

will depend on the resources you have available for monitoring activities. You should, at the very least monitor ALL inputs and MOST of the outputs so that you can assure the integrity of the program implementation. If an activity was not implemented as planned, for example, a radio drama series was not broadcast in one or more program locations because the transmitter was not functioning, the monitoring feedback would alert the program manager to make sure that the program was broadcast as soon as possible. If the program could not be broadcast, the monitoring feedback will help to explain any difference in program outcomes at the end of the program since the intended population members were not exposed to the

program in the same way that other population members were in other areas. You can ask program managers, stakeholders and decision-makers which data will be most useful to them and then collect only that information that can be used in a timely manner.

Table 6 provides examples of what to monitor for C4D programs and what types of questions to ask.

Table 6. Examples of What to Monitor for C4D Programs and The Types of Questions to Ask.

What to Monitor	Types of Questions to Ask
1. Inputs (resources used to develop the program)	• Are the resources sufficient for producing adequate quantities of quality materials, paying staff to conduct/attend trainings? • Is there enough time to develop all the necessary materials, meetings, trainings, monitoring and evaluation templates and processes? • Are the distribution channels in place to ensure that program materials reach the intended locations? • Are all communication channels operating as intended?
2. Outputs (program activities/implementation)	• Are training sessions being conducted as planned? • Are the program activities taking place on scheduled and according to the planned frequency? • Are pneumonia and diarrhoea prevention and control supplies (commodities) and services available to the intended population? • Are the messages and materials being delivered as intended in the program plan? • Are intended population members reacting to program activities as expected?
3. Program Coverage	• Are the planned numbers of intended population members being reached by the program activities? • Do the characteristics of the population members you are reaching match the population members you intended to reach? • Who is not being reached? Why not?
4. Process (partnerships, collaborations, reporting mechanisms)	• Are the relevant partners and stakeholders involved/contributing to in the C4D program as outline in the program plan? • Are the data collection and reporting mechanisms sufficient, efficient, and user-friendly? • Are there program management issues that require attention? • Is program staff capacity suited to the program tasks?

Steps for Monitoring C4D Programs

Following are the key steps for monitoring C4D programs:

1. Clarify the purpose and scope of the program monitoring: Decide on what information you need about the program inputs and outputs, and the reactions to program activities among your intended population (including short-term outcomes if appropriate), and how much data you will collect at what points in time. Only collect information that is immediately useful for program process oversight
2. Prepare an operational plan: Describe the information that will be collected, from which source(s), by whom, by what dates, and at what cost. Be mindful of ethical practices of ensuring the privacy and security of information regarding program participants
3. Develop process monitoring indicators (Appendix 10): For example, you may want to know the number of training sessions conducted for community health workers compared to the number of overall training sessions that were planned. Every indicator should have a numerator and a denominator:

   $$\frac{\text{Number of CHWs trained to deliver home-based educational modules at time}_X}{\text{Total number of CHWs to be trained to deliver home-based modules}}$$

   Or, you may want to know the quality of womens' experience with regard to their participation in community meetings. For example, "At least 50% of women participating in a community meeting about access to healthcare for their child felt that their opinion contributed to a solution to the problem."

4. Develop monitoring data collection templates: Create the tools that program staff will use to conduct monitoring activities, for example, an observation checklists, audit templates, brief survey questionnaires, and tracking/activity logs. Be sure to allow for recording any unintended consequences of program activities
5. Develop a monitoring data analysis plan: Describe what information will be analyzed, how, by whom, and by what dates
6. Develop monitoring reporting templates: Create easy-to-use reporting forms that are mindful of the time it will take to complete and read. The format should be concise so that the information can be readily interpreted and acted upon
7. Develop a mechanism for using monitoring reports to support on-going program activities: Create a process for reviewing monitoring reports, discussing them with staff,

partners, and stakeholders as necessary, and delegating tasks to address any issue that are detected through the monitoring activities.

The UNICEF MoRES Approach to Monitoring

The Monitoring Results for Equity Systems (MoRES) developed by UNICEF consists of four levels of monitoring that support the process of strengthening the focus on equity in programs (UNICEF Briefing Note, November 27, 2012). Figure 7 shows the cup-shaped framework. The cup is divided into four sequential levels of monitoring. Level 1 requires a review by each country office of their situation analysis using an equity-focused lens to identify bottlenecks and potential strategies for unblocking the bottlenecks. Level 2 requires that each country office monitor UNICEF program inputs and outputs. Level 3 monitoring provides an intermediate assessment of program progress, with attention to the removal of bottlenecks, and supply- and demand- side inputs and outputs, through joint inputs from all partners. Level 4 is the country office's impact evaluation, in collaboration with partners, of the degree to which bottlenecks were removed and the program achieved its equity objectives.

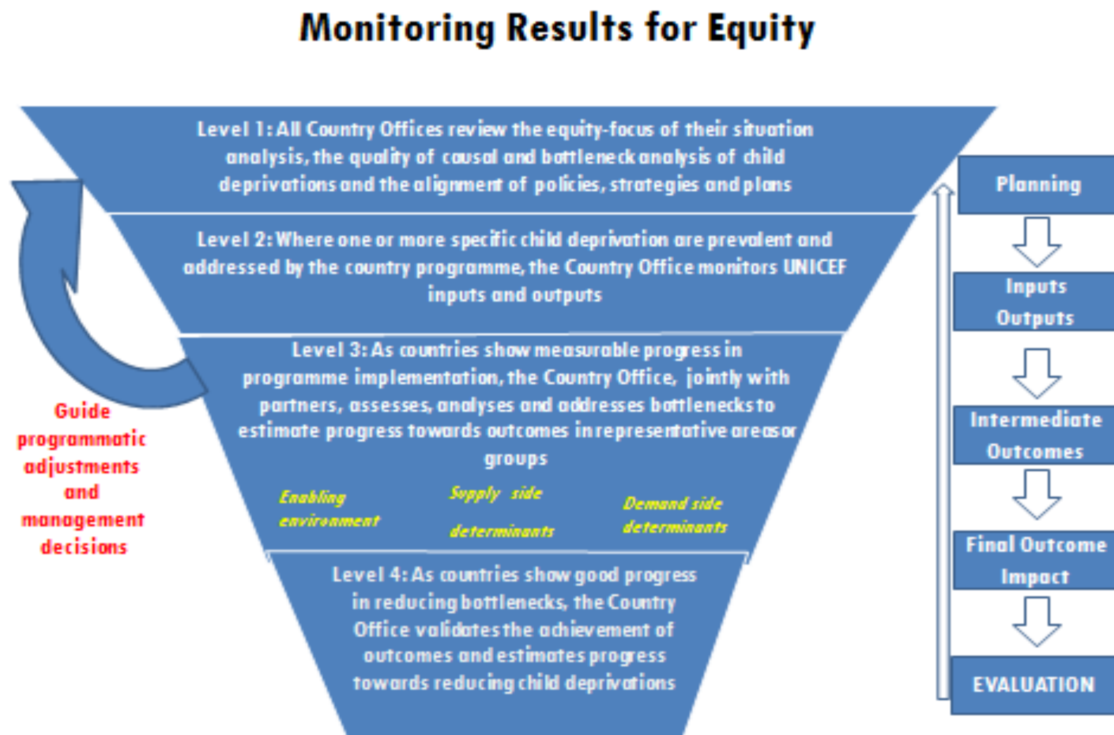

Figure 7: The UNICEF MoRES Framework.

The handle of the MoRES cup represents the iterative process for monitoring program progress; each level of monitoring can inform program development, implementation, and management decisions.

The bottleneck analysis is based on the idea that there are critical determinants that contribute to effective quality coverage of health services, practices and systems. Figure 8 shows the key determinants for identifying bottlenecks. Understanding the determinants and how they affect the desired program results is a prerequisite for programs that achieve the desired impacts. [6]

Appendix 13 provides a checklist for developing a monitoring plan.

UNICEF Determinants to identify bottlenecks

	Determinants	Description
Enabling Environment	Social Norms	Widely followed social rules of behaviour
	Legislation/Policy	Adequacy of laws and policies
	Budget/expenditure	Allocation & disbursement of required resources
	Management /Coordination	Roles and Accountability/ Coordination/ Partnership
Supply	Availability of essential commodities/inputs	Essential commodities/ inputs required to deliver a service or adopt a practice
	Access to adequately staffed services, facilities and information	Physical access (services, facilities/information)
Demand	Financial access	Direct and indirect costs for services/ practices
	Social and cultural practices and beliefs	Individual/ community beliefs, awareness, behaviors, practices, attitudes
	Timing and Continuity of use	Completion/ continuity in service, practice
Qlty	Quality of care	Adherence to required quality standards (national or international norms)

Figure 8. UNICEF Determinants to Identify Program Bottlenecks.

[6] For an example of how to use the MoRES framework, see http://www.unicef.org/uganda/MoRES_Uganda_-_results_and_lessons_learned_July_30th_2012(2).pdf.

ADDITIONAL RESOURCES

Boyce, C., Neale, P. (2006). Using mystery clients for evaluation input. Pathfinder International Tool Series, Monitoring & Evaluation. Watertown, MA, Pathfinder International (http://www2.pathfinder.org/site/DocServer/m_e_tool_series_mystery_clients.pdf)

W.K. Kellogg Foundation Logic Model Development Guide (2004). Battle Creek, MI: W.K. Kellogg Foundation (http://www.wkkf.org/knowledge-center/resources/2006/02/wk-kellogg-foundation-logic-model-development-guide.aspx).

STEP 5: EVALUATION AND RE-PLANNING

Evaluation of C4D program activities provides program managers, government officials, stakeholders and participants with a means for demonstrating results, learning from past experience, and improving planning and resource allocation for future programs. While monitoring is the routine (day-to-day) follow-up of inputs and outputs, evaluation is the episodic assessment of the outcomes and impacts of the C4D program on your intended populations, and on their social system at large. Evaluation is a systematic way of gathering evidence to show what program activities produced the intended results and which did not achieve the expected results for the specified intended populations. The evaluation is designed specifically with the intention to attribute changes to the program interventions.

Measure Outcomes and Assess Impact

Figure 9 shows the components of the C4D program that are evaluated. There are two types of outcomes, short-term and medium-term (also referred to as immediate and intermediate outcomes). Short- and medium-term outcomes are measured to determine what changes resulted among the intended populations (e.g., individuals, communities, organizations, policymakers) as a result of exposure to the program activities. The short-term outcomes are the changes in awareness, knowledge, attitudes, beliefs, self- and collective- efficacy, skills, intentions and motivations of the intended population members. The medium-term outcomes are the changes in the behaviors, practices, decision-making processes, power relations, policies and social norms as a result of program activities. Medium-term outcomes usually take longer to realize than short-term outcomes. The program impact is the long-term change in the social, economic, policy, and environmental conditions that result from the C4D program initiatives. Not all programs have the time and budget to measure the long-term impacts, as these might not be realized until after the program has ended.

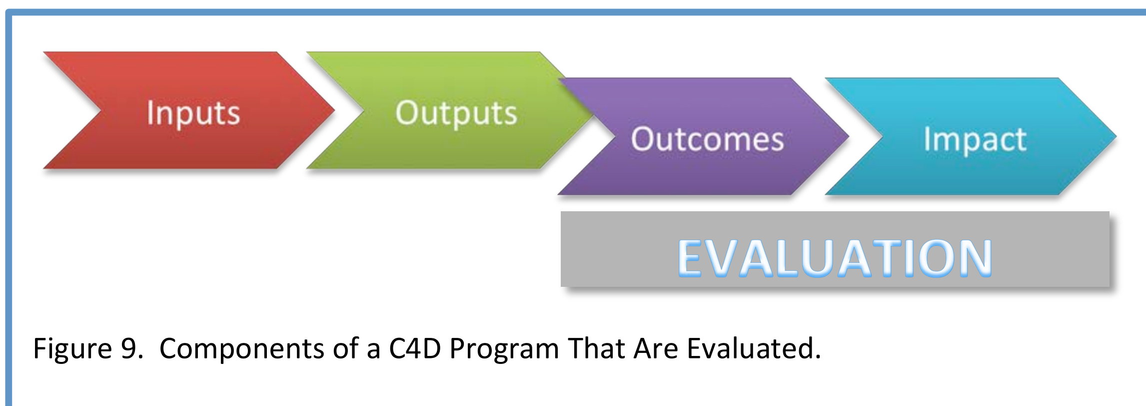

Figure 9. Components of a C4D Program That Are Evaluated.

The initial planning for the program evaluation occurred in Steps 1 and 2 of the P-process, where you conducted the baseline research and stated the program objectives. The evaluation indicators, that is, the measures of the success of the C4D program, are tied to the program objectives (**Appendix 14**). A general indicator may be: Knowledge of the symptoms of pneumonia. Like the monitoring indicators, this indicator has to be operationalized, that is, be translated into a numerator and a denominator. For example:

$$\frac{\text{Number of symptoms of childhood pneumonia that a mother can identify at time}_X}{\text{Total numbers symptoms of childhood pneumonia addressed by the C4D program}}$$

In order to draw conclusions about the program over time, the definition of each indicator must remain constant from baseline to impact evaluation. If your program activities were successful, then using the same indicator at baseline and at the end of the program would show an increase in the number of symptoms that mothers could identify from the baseline assessment.

Evaluation Designs and Methodologies

There are many ways to evaluate a C4D program and the most appropriate will depend on the financial resources and capacities available, the types of questions that are to be answered, and the timeframe allotted. Quantitative and qualitative data collection methods are both important for assuring the broad strokes and nuances of changes produced by the program are adequately captured. The overall questions to answer are “How well have we done?” and “How can we do better?”

Evaluation Designs

There are three main types of evaluation research designs, experimental, quasi-experimental, and non-experimental (Table 7). Following is a brief description of the three main evaluation designs. Although it is beyond the scope of this guide to provide a detailed analysis of the strengths and weakness of each design type, it is important for the evaluation researcher to be aware of potential pitfalls of any research design and to take these into account when designing and drawing conclusions from a study.

Table 7. Three Main Types of Evaluation Research Designs.

Research Design	Experimental	Quasi-Experimental	Non-Experimental
Random Assignment of Subjects to Group	Yes	No	No
Control Group or Multiple Waves of Measurement	Yes	Yes	No

Experimental Designs

Experimental research aims to attribute differences in outcomes and impacts directly to the program activities. The gold-standard experimental design is the randomized controlled trial (RCT) in which members of the intended population are randomly assigned to groups who receive the intervention(s) or do not, which then enables evaluators to establish causality between the activity and a specific outcome or set of outcomes. Random assignment makes it unlikely that the treatment and control groups differ significantly at the beginning of a study on any relevant variable, and increases the likelihood that differences on the dependent variable (e.g., immunizing a child) result from differences on the independent variable (e.g., group that listened to a radio talk show about childhood immunization vs. control group that were not exposed to the radio talk show). Random assignment controls for self-selection and pre-existing differences between groups; random selection or sampling is relevant to the generalizability or external validity of the research. This type of design, however, cannot go beyond demonstrating causality to describe the phenomenon that led to the causal relationship. Non-experimental designs can supplement experimental research to understand underlying factors related to causality. Experimental designs are also difficult to implement in real-world settings, are costly, and not always ethical (e.g., if program participants are being denied lifesaving interventions).

Quasi-Experimental Designs

Quasi-experimental designs differ from experimental designs in that intended population members are not randomized to intervention and control groups. There are many variations of designs that would be classified as quasi-experimental. For example, in a *cross-sectional design* the researcher gathers data from several different groups of subjects at approximately the same point in time. *Longitudinal studies* (sometimes also called *time series designs*) involve gathering information about one group of people at several different points in time. Longitudinal studies, however, are not often undertaken because of time and budget restraints on program implementation. The *Pretest, post-test single group design* examines the difference between pre- and post-test scores for one group of intended population members; there is no assurance, however, that the difference in pretest and post-test scores is due to the C4D program activity. The *post-test only, static groups design* compares the outcomes of a pre-existing treated group to the outcomes of a pre-existing untreated group.[7]

[7] The pre-test, post-test single group design and the post-test only static groups design are sometimes classified as non-experiments or pre-experiments (Campbell & Stanley, 1966) because the designs generally do not permit reasonable causal inferences. Later authors (Cook & Campbell, 1979; Trochim, 2006) include these designs in the category of quasi-experiments.

Non-Experimental Designs

Non-experimental designs do not use control or comparison groups, do not use multiple waves of measurement, and do not provide information on causality among variables. The simplest for on non-experiment is a one-time survey, which is useful for descriptive research, for example, to measure attitudes about community health volunteers following an immunization campaign. A common form of non-experimental research design is correlation research to determine the degree to which one variable is related to, or dependent, on another variable. It is important to note that correlation does not imply causation; correlation studies can help to see the frequency of co-occurrence of variables in two or more natural groups, for example, the co-occurrence of home-visits by CHWs to educate mothers about using ORS for infant diarrhoea and an increase in the number of ORS packets sold in a community.

Non-experimental designs are easier to implement and less expensive than experimental or quasi-experimental designs. These designs can use quantitative or qualitative methods including surveys, case studies, ethnography, participant observation and focus groups. They are helpful when it is necessary to understand social or human behavior and the meanings that people attach to their actions, and points of view or life experiences from your intended population's perspective. They can provide a depth of understand that quantitative research cannot. Non-experimental designs can also be used for capturing or describing naturally occurring phenomena in their real-life context, for example, anti-vaccine movements in a community.

Data Collection Methods

There are many methods for collecting quantitative and qualitative data. Table 8 provides a list of common data collection methods and descriptions. The method(s) selected for an evaluation will depend on (1) the purpose of the evaluation, (2) the users of the evaluation, (3) the resources available to conduct the evaluation, (4) the accessibility of study participants, (5) the type of information (e.g., generalizable or descriptive), and (6) the relative advantages or disadvantages of the method(s). All evaluations should aim to use mixed methods, that is, a combination of quantitative and qualitative methods in order to capture multiple facets of the program outcomes/impacts, and to be able to triangulate the findings.

Steps for Evaluating C4D Programs

Following are the key steps for evaluating C4D programs:

1. Clarify the purpose and scope of the program evaluation: Decide on what information you need about the program outcomes and impacts and who will use the findings.

Table 8. Common Evaluation Data Collection Methods and Descriptions.

Method	Description
Audits	Routine data collection from health information systems.
Case Study	A case study involves the observation of a single unit (e.g., an individual, a group, a community, a site/location, a culture) to gain an in- depth understanding of the unit being studied. While case studies may make use of either qualitative or quantitative methods (or both), most use qualitative methods. The main techniques used are observation, interviewing and document analysis. Case studies, however, cannot necessarily be generalizable to the whole population.
Diary/Journal	A record of events over time that provide the personal perspective of the writer.
Document Review	A review of relevant published and unpublished documents.
Ethnography	Ethnography most commonly refers to the study and systematic description of communities, cultures or social systems. The study is based on fieldwork.
Focus Group Discussions	A focus group is a facilitated group interview around a topic or series of topics supplied by the researcher. Focus groups discussions are encouraged to be free-flowing conversations that provide information, perspectives, and perceptions, stimulated by interaction with others. A limitation of this approach is that people may be influenced by others in the group and may be afraid to express their true views and beliefs.
In-Depth Interviews (structured, semi-structured and unstructured)	Tailored interviews with key informants, experts, stakeholders, and others can help gain insights and perspectives for specific topics or issues. It is important to test the interview protocols (questions) to ensure that the questions are clearly understood and phrased in a way that does not lead the interviewees to provide what they perceive to be the "correct" or "socially desirable" answers rather than giving their own thoughts, views and opinions.
Observation	In this approach, the researcher enters a culture to listen, observe and understanding that culture (for example, recording a day-in-the-life of a mother with a newborn). Observations can be structured or unstructured.
Surveys	Surveys can be used to collect standardized information from a selected sample of people or households. They are often used when it is important to understand characteristics about populations at a given point in time. Surveys can be implemented using written questionnaires, via the Internet, or via face-to-face or telephone interviews.
Most Significant Change	A systematic process of collecting and analyzing stories from program participants about the most significant change they experienced as a result of exposure to an intervention.

2. Prepare an operational plan: Describe the information will be collected, from which source(s), by whom, by what dates, and at what cost. Be mindful of ethical practices of ensuring the privacy and security of information regarding program participants.
3. Develop evaluation indicators based on the program objectives and activities (**Appendix 14**).

4. Develop and pretest evaluation data collection protocols and instruments: Create the tools that program staff will use to conduct evaluation activities, for example, survey questionnaires, focus group discussion questions, and the protocols for selecting participants (sampling) and conducting the data collection. Pretest all tools with representative samples of the intended population.
5. Develop a data analysis plan: Describe what information will be analyzed, how, by whom, and by what dates. It is helpful to create dummy tables for the data analysis.
6. Collect the data.
7. Analyze the data.
8. Write a report on the findings from the evaluation study: Communicating evaluation results effectively is critical if they are to be used for advocacy and re-planning. The narrative should be supported by graphics and illustrations to help the reader understand the findings. Translate the report into local languages as necessary.
9. Disseminate Results: Share and discuss evaluation results with relevant partners, donors, and all stakeholders, and program/study participants as appropriate. Program staff should seek out opportunities to convey evaluation results via briefings, Websites, e-mail, bulletins, Listserves, press releases, journal articles, conference presentations and other appropriate forums. In order for the findings to be most useful, you should make sure that they are communicated using formats that fit the needs of the recipients. For example, the full report can be given to program personnel and donors. The executive summary can be distributed to government officials, policymakers, and partner organizations (you may indicate that they can request a full report as appropriate). The executive summary can be turned into a one-page brief for media outlets. The findings can be used to further advocacy efforts, invigorate social mobilization initiatives, and secure support for future C4D programs.

Appendix 15 provides an evaluation plan checklist.

Revise and Redesign the Program

The program evaluation will reveal (1) the weaknesses of the interventions in achieving the program objectives, and point to areas that can be revised and strengthened, and (2) highlight what worked well and how those positive outcomes can replicated, and even scale up. The evaluation findings should feed forward into the design of similar, future programs.

Capacity Strengthening

Capacity strengthening at the institutional and community levels is an important component for strong and effective C4D programs. There are many strategies for developing capacities for the management and delivery of C4D programs, including formal and informal skills training, mentoring, supportive supervision, and team building exercises. The type of strategy selected depends on the existing level of capacity, the type of strengthening required and the level at which the capacity needs to be strengthened (e.g., individual, group, community, organization/institution, or national level).

Individuals might benefit from topic- or skills- based trainings, demonstrations, study-tours, observations, and supportive supervision. Groups and communities might engage in participatory training workshops, group education meetings, and team-building exercises. Organizations and institutions might gain insight into their capacities through special studies, for example a SWOT analysis, that engages members of the organization in an exercise to determine the strengths, weaknesses, opportunities, and threats facing the institution in such areas as partnerships, research, monitoring, and evaluation, and resource mobilization, and enable them to make recommendations for leveraging internal strengths, improving internal weaknesses, exploiting external opportunities, and minimizing external threats.

For example, recent SWOT analyses for UNICEF offices in East Asia and the Pacific identified weaknesses in the area of research, monitoring and evaluation (RM&E). Training programs for national staff may be designed to cover specific topics (e.g., how to develop a survey questionnaire, how to write an evaluation report) or the more broad area of how to implement and manage the monitoring and evaluation component of a program. Training may be provided formally, through workshops and courses, or informally, through working together. Program managers might identify and circulate copies of a well-written monitoring plan or evaluation to illustrate what end products are expected. Formal training followed by on-site technical assistance is an effective way of supporting the skills building process.

Strengthening capacity at the national level, for example, with government officials who are not clear on the contributions of C4D for child survival programs, might involve briefings, study tours, focused trainings, invitations to participate in special events (e.g., National Immunization Days), and educational materials (e.g., DVDs, booklets). It is useful to conduct an inventory of current skills and gaps in capacity to decide what type of capacity strengthening is needed and at what level. Program managers also need to be mindful of strengthening program staffing and institutional policies that can affect overall program capacity.

Moving Forward With Writing Your Strategic Plan

In Part I of the present Guide, you read a brief overview of the problem of childhood pneumonia and diarrhoea prevention and control. In Part II, you were exposed to the social ecological model (SEM) and the related communication for development (C4D) approaches that ensure a holistic and evidence-based approach to developing a C4D strategic plan for your child survival program. Keeping the SEM in mind while designing your program plan will assure that you broaden your focus from individual-level activities (namely BCC or IEC activities), to address factors in the environment that present bottlenecks and inhibit your intended population(s) from engaging in the behaviors or developing social norms that result in increased child survival rates.

Part III of this Guide provided you with the five steps for designing a C4D strategic plan. You learned (1) how to analyze the health situation, (2) how to identify key intended populations for your program, (3) how to develop SMART objectives, (4) what communication approaches are most effective for reaching specific populations, (5) how to develop and pretest messages, materials, and activities, (6) how to monitor your program, and (7) how to evaluate your program. These steps are the necessary "introduction" to writing your strategic plan. Now it is time for you to move forward with writing your strategic plan.

Checklists corresponding to each Step in the P-Process are included in the appendix section below. You can use each checklist as a worksheet to ensure that you amass and document all the information you will need to write your national-level C4D strategic plan. Your C4D strategic plan should be written as a roadmap that all partners and stakeholders could easily follow.

A good C4D strategic plan delineates not only what will be done, with whom, by whom, and how it will be done, but also why. As you design your strategic plan, you should ask, "Why are we proposing this direction?" at every step of the planning process. Question whether your communication activities fit well with other program functions, including service delivery, policies, and resources (e.g., healthcare providers to deliver messages and services). Ask whether the communication messages are consistent with the availability of/access to the service(s). Question whether the communication channels and tools are the most appropriate (not just the most convenient) for reaching various intended populations. Finally, ask whether all partners are fully invested and integrated into the process and implementation of the strategic plan.

The plan should include a background section that explicitly states the problem and provides evidence and justification for why and how your program will address the problem. The plan should clearly identify the program's SMART objectives, and the remainder of your document should outline what activities (at which levels of the SEM) will be implemented to achieve your objectives. You should include a monitoring plan to gage the progress of the processes involved in implementing your program. The evaluation plan should be expressly tied to the program objectives and should be documented in enough detail so that any researcher would be able to replicate the evaluation study.

Table 9 provides a template that summarizes the key elements that make up your strategic plan document. You should be able to synthesize the information from the checklists/worksheets for Steps 1 to 5 to fill in the template and guide your writing of the plan.

Table 9. C4D Communication Strategy Summary Template.

Key Elements of the Strategy Document	Description
1. Situation Analysis	
A. Purpose (What is the health situation that the program is addressing and why?)	
B. Key Health Issue (What are the behavior and social changes that need to occur in order for the health situation to improve)	
C. Context (What does the SWOT analysis show and how does the context for the program affect the health situation and how it can be addressed?)	
D. Formative Research (What directions does your formative research point to for addressing the health issue? What information is missing that may limit your ability to develop an evidence-based strategic plan? How will the gaps be addressed prior to implementing the strategy?)	
2. Communication Strategy for Addressing Multiple SEM Levels	
A. Intended Populations/Participant Groups	
B. SMART Objectives	
C. Strategic Communication Approach	
D. Key Messages	
E. Message Delivery Channels and Tools (including dialogic approaches)	
3. Program Implementation, Management & Monitoring	
A. Partner Roles and Responsibilities	
B. Implementation Plan (including timeline and responsibilities)	
C. Monitoring Plan and Tools (including timeline and responsibilities)	

D. Budget	
4. Evaluation	
A. Evaluation Plan (including timeline and responsibilities)	
B. Reporting (including dissemination plan)	

A good C4D strategic plan requires re-visiting and re-planning to ensure that the program continues to follow an efficient path toward addressing the health issue. Monitoring and reviewing the implementation of your C4D strategic plan for changes in the environment that may present new bottlenecks or new opportunities to effect change will help you to reach your program objectives and goal.

ADDITIONAL RESOURCES

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Appendix 1: Key Elements to Consider Before Developing C4D Promoting Advocacy Activities for Newborn Care and Childhood Pneumonia and Diarrhoea Prevention and Control Program

Audience Group	What You Need from Each Audience Group	Key Issues/Concerns of Each Audience Group	Possible Advocacy Activities	Possible Advocacy Tools
Policymakers/Political Decision Makers	▪ Public statements about the importance of C4D for childhood pneumonia and diarrhoea prevention and control ▪ Inclusion of C4D in maternal and child health program policies. ▪ Resource allocation for C4D child survival programs	▪ Public opinion ▪ Leadership image ▪ Ability to take credit for C4D program successes ▪ Budgetary implications ▪ Consequences of actions and inaction	▪ Study tours/field visits ▪ Face-to-face meetings with policy-/decision-makers and their key staff members ▪ Participation in national and international level forums	▪ Briefing card/fact sheets/pamphlets (with talking points) ▪ PowerPoint presentations including photos and personalized stories of children/families positively impacted by C4D programs ▪ Articles from newspapers, journals ▪ Video clips from television coverage of C4D child survival programs ▪ Cost-effectiveness analyses (national and local burden of disease) ▪ Flash mobs ▪ Electronic media (e.g., YouTube or other video clips, Facebook page) describing C4D program activities and

Audience Group	What You Need from Each Audience Group	Key Issues/Concerns of Each Audience Group	Possible Advocacy Activities	Possible Advocacy Tools
				outcomes
Health Decision Makers	▪ Development of a national policy(ies) childhood pneumonia and diarrhoea prevention and control that integrates C4D approaches ▪ Promotion of the policy(ies) and public statements about the importance of C4D for child survival programs ▪ Resource allocations (funds for C4D activities, provision of intervention supplies, budget for field workers and other health personnel training in C4D)	▪ Budget implications for C4D programs ▪ Necessity and consequences of using C4D (proof of efficiency and effectiveness) ▪ Cost-effectiveness of using C4D ▪ Appropriateness of C4D approaches within the social and cultural context ▪ Liabilities of using C4D approaches	▪ Study tours/field visits of existing and successful C4D pneumonia and diarrhoea prevention and control programs ▪ Face-to-face meetings with experts, donors, and partners ▪ Participation in national and international level forums or events to call attention to the issues (may involve high-profile celebrities) ▪ Inclusion in C4D program launches, events	▪ Briefing card/facts & figures sheets/pamphlets (with talking points) to state the issues and propose actions ▪ PowerPoint presentations including photos and personalized stories of children/families positively impacted by C4D programs ▪ Articles from newspapers, journals ▪ Documentation (e.g., video clips from television coverage) of successful C4D childhood pneumonia and diarrhoea prevention and control programs ▪ Cost-effectiveness analyses (national and local burden of disease) ▪ Electronic media (e.g., YouTube or other video clips, Facebook page) describing C4D program activities and outcomes that they can also use to appeal to policymakers
Community Leaders	▪ Ownership and support for C4D programs for child survival	▪ Health of all children in the community ▪ Capacity of community	▪ Study tours/field visits of existing and successful C4D pneumonia and	▪ Briefing card/fact sheets/pamphlets (with talking points)

Audience Group	What You Need from Each Audience Group	Key Issues/Concerns of Each Audience Group	Possible Advocacy Activities	Possible Advocacy Tools
	▪ Promotion of C4D for childhood pneumonia and diarrhoea prevention and control program in the community ▪ Participation in community coalition or action group to facilitate/remove barriers for implementing C4D child survival programs	members to participate in childhood pneumonia and diarrhoea prevention and control program activities ▪ The social and cultural appropriateness and consequences of childhood pneumonia and diarrhoea prevention and control program activities for the community ▪ Leadership image	diarrhoea prevention and control programs in other (similar) communities ▪ Face-to-face meetings with experts, donors, and community partners ▪ Inclusion in C4D program launches, events	▪ PowerPoint presentations including photos and personalized stories of children/families positively impacted by C4D programs ▪ Articles from newspapers, journals ▪ Documentation (e.g., video clips from television coverage) of successful C4D childhood pneumonia and diarrhoea prevention and control programs ▪ Posters
Community Members	▪ Participation and ownership in C4D childhood pneumonia and diarrhoea prevention and control programs ▪ Trust in C4D childhood pneumonia and diarrhoea prevention and control programs	▪ Risks and consequences for participating in childhood pneumonia and diarrhoea prevention and control programs ▪ Costs (e.g., time, money, status) of participating in childhood pneumonia and diarrhoea prevention and control programs ▪ Access to the C4D programs ▪ Quality of the C4D programs ▪ Social and cultural appropriateness of the programs	▪ Behavior communication/social change campaigns including mass media, small media, electronic media and interpersonal communication activities ▪ Social marketing	▪ Television and radio spots ▪ Television and radio entertainment education programs ▪ Special events (e.g., immunization days) ▪ Street theater/puppet shows ▪ Posters ▪ Billboards ▪ Flash mobs
Mass Media Partners	▪ Promotion/awareness-raising and advocacy for	▪ Newsworthiness of C4D child survival programs	▪ Press briefing ▪ Media advisory	▪ Press packet (briefing card/fact sheets/pamphlets

Audience Group	What You Need from Each Audience Group	Key Issues/Concerns of Each Audience Group	Possible Advocacy Activities	Possible Advocacy Tools
	C4D childhood pneumonia and diarrhoea prevention and control programs ▪ Balanced reporting of C4D childhood pneumonia and diarrhoea prevention and control programs	(importance in relation to the public and policy agendas) ▪ Audience appropriateness of C4D childhood pneumonia and diarrhoea prevention and control program reporting ▪ Broadcast and print costs ▪ Availability of interesting and effective spokespersons	▪ Editorial article submissions (opinions, letters to the editor) ▪ Field visits to see C4D childhood pneumonia and diarrhoea prevention and control programs	with talking points, photos) ▪ Electronic media updates
Donors/Partners	▪ Resources for developing and implementing C4D childhood pneumonia and diarrhoea prevention and control programs ▪ Support and collaboration for implementing C4D childhood pneumonia and diarrhoea prevention and control programs ▪ Facilitate the integration of C4D childhood pneumonia and diarrhoea prevention and control programs with existing child survival programs/activities ▪ Promotion of C4D Support and collaboration for	▪ Return on investment (outcomes, impacts, "bang for the buck") for C4D approaches ▪ Sustainability of C4D childhood pneumonia and diarrhoea prevention and control programs ▪ Quality and appropriateness of C4D initiatives ▪ Equity ▪ Evaluation results	▪ Study tours/field visits of existing and successful C4D pneumonia and diarrhoea prevention and control programs ▪ Face-to-face meetings with experts, donors, and partners ▪ Participation in national and international level forums ▪ Inclusion in C4D program launches, events	▪ Briefing card/fact sheets/pamphlets (with talking points) ▪ PowerPoint presentations including photos and personalized stories of children/families positively impacted by C4D programs ▪ Articles from newspapers, journals ▪ Documentation (e.g., video clips from television coverage) of successful C4D childhood pneumonia and diarrhoea prevention and control programs

Audience Group	What You Need from Each Audience Group	Key Issues/Concerns of Each Audience Group	Possible Advocacy Activities	Possible Advocacy Tools
	implementing C4D childhood pneumonia and diarrhoea prevention and control programs among donors, partners, policymakers/decision makers, politicians, etc.			

Appendix 2: EXAMPLES OF FORMATIVE RESEARCH QUESTIONS ABOUT DIARRHOEA TREATMENT FOR MOTHERS (FATHERS/FAMILIES/COMMUNITIES)*

Illness Classification

1. What are the local names for diarrhoea?
2. Are there names for different types of diarrhoea?
3. What are the local names/descriptions for symptoms associated with diarrhoea?
4. What are the local perceptions of causality? Of seasonality?
5. What are the local perceptions of susceptibility of a child to diarrhoea?
6. What is the local perception of severity of diarrhoea?
7. What are the local terms for dehydration?
8. What are the local remedies for dehydration?
9. Is diarrhoea associated with child development markers?

Illness Management/Treatment

10. Who do mothers first go to for advice or treatment for their child's diarrhoea?
11. What are the local foods, drinks, traditional remedies used to treat diarrhoea? Are these different for male and female children?
12. What changes in diet are followed during a bout of diarrheoa? Are these different for male and female children?
13. Do mothers continue breastfeeding when their child has diarrhoea?
14. What are the medicines (e.g., zinc, ORS, antimicrobials, antimalarials) to treat diarrhoea? What forms of these medicines are taken? How much? For how long? Are these different for male and female children? What affects adherence to taking these medicines?
15. What are the local perceptions of these medicines?
16. What concerns do mothers have about medicines to treat diarrhoea? Cost? Adverse reactions?
17. Where or from whom are these medicines obtainable? What are the barriers to obtaining these medicines?
18. During her child's last diarrhoea, what did the mother do to manage/treat her child?

Sources of Information

19. Where or from whom do mothers/family members/community members get information or advice about diarrhoea? About treatments for diarrhoea?
20. Who are the individuals in the community that are perceived as opinion leaders when it comes to childhood illnesses?
21. Who in the household has the final say on how a child with diarrhoea is cared for?
22. What information about diarrhoea have mothers heard in the last 6 months? Where? What?

Care-Seeking Behavior

23. When do mothers seek healthcare from a trained healthcare provider for their child's diarrhoea? What are the reasons a mother would NOT seek help for her child?
24. What is the decision-process for seeking care for their child's diarrhoea? Is this different for male and

female children? Who makes the final decision?
25. Where do mothers usually go for treatment for their child's diarrhoea?
26. Do mothers feel confident that they can get the help they need for their baby?
27. What are the perceptions of local facilities where child healthcare is provided?

Media Habits

28. Can you read and understand a letter or newspaper easily, with difficulty, or not at all?
29. Which newspapers or magazines do you like to read?
30. Do you listen to the radio almost every day, at least once a week, less than once a week, or not at all?
31. What radio station(s) do you listen to most often?
32. What type of radio program do you like the most?
33. What types of radio program do you like the least?
34. When do you usually listen to the radio?
35. On average, how many hours per day do you listen to the radio?
36. Do you watch television almost every day, at least once a week, less than once a week, or not at all?
37. What television channel(s) do you watch most often?
38. What type of TV program do you like the most?
39. What type of TV program do you like the least?
40. When do you usually watch TV? (Air, cable, satellite?)

41. **Social Support**
42. How much support do you receive from you husband/wife when your child has diarrhoea? What type of support?

43. **Self-Efficacy**
44. Do you feel you are capable of taking care of your child when s/he has diarrhoea?

45. **Social Networking**
46. What clubs or organizations do you belong to, for example church clubs, community social or development clubs?
47. How often do you attend meetings at these clubs or organizations?
48. In the past (1, 3, 6 months) did you talk to anyone about the problem of childhood diarrhoea? With whom? How often?
49. **Subjective Norms**
50. Do you think your husband (wife, family, neighbors) would approve of you using ORS to treat your child's diarrhoea?

*These questions can be adapted for pneumonia and for newborn care issues. Open-ended questions can be used for focus group discussions and interviews. These questions can also be transformed into closed-ended questions for survey questionnaires.

Appendix 3: EXAMPLES OF FORMATIVE RESEARCH QUESTIONS ABOUT DIARRHOEA TREATMENT FOR PHARMACISTS *

1. How many people come to the pharmacy daily?
2. Do you sell generic drugs and/or brand-name drugs from major pharmaceutical companies?
3. Do you provide advice as well as medications?
4. What common child health/treatment problems do you see most often as a pharmacist?
5. When a mother comes to you with a child with diarrhea, how do they typically describe diarrhoea? What kinds of questions do they ask?
6. Do mothers ask for advice, or for a specific medication?
7. What advice/counseling do you usually provide?
8. What are the common medicines or combinations of medicines sold for diarrhoea? What medications do you usually recommend and why? How much do they sell for?
9. Do you provide different treatments for different types of diarrhoea?
10. Do caregivers come back to seek further advice or treatment if the diarrhoea continues?
11. How much medicine does a caregiver usually buy at a time?
12. How often do caregivers ask for oral rehydration solution/salts (ORS)? Where do you get your supply of ORS?
13. Do you ever recommend zinc treatment? How do caregivers react?
14. Where do you get your stock of zinc?
15. How often do caregivers come into the pharmacy/shop to purchase diarrhea treatments? (Weekly, monthly, seasonally?)
16. Are there other healthcare providers near your pharmacy? What type? Do you refer caregivers to that provider(s) for cases of childhood diarrhoea?

*These questions can be adapted for pneumonia and for newborn care treatment issues. Open-ended questions can be used for interviews. These questions can also be transformed into closed-ended questions for survey questionnaires.

Source: Adapted from Adeya G, Harvey P, Ntiru M, Swedberg E, Wansi E. 2006. Country Assessment Tool for the Introduction of Zinc in the Clinical Management of Diarrhea. Rational Pharmaceutical Management Plus (RPM Plus), A2Z Micronutrient and Child Blindness Project (A2Z), Helen Keller International, and Basic Support for Institutionalizing Child Survival (BASICS) for the United States Agency for International Development (USAID).

Appendix 4: Example of Baseline Knowledge, Attitudes, and Practice (KAP) Survey Questionnaire On Diarrhoea, ARI, IYCF and Outreach Services[8]

<table>
<tr><td>Village Name:</td><td rowspan="3">Respondent Name, Address, Tel. #:</td></tr>
<tr><td>Cluster #:</td></tr>
<tr><td>Household #:</td></tr>
<tr><td>Date of Survey Interview (mm/dd/yr): ____/_____/2013</td><td>Length of Interview (minutes):</td></tr>
<tr><td>Interviewer Code/Name:</td><td>Status of Interview (completed, incomplete, postponed, declined/refused, absent, dwelling vacant, dwelling not found, other (specify):</td></tr>
<tr><td>Field Supervisor Code/Name:</td><td></td></tr>
<tr><td>Coder Name:</td><td></td></tr>
</table>

INSTRUCTIONS:
ASK: Are there any woman who has children under 5 years living here?

If NO: Thank you anyway. Goodbye

If YES, *ASK:* Can I please speak to her?

OBTAIN CONSENT:
My name is ____________________________ [*INTERVIEWER NAME*]. I am from the National Center for Health Promotion, Ministry of Health. We are conducting a study on mother and child health. It would be grateful if you could provide some information for us. We will ask you some questions about your children and your health. This will takes about 30-45 minutes and will be completely anonymous. Your name will not be written down anywhere and all your answers will be kept totally confidential.

We will be interviewing many people and putting all the answers together. This will enable us to see what type of health information families and communities need to help them care for their children better so that they may grow strong and healthy. Do you agree to be interviewed?

[8] Adapted from draft KAP survey among mothers of children under 5 on diarrhea, ARI, IYCF and outreach services (UNICEF Cambodia, 21-04-04).

IF **NO**, thank you anyway for your time

IF **YES**, thank you very much. The survey begins with some general questions about you and then I will ask you some questions below.

INTERVIEWER NOTE: (*DO NOT READ OUT*)

If interviewees do not want to answer a question, they do not have to and they can choose to end the interview at any time if they change their mind about participating.

SECTION 1: Demographic Information

1. Could you please tell me your age? ____________years

2. What is your level of education?
   1 ☐ No education
   2 ☐ Primary (years 1-6)
   3 ☐ Lower Secondary (years 7-9)
   4 ☐ Upper Secondary (years 10-12)
   5 ☐ Higher/University

3. What is your average family income per month in Riel?
   1 ☐ < 100 000 Riel
   2 ☐ 100 000 – 200 000 Riel
   3 ☐ 200 001 – 400 000 Riel
   4 ☐ > 400 000 Riel

4. What is your occupation?
   1 ☐ Housewife
   2 ☐ Farmer
   3 ☐ OTHER ____ [*Please specify*]

5. How many children less than five years old you have? __________children
   CHILD 1: ______ years AND _____ months

   CHILD 2: ______ years AND _____ months

CHILD 3: ______ years AND _____ months

CHILD 4: ______ years AND _____ months

CHILD 5: ______ years AND _____ months

6. What is your religion?
   1 ☐ Buddhist
   2 ☐ Muslim
   3 ☐ Christian
   4 ☐ OTHER ___________________________ [*Please specify*]

7. How often do you watch TV?
   1 ☐ Often
   2 ☐ Sometimes
   3 ☐ Rarely
   4 ☐ Never

8. What TV channel do you watch most often?
   ____

9. How often do you listen to the radio?
   1 ☐ Often
   2 ☐ Sometimes
   3 ☐ Rarely
   4 ☐ Never

10. What radio station do you listen to most often?
    ____

11. How often do you read a newspaper/magazine?
    1 ☐ Often
    2 ☐ Sometimes
    3 ☐ Rarely
    4 ☐ Never

12. What newspaper/magazine do you read most often?
    ____

13. From which **source** do you get most of your information about health issue?(choose one)
    1 ☐ Television
    2 ☐ Radio
    3 ☐ newspaper/magazine
    4 ☐ Loudspeaker
    5 ☐ Poster
    6 ☐ Public meeting
    7 ☐ Other (specify)____
    8 ☐ Don't know
14. From what **person** do you get most of information about health issue?(choose one)
    1 ☐ Health workers
    2 ☐ Traditional healers
    3 ☐ Village/commune leaders
    4 ☐ Parents
    5 ☐ Relatives
    6 ☐ Friends
    7 ☐ Neighbors
    8 ☐ VHSG
    9 ☐ VDC
    10 ☐ VHV
    11 ☐ Other (specify)____
15. Which is most useful and informative?
    1 ☐ The **source**
    2 ☐ The **person**

SECTION 2: Diarrhoea

BY **<u>DIARRHEA</u>**, I mean that a child has watery, loose stools <u>3 or more</u> times in one day

16. Has your child under 5 <u>ever</u> had diarrhoea?
    1 ☐ YES

    2 ☐ NO

17. What are the causes of diarrhoea?
    ____

18. When a child has diarrhoea, did you…
    - ☐ Give less fluid?
    - ☐ Give same amount of fluids?
    - ☐ Give more fluids?
    - ☐ (Don't know/Can't say)
    - ☐ Depend on child asked
    - ☐ Stop giving fluid (go to q.20)

19. What kinds of fluids that you giving your child when she/he had diarrhoea?
    DO NOT READ OUT *TICK ALL MENTIONED*

    - ☐ Breast milk (go to q.21)
    - ☐ Oralit (go to q.21)
    - ☐ Coconut water (go to q.21)
    - ☐ Rice water (go to q.21)
    - ☐ OTHER ________________________________(go to q.21)

20. Why did you not provided fluids or provide less fluids to your child when s/he got diarrhoea?
    ____

21. When should you bring a child who has diarrhoea to hospital/health centre?
    DO NOT READ OUT *TICK ALL MENTIONED*

    - ☐ When there is blood in the stool
    - ☐ Diarrhea lasts more than 3 days
    - ☐ When there is very large quantities
    - ☐ When it is very watery
    - ☐ High thirst
    - ☐ When the child also has fever
    - ☐ Frequent vomiting
    - ☐ Eyes sunken
    - ☐ Abnormally sleepy
    - ☐ Skin pinch goes back slowly
    - ☐ NEVER
    - ☐ OTHER____

22. How to prevent diarrhoea?
    - ☐ Washing Hand (before eating and after toilet use)

- ☐ Use latrine
- ☐ Drinking clean water
- ☐ Drinking boil water
- ☐ Food cook well
- ☐ OTHER (specify)___________________________________

23. Have you ever seen/heard any information about take care, treating or preventing diarrhoea?

    1 ☐ YES

    2 ☐ NO [*Go to q.25*]

24. If yes, what is source information you received?

    DO NOT READ OUT *TICK ALL MENTIONED*

- ☐ VHVs
- ☐ Poster
- ☐ Leaflet
- ☐ Radio
- ☐ Television
- ☐ Other ______________________________________ [*Please specify*]

Section 3: ARI

25. How do you do to care for your child who has cough and cold at home?

    DO NOT READ OUT *TICK ALL MENTIONED*

- ☐ Removed child's clothing
- ☐ Wrapped child in wet cloth
- ☐ Kept child warm
- ☐ Gave paracetamol
- ☐ Gave aspirin
- ☐ Gave medicine ______________________________ [*Please specify*]
- ☐ Gave antibiotics ______________________________ [*Please specify*]
- ☐ Traditional medicine _______________________________________
  ____
  ____
- ☐ OTHER ____
  ____

26. What symptoms made you decide to take your child who has cough and cold for treatment?

    DO NOT READ OUT *TICK ALL THAT APPLY*

- ☐ Child became sicker
- ☐ Breathing became difficult
- ☐ Breathing became fast
- ☐ Child was unable to drink
- ☐ Child was unable to eat
- ☐ Vomiting

☐ Lethargy/Abnormally sleepy
☐ Fever/Very high temperature
☐ Convulsions
☐ Chest became retracted
☐ OTHER ____
____ [*Please specify*]

27. If a child is breastfeeding and has **cough and cold** do you stop or continue breastfeeding?
    ☐ Continued breast feeding
    ☐ Stopped breast feeding

28. Where do you take your child for treatment?
    DO NOT READ OUT

☐ Pharmacy	☐ Drug seller
☐ Health Centre	☐ Private health provider
☐ Referral Hospital	☐ Traditional healer

☐ OTHER ______________ ______________________________ [*Please specify*]

29. Have you ever seen/heard any information how take care, treating or preventing ARI?
    1 ☐ YES

    2 ☐ NO [*Go to q.31*]

30. If yes, what is source information you received?
    DO NOT READ OUT *TICK ALL MENTIONED*

    ☐ Poster
    ☐ Leaflet
    ☐ Radio
    ☐ Television
    ☐ Other ______________________________________ [*Please specify*]

SECTION 4: Infant Young Child Feeding (IYCF)

31. What is colostrum? ____
32. Is colostrum good or bad for baby?
    1 ☐ Good,

    2 ☐ Bad,

    3 ☐ Neither good nor bad (normal)

    4 ☐ Don't know

33. Do you give colostrum to your baby or squeeze away?
   1 ☐ Give colostrum, why? ____

   2 ☐ Squeeze away, why? ____

34. How long after delivery do you start breastfeeding?
   1 ☐ Less than 1 hour

   2 ☐ 1-3 hours

   3 ☐ 3-24 hours

   4 ☐ >24 hours

35. How long do you breastfeed your child?
   1 ☐3 months,

   2 ☐6months,

   3 ☐9 months,

   4 ☐12 months,

   5 ☐Until 24 months

   6 ☐ > 24 months

36. How long do you exclusively breastfeed your child?
   1 ☐ less than 6 months,

   2 ☐ up to 6months,

   3 ☐ more than 6 months,

37. At what age in months should you begin to give a child complementary foods along with breastfeeding?
   1 ☐ less than 6 months,

   2 ☐ up to 6months,

   3 ☐ more than 6 months,

38. Have you ever seen/ heard any information about breastfeeding?
   1 ☐ YES

   2 ☐ NO [*Go to q40*]

39. If yes, what is source information you received?
   DO NOT READ OUT *TICK ALL MENTIONED*

- ☐ Poster
- ☐ Leaflet
- ☐ Radio
- ☐ Television
- ☐ VHVs
- ☐ Other _______________________________________ [*Please specify*]
- ☐ Never seen/heard any information

Section 5:Immunizations

---

40. Have you ever heard about immunization?

Yes,

No,

41. If yes, what is the source of information you received?

1 ☐ Health workers

2 ☐ Village/commune leaders

3 ☐ Parents

4 ☐ Relatives

5 ☐ Friends

6 ☐ Neighbors

7 ☐ Poster

8 ☐ Leaflet

9 ☐ Radio

10 ☐ Television

11 ☐ Other (specify)____

42. What is the **most** important reason for immunizing a child?

1 ☐ Treat disease

2 ☐ Prevent disease

3 ☐ Improve health babies

4 ☐ Other (specify) ____

5 ☐ Don't know

43. Do you believe that healthy children should receive immunization?

1 ☐ Yes

2 ☐ No, if no why?____

44. Can you name any of the diseases that immunization can prevent?

1 ☐ Tuberculosis

2 ☐ Polio

3 ☐ Whooping cough

4 ☐ Tetanus

5 ☐ Diphtheria

6 ☐ Hepatis B

7 ☐ Measles

8 ☐ Other (specify) ____

45. How many times the children were 1 year should receive vaccines?

1 ☐ 1 time

2 ☐ 2 times

3 ☐ 3 times

4 ☐ 4 times

5 ☐ 5 times

6 ☐ More than 5 times

46. Your most recent child have you ever taken your children to receive vaccines?

1 ☐ Yes,

2 ☐ No, why not? ____

47. Did your child receive all the immunizations as scheduled?

1 ☐ Yes,

2 ☐ No, why not? ____

48. Have you ever been concerned about side effects that might follow immunization?

1 ☐ Yes,

2 ☐ No,

49. What side effects concern you most?
____

50. Do you know pregnant women must receive tetanus vaccine?
1 ☐ Yes, for what? ____

2 ☐ Don't know [*Go to q52*]

51. How many times the pregnant women should receive tetanus vaccines?
-First pregnancy

1 ☐ 1 time

2 ☐ 2 times

3 ☐ 3 times

-Second pregnancy

1 ☐ 1 time

2 ☐ 2 times

3 ☐ 3 times

-Third pregnancy

1 ☐ 1 time

2 ☐ 2 times

3 ☐ 3 times

52. Did you receive tetanus vaccine?
1 ☐ Yes, how many times? _________________times

2 ☐ No, why not?____

53. Have you ever seen any information about Immunizations?
1 ☐ YES

2 ☐ NO [*Go to q48*]

54. If you or your children have received immunization who advised you to receive them?
DO NOT READ OUT

☐ No-one – I decided myself to give vaccines for myself/my children
☐ Friend or relative

☐ TBA
☐ Pharmacist
☐ Health centre staff
☐ Private health provider

OTHER ____ [*Please specify*]

Section 6: Vitamin A

55. Have you heard about Vitamin A?
    1 ☐ Yes,

    2 ☐ No,

56. If yes, what is source information you received?
    ☐ Poster
    ☐ Leaflet
    ☐ Radio
    ☐ Television
    ☐ Other [*Please specify*] ______________________________________

57. What foods and vegetables have Vitamin A?
    1 ☐ Carrot

    2 ☐ Orange

    3 ☐ Pumpkin

    4 ☐ Liver (pork, fishs…)

    5 ☐ Other (specify) ____

58. What are the benefits of Vitamin A?
    1 ☐ Improving eyesight

    2 ☐ Improving Children Health

    3 ☐ Other (specify) ____

59. Do you know what age should children receive Vitamin A supplementary?
    1 ☐ Yes, ___________month/year

    2 ☐ Don't know

60. Did your children receive Vitamin A in the last 6 months?
    1 ☐ Yes,

    1 ☐ No, why not? ___________________________________[*Go to q62*]

61. If yes, how did you use with your children under 5 year olds?

1 ☐ Once month

2 ☐ Twice month

3 ☐ Twice three months

4 ☐ Twice six months

5 ☐ Twice year

62. Do you know post-partum mother need Vitamin A supplementary?
 1 ☐ Yes,

 2 ☐ Don't need [*Go to q65*]

63. If yes, when?
 1 ☐ Not sure/ don't know

 2 ☐ One week after delivery

 3 ☐ Three weeks after delivery

 4 ☐ Five weeks after delivery

 5 ☐ Eight weeks after delivery

 6 ☐ Over eight weeks after delivery

64. If yes, how did you use?
 1 ☐ Once month [*Go to q66*]

 2 ☐ Twice month [*Go to q66*]

 3 ☐ Twice three months [*Go to q66*]

 4 ☐ Twice six months [*Go to q66*]

 5 ☐ Twice year [*Go to q66*]

65. If no need, why not? ____
____

66. Did you received or bought Mebendazole from HC or any places to give your children?
 1 ☐ Yes,

 1 ☐ No, [*Go to q68*]

67. If yes, how did you use with your children under 5 year olds?
 1 ☐ Once month

2 ☐ Twice month

3 ☐ Twice three months

4 ☐ Twice six months

5 ☐ Twice year

68. Have you ever seen any information about Vitamin A and De-worming?

1 ☐ YES

2 ☐ NO [*Go to q70*]

69. Who advised you to receive Vitamin A and Mebendazole?
DO NOT READ OUT

☐ No-one – I decided myself to give medicine to child
☐ Friend or relative
☐ TBA
☐ Pharmacist
☐ Health centre staff
☐ Private health provider

OTHER ____ [*Please specify*]

SECTION 7: Miscellaneous

70. What water do you use for drinking?
DO NOT READ OUT *TICK ALL MENTIONED*

☐ Water from river, stream, lake or pond
☐ Water from a well
☐ Boiled water
☐ Bottled water
☐ OTHER ___________________________________ [*Please specify*]

71. When your child is sick, who usually decides how he/she should be cared for?

☐ Mother of child
☐ Father of child
☐ Both mother and father of child together
☐ Grandmother of child (mother or mother-in-law)
☐ Grandfather of child (father or father-in-law)
☐ OTHER ____[*Please specify*]

72. Do you think you know enough about how to take care of your child properly if he/she gets sick?

☐ YES
☐ NO

73. Would you like to learn more about how to take care of your child if he/she gets sick?

☐ YES
☐ NO [*Go to "THAT IS ALL THE QUESTIONS I HAVE FOR YOU TODAY"*]

74. How would you like to learn more?
____
____

75. Would you like to learn more from a volunteer? (E.g. VHV, VHSG, volunteer from NGO)
    ☐ YES ____ [*Please specify*]
    ☐ NO

THAT IS ALL THE QUESTIONS I HAVE FOR YOU TODAY.

BEFORE WE FINISH, ARE THERE ANY COMMENTS YOU WOULD LIKE TO MAKE ABOUT ANY OF THE TOPICS WE HAVE BEEN TALKING ABOUT TODAY?

____
____

THANK YOU VERY MUCH FOR YOUR TIME. GOODBYE.

FINISH TIME: ___________________ AM / PM

Appendix 5: The Focus Group Analysis Process

1. **Planning for the Focus Group Discussion (FGD)**
    a. Assemble the research and analysis team and determine team member responsibilities
    b. Select the methods for recording the FGDs (e.g. taking notes, tape recorder, video recording, transcripts)
    c. Outline the purpose for the FGDs (e.g., formative research, pretesting, impact evaluation)
    d. Develop the FGD guide (including introduction, research questions, concluding remarks).
    e. Develop preliminary codes (e.g., Mass Media=MM, Pneumonia=PNEUM)
    f. Develop the timeline and budget (including equipment/supplies, refreshments or small gifts, salaries, transportation for data collection and analysis)

2. **Data Collection and Management**
    a. Record each FGD (ideally, there should always be two people conducting a FGD, one to facilitate the discussion and the other to take notes (in addition to using recording devices) to record important participant reactions and non-verbal communication among participants
    b. Label all recording documents (ID code, date, location of FGD, number and type of participants, name of the moderator and note-taker or observer)
    c. Debrief with the FGD team after each FGD and discuss management issues (e.g., discuss important themes or ideas, unexpected findings, specific quotes, logistics, modifications to the FGD guide)
    d. Expand notes and transcribe tapes

3. **Data Analysis**
    a. Code the data (e.g., using letters, numbers, words, colors)
    b. Organize and display the data (by group, by research topic across FGDs, by codes across FGDs)
    c. Describe the data using tables, figures, graphics

4. **Interpretation**
    a. Elucidate the context and how it may influence the findings (FGD setting, moderator/observer influence)
    b. Understand the data from a specific perspective (e.g., behavior change)
    c. Draw conclusions and make recommendations
    d. Consider alternative/rival explanations for findings
    e. Validate the results by sharing with others and asking for feedback

5. **Report Writing and Dissemination**
    a. Determine the format of the report (e.g., full, summary) the population, and the level of analysis
    b. Outline the report (e.g., introduction, study design and methodology, findings/results, conclusions and recommendations, references, annexes)
    c. Write the report
    d. Disseminate findings using a medium that is appropriate for the recipient

Source: Adapted from de Negri, B., Thomas, E. (2003). Making sense of focus group findings: A systematic participatory analysis approach. Washington, DC: AED, http://www.rhrc.org/resources/general.

Appendix 6: Community Mapping

Background
A community map is a participatory activity with community members to develop a visual representation of the important places in their community (e.g., places of worship, markets, health service centers, schools, meeting places). Community mapping is useful for identifying local assets and capacity, barriers to accessing services, and networks, and for starting a discussion about child survival issues that are important to a community, village or district.

Data from the community maps can help to plan a C4D program by determining where key stakeholders and resources are located in the communities, and the coverage of services available in the community.

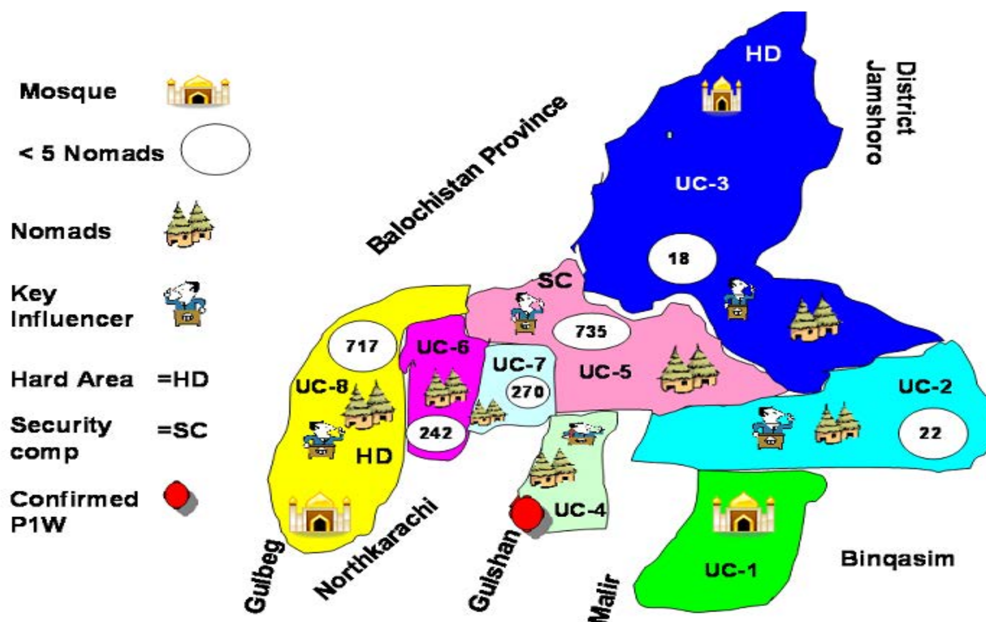
Steps in the Community Mapping Process

1. Define the community of interest.
2. Define the problem or issue that you want the community participants to explore.
3. Select the field staff that will facilitate the community mapping activity.
4. Invite community members to participate in the mapping activity.
5. You can ask a large group to develop one map, or divide the participants into small groups (4-6 per group) and have each group draw a map based on their group consensus.
6. Briefly introduce the problem or issue that you want the community participants to explore without leading them in a particular direction.
7. Distribute the materials (e.g., markers and paper) that will be used to record the map to all participants.
8. Provide directions to the participants about what locations you would like to see on the map (e.g., ask them to include places that they take their young children for healthcare, transportation routes, schools, religious/community centers, pharmacies, homes of opinion leaders/influential, wells, latrines, stores where they may purchase soap, government buildings, rivers). Reassure the participants that things do not have to be drawn exactly as they are in their community. Ask the participants to identify the various community resources by name or with a symbol. Add more paper as the map grows. If the group has trouble getting started, suggest that they begin by marking where they are right now on the map. Be careful not to direct what is being presented and how it is being presented.
9. Once the group(s) have finished, place the map(s) so all participants can see it (e.g., tape the map(s) to a wall).
10. Lead a group discussion about the map that explores issues of mobility and access to resources. You can begin the discussion about the map by asking a participant to point to and discuss a place on the map that they think is important to them in relation to, for example, nutrition and breastfeeding. Encourage other participants to discuss their

perspectives and provide their opinions. Ask probing questions to draw out more information from the map(s). If more than one map was drawn, point out similarities and differences among them. Facilitate a discussion with the group. The facilitator or a note-taker should take notes or record the discussion.

11. At the end of the group discussion, write up your notes from the session, including key points, local words and phrases, debates, and disagreements. Also record the participant's behavior and interactions with one another during the mapping exercise. Notes taken during the mapping exercise do not need to be detailed; however, in order to capture all the information, the facilitator should expand their notes immediately following the exercise.
12. Analyze the map(s) and the write a brief summary using the map and your notes, including a brief summary of the mapping process and participants. Your summary should answer the following questions:
    - Were the participants able to identify services and resources available in the village/district, and gaps in services? What are the resources? What are the gaps?
    - Were the participants able to identify which people are important in the village/district? Who did they identify? Describe the persons and why they are important.
    - What were the participant's concerns about their community with regard to the specified issue and what they would like to change? What changes would they make?
    - Did the participants agree with one another when they were drawing the map? Provide a brief description of how each session went.

Example of a Community Map



Appendix 7: Social Mapping

Background
Social maps are diagrams that show relationships and social networks that are important to an individual, family or group. A social mapping exercise asks participants to identify who they consider to be sources of social and institutional support within their community. Social mapping is useful for exploring network ties and clusters, and for identifying opinion leaders in a community and the centrality of opinion leaders to various community members. It can help to understand where and from whom people receive information about a particular topic, how that information is shared within and among social groups, and to explore the decision-making process of individuals or groups. A social map can also highlight community members that are isolated and thus underserved or overlooked in some health capacity.

Steps in the Community Mapping Process
1. Define the community of interest.
2. Define the problem or issue that you want the community participants to explore. For example, you may want to explore how a mother decides whether or not to take her child to a clinic for a case of diarrhoea. You can ask where she gets her information or advice about child health matters, who she speaks to, when she seeks advice or information, and who influences her decision-making. Or, you may want to know who in the community provides social support (emotional, tangible, instrumental) to a mother with a newborn.
3. Select the field staff that will facilitate the community mapping activity.
4. Invite community members to participate in the mapping activity.
5. You can ask a large group to develop one map, or divide the participants into small groups (4-6 per group) and have each group draw a map based on their group consensus, or ask each person to draw their own map.
6. Briefly introduce the problem or issue that you want the community participants to explore without leading them in a particular direction.
7. Distribute the materials (e.g., markers and paper) that will be used to record the map to all participants. For example, ask the participants to draw a woman from their community in the middle of the page. Then ask the participants to put all the sources of influence regarding child health on the map in squares. Participants may wish to include organizations they have relationships with, as well as people on the map. Next, ask the participants to draw a circle around the sources of influence that offer women the most social support about child health. Reassure the participants that things do not have to be drawn exactly as they are in their community. Ask the participants to identify the various community resources by name or with a symbol. Add more paper as the map grows. Be careful not to direct what is being presented and how it is being presented.
8. Once the group(s) have finished, place the map(s) so all participants can see it (e.g., tape

the map(s) to a wall).

9. Lead a group discussion about the map that explores the key issues identified by the mothers. You can begin the discussion about the map by asking a participant to point to and discuss why that person or institution is important to them in relation to, for example, diarrhoea treatment. Encourage other participants to discuss their perspectives and provide their opinions. Ask probing questions to draw out more information from the map(s). If more than one map was drawn, point out similarities and differences among them. Facilitate a discussion with the group. The facilitator or a note-taker should take notes or record the discussion.
10. At the end of the group discussion, write up your notes from the session, including key points, local words and phrases, debates, and disagreements. Also record the participant's behavior and interactions with one another during the mapping exercise. Notes taken during the mapping exercise do not need to be detailed; however, in order to capture all the information, the facilitator should expand their notes immediately following the exercise.
11. Analyze the map(s) and the write a brief summary using the map and your notes, including a brief summary of the mapping process and participants. Your summary should answer the following questions:
    - Were the participants able to identify which people/institutions that are important in their community? Who did they identify? Describe the persons and why they are important.
    - How do mothers communicate with these sources of information?
    - Are there differences in the type of support, advice or information seeking, decision-making for older and younger mothers? Primipara versus multiparous mothers?
    - How isolated or connected do mothers feel within their community?
    - What are the benefits or risks with the different relationships?
    - Were there connections between the persons/institutions identified by the mothers?
    - What were the participant's concerns about seeking advice and/or decision-making? What other types of sources of support would they like?
    - Did the participants agree with one another when they were drawing the map? Provide a brief description of how each session went.

Appendix 8: Step 1 - Situation Analysis Checklist

INSTRUCTIONS: First, read through the following checklist items as a reminder of the type of information that you will need to obtain through primary and secondary research. Once you have conducted your formative research, you can fill in the answers to the following questions for each level of the SEM. Once you have answered the questions, you can begin to prioritize areas of program engagement based on your available resources.

Questions		Answers				
		Individual	Interpersonal	Community	Organizational	Policy/Societal
The Problem						
☐	What is the problem at each level of the SEM?					
☐	What is the evidence?					
☐	Which risk practices are most widespread/relevant?					
☐	What are the social/cultural norms regarding the problem?					
☐	What are the challenges to addressing this problem at each level of the Social Ecological Model? (Prioritize the challenges)					
☐	What are the desired behaviors/practices to address the problem?					
☐	What is the key benefit to remedying the problem?					
☐	What are the communication challenges associated with this problem?					

☐	What resources are available for addressing the problem?					
☐	What is our timeframe for addressing the problem?					
The Participant Groups						
☐	Who is the primary participant group affected by the problem? (Most vulnerable, hard-to-reach?)					
☐	Who is the secondary participant group affected by the problem?					
☐	Do we need to segment the populations within each of the participant groups? If so, how?					
☐	Who are the participant groups that can affect the problem?					
☐	What is the current level of knowledge, attitudes, perceptions (susceptibility, severity, safety of prevention/treatment methods), and practices (including traditional) for each participant group?					
☐	What is the participant group's readiness to change?					
☐	What is the perceived benefit to each participant group for addressing the problem?					
☐	What misinformation or rumors exist among the participant groups affected by the problem?					
☐	What are the challenges that participant groups face in trying to implement the desired behaviors? (Prioritize the challenges)					
☐	Is remedying the problem a priority for each participant group?					
☐	What do the participant groups want to know about the problem and about the prevention and treatment methods?					

☐	Where or from whom do the participant groups get their information about the problem or similar health issues?					
☐	Who are the opinion leaders in each of the participant groups with regard to the problem?					
☐	What communication strategies/channels will be most efficient/effective in reaching the participant group to change KAP, self/collective efficacy, the enabling environment, etc.?					
☐	What are the social and media habits of the intended participants groups?					
☐	How will the participant groups be involved in developing the interventions to address the problem?					
Existing Programs and Policies						
☐	What current or recent programs exist that address the problem with your intended participant groups?					
☐	What are the current policies related to the problem?					
Communication Capacities						
☐	What are the available communication channels that are accessible to the intended participant group?					
☐	What are the capacities of the (local) media to generate information about the problem and about prevention and treatment for the problem?					
☐	What traditional media are relevant for the intended participant group?					
☐	What are the capacities for developing print and other materials?					
☐	What are the capacities for interpersonal communication and counseling?					

Partnerships						
☐	Who are the potential partners for the program? (Don’t forget about private partners and media partners)					
☐	What are the key roles for each of the partners?					
☐	How will partners communicate about program activities/issues?					

Appendix 9: The Key Characteristics of Common C4D Program Communication Channels

Channel	Message Reach	Message Complexity	Audience Engagement	Cost
Television	• Usually reaches large numbers of people simultaneously • May be biased toward urban areas in some countries • Is dependent on electricity supply and reception • Reach differs for government, private terrestrial, satellite and cable channels • Gender equity, rights, and ethnic groups can be visually represented in the in order to break stereotypes and include all participant groups	• Simple, general messages can be delivered via spot advertisements • More complex messages can be delivered via entertainment-education programs, talk-shows	• Can elicit participant group feedback and inputs through viewer groups that mail, e-mail, text message or phone in comments • Can engage participant group members through related local contests	• Generally high production cost • Cost of broadcasting is higher than radio
Radio	• Usually reaches large numbers of people simultaneously • Can be designed to reach local populations with tailored local content and language (through regional or community radio stations) • Often depends on availability of electricity (especially where	• Simple/general information can be conveyed through news, information, and entertainment programs • More complex messages can be delivered through talk shows, dramas, and longer-format programs • Focuses messages can be	• Can request immediate phone-in or text message feedback to live radio programs (e.g., talk shows, debates) • Can elicit participant group feedback and inputs through listener groups that mail, e-mail, text	• Generally low production cost compared to television • The radio device requires an investment; costs vary depending on the power source (battery, electricity, or solar)

Channel	Message Reach	Message Complexity	Audience Engagement	Cost
	cost of batteries is prohibitive) • Appropriate for reaching low-literate/illiterate/aural/oral populations	developed for local community radio	message or phone in comments • Can engage participant group members through related local contests	
Film	• Can reach multiple medium-sized audience where viewing facilities and electricity are available (e.g., cinema, school classrooms, mobile cinema van)	• Can convey complex messages through short or long films • Can be tailored to fit regional or local information needs and tastes	• Film viewing can be followed by facilitated discussion sessions with participant group members	• Cost of production can be high in terms of time and money
Video (DVD)	• Can reach multiple large or small audiences depending on distribution • Can reach audience members in public or at home (depending on distribution and availability of electricity) • Can be viewed on-demand in a home setting, and reach multiple individuals depending on viewing habits	• Can convey simple and complex messages (through visuals and text) • Can convey general or tailored messages to fit regional or local information needs and tastes	• DVD screenings in public can be followed by facilitated discussion sessions with audience members • DVDs distributed for home use can be accompanied by materials that viewers can use to provide feedback (e.g., questionnaires, reminder cards with phone numbers or e-mail addresses to send in comments)	• Initial cost can be high depending on the production quality • Distribution costs are usually low
Newspapers (print and Web-based)	• Can reach large numbers of readers in a timely manner, depending on circulation and access • One paper copy of a newspaper can be read by multiple individuals (especially if posted in a central location in a community or	• Can convey simple and complex messages (often supported by photos, cartoons, graphic illustrations) • Suited to in-depth explanations and reporting of issues	• Readers can react to articles through opinion and editorial inputs • Newspaper can elicit feedback to online versions through e-mail or text messages • Reporters and program facilitators can engage	• Cost of production/printing can be high • Cost of placing advertisements can be high • The inclusion of articles/stories is free

Channel	Message Reach	Message Complexity	Audience Engagement	Cost
	neighborhood)		groups of readers in discussions about relevant featured articles	
Magazines	• Can reach large numbers of readers in a timely manner, depending on circulation and access • One paper copy of a magazine can be read by multiple individuals (especially if available in a central location in a community or neighborhood) • Tailored messages can reach specific segments of a population through niche publications	• Can convey simple and complex messages (often supported by photos, cartoons, graphic illustrations) • Suited to in-depth stories and reporting of issues	• Readers can react to articles through opinion and editorial inputs • Editors can elicit feedback to online versions through e-mail or text messages • Writers and elicit feedback for follow-up articles	• Cost of production/printing can be high • Cost of placing advertisements can be high • The inclusion of articles/stories is free
Posters	• Can reach large numbers of people depending on distribution and placement	• Best for conveying short, specific awareness-raising and action-oriented messages	• Can be used as a discussion-starter by community health workers, leaders, etc.	• Cost of production can depends on the quality of the design and graphics • Cost of printing can be high • Cost of distribution depends on the locale and distribution channels
Billboards/Wall Paintings	• Can reach large numbers of people depending on placement	• Best for conveying short, specific awareness-raising and action-oriented messages (usually through large graphics/pictures and few words)	• Can be used as a discussion-starter by community health workers, leaders, etc.	• Cost of production usually depends on the size • Cost of placement varies by setting
Leaflets/Flyers	• Can reach large numbers of people depending on distribution	• Can convey simple or complex messages (including photos, cartoons, graphic	• Can be used as a discussion-starter by community health	• Cost of production is usually low • Cost of distribution varies

Channel	Message Reach	Message Complexity	Audience Engagement	Cost
	• One leaflet or flyer can be read by multiple individuals	illustrations) depending on the size of the leaflet/flyer	workers, leaders, etc.	by setting
Folk Media (Interactive Theater, Songs, Dance)	• Folk theatre and folk songs reach audiences that are beyond the mass media footprint • Can reach small or medium audiences in local venues	• Can convey simple messages in local languages/dialects	• Interactive formats can elicit immediate audience inputs and feedback • Facilitators can engage viewers to participate in discussions following each performance	• More cost-effective than household visits in low-density populations
Interpersonal Communication (IPC)/Community Dialogue	• Usually reaches individuals and small groups using community health workers/volunteers, peer educators and other facilitators	• Can convey simple or complex messages depending on the amount of time and credibility of the source	• Usually highly interactive discussion	• Cost of facilitators' training, time, transportation, materials, remuneration, and supportive supervision can be relatively high depending on the number of individuals or groups reached
Text Messaging (SMS)	• Can reach large numbers of individuals simultaneously depending on mobile network coverage and access	• Suited to conveying short, simple messages	• Can elicit immediate text-message responses	• Cost depends on the local rates for mobile messaging
Internet/Social Media (e.g., Facebook, Twitter, LinkedIn)	• Can reach large numbers of individuals simultaneously or on time-delay depending on mobile network coverage and access	• Can convey simple or complex messages using text, visuals, graphics, embedded video	• Can be highly interactive	• Cost depends on the Web design requirements and staff required for maintaining a Website
Flash Mobs*	• Can reach small to medium sized population segments depending on the locale and access to the Internet	• Suited to conveying short, simple messages	• Audience members generally observe the performance or event and then disperse once the event has ended	• Cost is usually low

* A flash mob is a group of people who assemble suddenly in a public place, perform an unusual act for a brief time, then quickly disperse, often for the purposes of entertainment, but can be used to create awareness about an issue. Flash mobs are usually organized via social media, viral e-mails or texts.

Appendix 10: Step 2 - Strategic Design Checklist

INSTRUCTIONS: By the time you finish Step 1 (Situation Analysis), you should have enough evidence and information to write your program goal and objectives, and identify what theory(ies) or model(s) help to explain the pathways to achieving your goal. Use the following checklist of the key components for Step 2 to articulate the program strategy for each level of the SEM.

	Question	Answer				
☐	What is the overall program goal? (One sentence)	Goal:				
		Individual	Interpersonal	Community	Organizational	Policy/Societal
☐	What are the program's SMART objectives? (E.g., Behavioral, normative, capacity-building Template: "To increase/decrease by [X] percent the number of [participant group] that [behavior] by [timeframe].					
☐	What theory/model best explains the process for behavior change in our population/participant group(s) for the different levels of the Social Ecological Model? Note: It is helpful to diagram the theory/model and fit your scenario with the concepts/constructs of the theory/model.					
☐	What C4D approaches will you use to achieve the objectives? (E.g., Advocacy, social mobilization, community mobilization, BCC)					
☐	Which communication activities/channels will you use for each participant group? (E.g., CHW counseling, community					

	theater, billboards, social media, advocacy briefs)					
☐	What supplies/resources are necessary to implement the activities/interventions?					
☐	Have you researched/visited media or creative agencies that might develop the messages and materials? Which agencies will you ask to bid on a contract?					
☐	Have you developed an implementation plan and shared it with all stakeholders/partners?					
☐	☐ What program processes will you monitor? ☐ What are the key monitoring indicators? ☐ What data sources/methods will you use to collect monitoring information? ☐ How will the data be collected? ☐ Who will collect the data? ☐ When will the data be collected? ☐ Who will analyze the data? ☐ When will the analysis be completed? ☐ How will the results be used? By whom? ☐ How will the results be shared with stakeholder? Note: It is helpful to develop a table listing each process/activity to be monitored, the indicators, the data sources, how often data will be collected, and by whom.					
☐	☐ What program outcomes will you evaluate? ☐ What are the key evaluation indicators? ☐ What data sources/methods will you use to collect evaluation information? ☐ How will the data be collected? ☐ Who will collect the data? ☐ When will the data be collected?					

	☐ Who will analyze the data? ☐ When will the analysis be completed? ☐ How will the results be used? By whom? ☐ How will the results be shared with stakeholder? Note: It is helpful to develop a table listing each outcome (from the objectives), the indicators, the data sources, how often data will be collected, and by whom.					

Appendix 11: Example of a Focus Group Discussion Guide for Pretesting Communication Messages and Materials

RECRUITING AND CONDUCTING A FOCUS GROUP DISCUSSION (FGD)

The FGD participants should be representative of your intended population. Select participants based on relevant factors (e.g., gender, age, ethnicity, socioeconomic status, parity). Include the following in your invitation (verbal or written) to participate in the FGD:

- Explain the general purpose of the FGD
- Describe what taking part in the FGD means, including time commitment
- Make clear that participation is voluntary
- Describe how the information from the FGD will be used
- If compensation for their time will be given, explain what that compensation will be

CONDUCTING THE FGD

- Allot 1 to 2 hours per focus group and screen between 8 to 12 participants
- All questions should be open-ended to elicit in-depth responses
- Allow 10-20 minutes for each discussion topic
- Record FGD information (place, number of participants, date facilitator's name, time (start to finish)
- Record the names of participants (and contact information if appropriate)
- Collect socio-demographic data on the participants

THE MODERATOR'S/FACILITATOR'S ROLE

- The role of the moderator is to facilitate the discussion not lead it
- Ensure that the setting allows for the participants to be in a comfortable and quiet area, and seated in a circle facing one another
- Set the scene, explaining the purpose of the focus group
- Introduce participants to the topics for discussion
- Keep the group on time and focused on the topics
- Encourage participation from all the group members. Call on participants that are not contributing as much to the discussion
- Use your judgment to determine if the topic is providing valuable data and need to adjust the amount of time spent on that particular topic
- Suggest to participants to speak up when they have difference of opinion, rather than agreeing with everyone else's opinions and values

- Summarize discussions from time to time to check appropriate understanding of participants' comments
- Ensure that all the key issues are addressed

I. PRETESTING MESSAGES

Objective: To determine the comprehension and acceptability of messages

Materials Needed
- Tape recorder to document the discussions
- Messages typed on individual sheets of paper or recorded for playback using the recording device
- Mock-ups of communication materials
- Flip chart and pens

Conducting the Pretest
- Record each message on a tape recorder and write/type each message on separate sheets of paper (only one message per page).
- Recruit 8-10 participants that represent the members of your intended population
- Test both audio and visual messages. One FGD should listen to the messages and one FGD should read the messages.
- Show each of the written messages to the focus group. Ask questions following each message that is shown.
- Let the audio group listen to a message and then ask questions after each message.

EXAMPLES OF QUESTIONS

Comprehension
a. If you were to relate this message to a friend, what would you tell them the message was about?
b. What did that message mean to you?
c. Are there any words in the message whose meaning you did not understand? Which one(s)? Which word to you think should be used instead?
d. What could be done to make the message clearer?

Acceptance
e. Is there anything in the message that you think is not true? What do you think is not true? What should the message say instead?
f. Is there anything about the message that is upsetting/disturbing to you? What?
g. Is there anything about the message that you find offensive? What?
h. Do you think that your family, friends, or people in your community would find the message

upsetting/disturbing?

i. Do you think that your family, friends, or people in your community would find the message offensive?
j. Would you talk about this message with your family or friends? Why? Why not?

Attractiveness

k. What did you like most about the message?
l. What did you like least about the message?
m. What do you think others would like most about the message?

Call to Action

n. What do you think this message is asking you to do?
o. Are you willing to follow the advice being given to you in this message?
p. What part of the message do you find persuasive/motivating to follow the advice?
q. What would discourage you from following the advice in the message?
r. Do you think feel that this message is directed to you? What part of the message makes you think that?
s. Do you think that this message is directed to people NOT like yourself? What part of the message makes you think that?
t. Does the form of speech or the way the message is phrased reflect the way that you speak? That people in your community speak? Is there anything in the message that you or people in your community would say differently? What? How would you say it?

Play the taped message again (or have the respondent read the message again), and ask the respondent:

General Opinion Question

u. Was this message new to you?
v. In your opinion, what could be done to improve this message?

II. PRETESTING MATERIALS

1. Pretesting Print Materials (including logos)

A. Drawings and Illustrations *(show the picture without any text)*

Comprehension

a. Describe what you see in the picture.
b. What is this picture trying to tell you? What do you think about that?
c. Is there any part of this picture that is not clear? What part?
d. What could be done to make the picture clearer?

Acceptance

e. Is there anything in the picture that does not seem correct? What do you think is not correct? How should the picture be changed to make it correct?
f. Is there anything about the picture that is upsetting/disturbing to you? What?
g. Is there anything about the picture that you find offensive? What?
h. Do you think that your family, friends, or people in your community would find the picture upsetting/disturbing?
i. Do you think that your family, friends, or people in your community would find the picture offensive?

Attractiveness

j. What did you like most about the picture?
k. What did you like least about the picture?
l. What do you think of the colors?
m. What do you think of the style?
n. What do you think about the (faces, places, etc.) in the picture?
o. Do the faces seem familiar to you? Are these faces that you would see in your community? If not, what would you change about the faces?
p. Do the places seem familiar to you? Are these places that you would see in your community? If not, what would you change about the places?

Call to Action

q. Is this picture asking you to do anything? What?

General Opinion Question

r. In your opinion, what could be done to improve this picture?

B. Text

Comprehension

a. What does the text mean to you?
b. How easy or difficult is it to read the text? Why?
c. Are there any words whose meaning you did not understand? Which one(s)? Which word to you think should be used instead?
d. What could be done to make the text clearer?

Acceptance

e. Is there anything in the text that does not seem correct? What do you think is not correct? How should the text be changed to make it correct?
f. Is there anything about the text that is upsetting/disturbing to you? What?
g. Is there anything about the text that you find offensive? What?

h. Do you think that your family, friends, or people in your community would find the text upsetting/disturbing?
i. Do you think that your family, friends, or people in your community would find the text offensive?

Attractiveness

s. What did you like most about the text?
t. What did you like least about the text?
u. What do you think of the colors?
v. What do you think of the style?
w. Is the lettering big enough?
x. Is the lettering bold enough?

General Opinion Question

y. In your opinion, what could be done to improve the text?

2. Pretesting Mass Media Materials

You can adapt the questions above for mass media materials and add the following questions about music and characters for TV spots and radio spots, and TV dramas and radio dramas. Bes sure to let the participants see or listen to the spots or dramas:

STORY-LINE/MESSAGE CLARITY/COMPREHENSION

1. Did you like the story?
   a. In your opinion, how realistic was the story?
   b. What made the story realistic or unrealistic?
   c. Was there anything in particular that was hard to believe?
   d. What did you like most about the story?
   e. What did you like least about the story?
   f. Would you talk about this story with your family/friends? (Why/why not?)
2. In your opinion, what was the key message(s) from the story?
3. What does the story ask people to do?
4. How well does the story resonate with you?
5. What would you change about the story?

CHARACTERS AND DESIGN ISSUES

1. Which character(s) did you like the most?
   a. What was it about the character(s) that you liked?
2. Which character(s) did you like the least?
   a. What was it about the character(s) that you did not like?
   b. What would you change about this character(s)?
3. Would you change the gender of any of the key characters?

4. With which character(s) did you most closely identify?
5. Which character did you feel was the most trustworthy for providing information about (topic)?
6. Did the characters remind you of people that you know?
7. What other character(s) do you think we should include to help tell the story?
8. What came to mind when you heard the music?
   a. What did you like about the music?
   b. What did you dislike about the music?
   c. What changes to the music would you suggest?
9. What are your thoughts about the voices of the characters?
   a. Were there any voices that you found unpleasant to listen to?
   b. What changes would you make to the voices of the characters?

ACCENT/LANGUAGE/DIALOGUE

1. What are your thoughts about the accents of the characters?
   a. What changes to the accents would you suggest?
2. What did you think about the language used?
   a. What words or phrases were not clear?
   b. What words or phrases did you feel might be inappropriate or offensive?
   c. What changes would you make to the language used?
   d. How easy or difficult was it to follow the dialogue? Why?
   e. How natural did the dialogue seem to you?
3. In your opinion, did the dialogue sound like a realistic conversation that you might overhear?
   a. What, if anything, was unrealistic in the dialogue?
   b. How would you change the dialogue to make it sound more realistic?

Appendix 12: Step 3 - Activities Development & Testing Worksheet

INSTRUCTIONS: The following table will help you to chart the activities that will help to meet your program objectives. For each program objective, identify the training/capacity building activities necessary (for example, training of community health volunteers or training of journalists), and what behavior change communication, social mobilization, social change, and/or advocacy activities you will develop and implement. Once you have decided on the activities, determine the means by which you will pretest all messages and materials for each activity, and map out the timeline for completing the development and delivery of the trainings and materials for all activities. (Note: You can use this worksheet as a template and expand the boxes as necessary.)

Objective	**Activity**						
	Training/Capacity Building	Behavior Change Communication	Community/Social Mobilization	Social Change Communication	Advocacy	PRETESTING	TIMELINE
Objective #1							
Objective #2							
Objective #3							

Appendix 13: Step 4 - Monitoring Plan Checklist

INSTRUCTIONS: The following is checklist for the program monitoring activities. Develop indicators for each monitoring activity you will undertake. Determine the information sources for each indicator, and who will be responsible for collecting and recording the data, the cost for collecting and recording the data, and the dates by which the indicators will be recorded. You should have an implementation/operational plan in place and use the items from the operational plan for the monitoring checklist.

Activity	Indicators	Information Sources	Person(s) Responsible	Cost	Completion Schedule
Monitoring Processes					
1. Project approval and initiation					
2. Are relevant stakeholders involved in program development, implementation, monitoring?					
3. Are program support/follow-up mechanisms in place?					
4. Are program reporting mechanisms in place?					
5. Are resources in place a. Staff hiring/training b. Budget allocations and access c. Communication/IT d. Data management e. Outside agency(ies) contracted					

Monitoring Implementation of Activities					
6. [List each key element being monitored – e.g., trainings, materials development, Coordinating Committee meetings, etc.] a. Did the tasks/activities take places on schedule at the planned frequency? b. Were the deliverable benchmarks met? c. Were the deliverables distributed to the relevant recipients? d. Were broadcasts made according to schedule? e. Were activities within budget?					
Monitoring Program Coverage					
7. Are planned numbers of the participant groups being reached over time? 8. Are participant groups' information needs changing over time?					
Monitoring Quality					
9. Was the content/quality of the deliverables acceptable? 10. Are the messages appropriate for each participant group? 11. Are counselors/field workers providing accurate information? 12. Has training increased staff knowledge, attitudes, and skills?					
Monitoring Reporting Mechanisms					
13. Are reports submitted on time and in a user-friendly format?					

Appendix 14: Examples of Process (Monitoring) and Outcome Indicators for Breastfeeding

Process (Monitoring) Indicators

Training Indicators
- Curriculum development completed
- Trainings for providers completed for breastfeeding counseling
- Trained providers who are knowledgeable in breastfeeding counseling

Message and Materials Development Indicators
- Focus groups completed
- Breastfeeding communications products developed
- Dissemination plan developed
- Breastfeeding communications materials disseminated
- Intended population exposed to messages/materials on breastfeeding

Policy Development Indicators
- Decision made by policy working group to write national breastfeeding policy
- Existence of national breastfeeding policy
- Existence of national breastfeeding plan
- New policy implemented

Monitoring and Evaluation Progress Indicators
- Identification of necessary technical assistance
- Completion of approved evaluation plan
- Development of data collection forms
- Completion of data collection
- Evaluation activities completed

Outcome Indicators

Knowledge About Exclusive Breastfeeding
- Knowledge of the key benefits of exclusive breastfeeding
- Knowledge of the recommended duration for exclusive breastfeeding

Attitudes Toward Exclusive Breastfeeding
- Positive attitudes toward exclusive breastfeeding

Breastfeeding Rates
- Exclusive breastfeeding rate <6 months
- Exclusive breastfeeding rate months 0, 1, 2, 3, 4, and 5
- Never breastfed rate

Timely Initiation of Breastfeeding
- Initiation of breastfeeding in first hour of life

Duration of Any Breastfeeding
- Continued breastfeeding rate at 12 months
- Continued breastfeeding rate at 24 months
- Mean duration of breastfeeding

Intensity of Breastfeeding
- Frequency of breastfeeding in 24 hours
- Full/partial/token breastfeeding
- Mean duration of lactational amenorrhea

Timely Complementary Feeding
- Timely complementary feeding rate

Self-Efficacy for Exclusive Breastfeeding
- Confidence to exclusively breastfeed for six months

Appendix 15: Step 5 - Evaluation Plan Checklist

INSTRUCTIONS: The following is checklist for the program evaluation activities. Refer back to the program objectives as a guide for what outcomes/impacts to measure. Use the questions below as a guideline to determine how, from where, by whom, and on what timeline the data will be collected.

	Preliminary Steps
	Purpose of the evaluation:
	Are all approvals/consents in place?
	Are consultants/agencies contracted?
	Are relevant stakeholders/participant groups involved in program evaluation?
	Are resources in place ○ Staff hiring/training ○ Budget allocations and access ○ Data collection equipment (e.g., tape-recorder, video-recorder, copies of instruments) ○ Data processing equipment
	Have all data collection instruments been developed?
	Have all data collection instruments been pretested?
	Have all data collection instruments been revised and finalized?
	Have the data collection field workers been briefed/trained?
	Has a data collection implementation plan been developed?
	Who will analyze the data?
	Has a data analysis plan been created? Have dummy tables been created for quantitative data?
	Has the findings report(s) been outlined?

	How will the evaluation report(s) be disseminated? (To whom? By when?)								
Activity	Design/Method	Sample Size/Sampling	Indicator(s)	Instruments	Data Source(s)	Person(s) Responsible	Cost	Complet Schedu
[List each evaluation study]								

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