Practitioner's Guide

Social and Behaviour Change

Insights and Practice

Photo: GIZ/Jörg Boething

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Foreword

Every day we take dozens of decisions that influence the nutrition of our family members, friends, colleagues and our own. These decisions depend on the determinants for good nutrition of the UNICEF Framework and the four dimensions of Food and Nutrition Security: availability, access, use/utilization and stability. They are therefore very different in the North of Mali, a mega-city in India or rural Europe. At the same time there is more to food than the socio-economic facts. Food has cultural and religious dimensions; it can define affiliation to groups of society or status. Not only long-term well-being but also short-term personal satisfaction is linked to our food intake.

Therefore, these guidelines cover a topic that goes beyond these four dimensions by addressing the existing scope for behavioural changes in any given environment. Our joint vision to overcome hunger and malnutrition in all its forms by 2030 will only come true, if we not only strengthen the socio-economic capacities of people but also strengthen the capacities to make the right nutrition choices and stick to them.

Information on healthy diets is important but not enough to make a difference in the long run. We have to question our approach and develop it further based on evidence not assumptions. Sound analyses of the target group and the underlying factors of nutrition choices are key. Applying the knowledge of behavioural science helps to tap into the psychological and social effects. This tool guides you systematically with concrete examples to work on increasing motivation and breaking barriers for nutrition. With frequency and consistency.

There is no quick fix for behavioural change. This might be disappointing for you but the reward for perseverance is long-term change on an individual and household level, which will shape demand and markets. Sustainable, nutrition-sensitive and inclusive food systems need to be built on informed consumer choices. Let's use this tool, develop it further, exchange experience and contribute to getting the number of stunted children finally down from 149 million to zero.

Dr. Heike Henn

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List of Abbreviations

ANF4W	Affordable Nutritious Foods for Women
BCC	Behaviour Change Communication
DBC	Designing for Behaviour Change
ENA	Essential Nutrition Actions
ENGINE	Empowering New Generations to Improve Nutrition and Economic Opportunities
EU	European Union
EWA	Essential WASH Actions
FGD	Focus Group Discussions
GIZ	Gesellschaft für Internationale Zusammenarbeit
HKI	Helen Keller International
IEC	Information, Education, Communication
LSHTM	London School of Hygiene & Tropical Medicine
MAD	Minimum Acceptable Diet
MUAC	Mid-Upper Arm Circumference
NGO	Non-Governmental Organisation
NRM	Natural Resources Management
NSAP	Nutrition Sensitive Agriculture Project
PIN	People in Need
RANAS	Risks, Attitudes, Norms, Abilities, and Self-regulation
SBC	Social and Behaviour Change
SBCC	Social and Behaviour Change Communication
SMS	Short Message Service
TIPS	Trials of Improved Practices
UN	United Nations
UNICEF	United Nations International Children's Emergency Fund
USAID	United States Agency for International Development
WASH	Water, Sanitation, and Hygiene
WHO	World Health Organisation

Introduction

This guide was prepared primarily for those people who participate in the implementation of GIZ's food and nutrition security programmes. If you are one of these, you most likely acknowledge that producing enough food for consumption or income alone will not ensure the end of hunger and malnutrition. You have also probably experienced that in order to help people improve their nutrition, **you need to impact the way people „behave"** – meaning, the people you are trying to benefit need to consume the right types of foods, in the right quantities, at the right times, and in the right way. Also, they need to ensure the retention of nutrients through optimal food preparation and hygiene practices.

You will have recognised that having one or two awareness-raising sessions with the target group members in which 'optimal' behaviours are explained, does not change much if anything at all, even though your curriculum seems perfectly sound and makes sense, and is perhaps even fun! You might also sense that counting the number of trainings or awareness-raising sessions held is not the most helpful way of measuring the results of your behaviour change activities. You can also observe, not only through your work, that people's individual behaviours are powerfully influenced by their environment, their socio-economic and political reality, and a multitude of other factors.

Where do you begin? What essentials should you know? What steps should you take? What mistakes should you avoid? What can you do on your own and where should you look for external assistance? You may not be the person to carry out all the steps of a social and behaviour change process, but you will want to know enough about it to confidently ensure the process is on course as you draw on experts. This guide was prepared to answer these (and many other) questions.

THIS DOCUMENT WILL HELP YOU UNDERSTAND:

- ✓ what is social and behaviour change (SBC)
- ✓ what drives human behaviour (a few key things; no one knows it completely!)
- ✓ step by step, how you can integrate SBC into the various stages of your intervention, starting from the design to its final evaluation
- ✓ where can you find the most helpful tools, guidance, examples and other resources

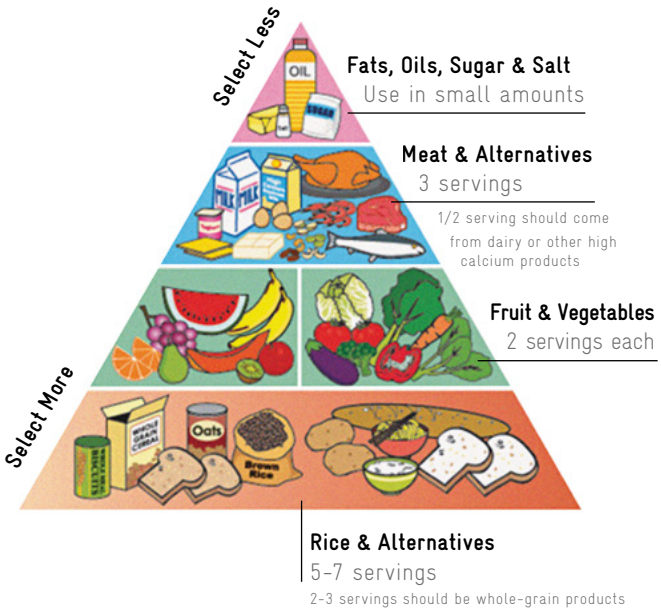
Chapter 1
What is Social and Behaviour Change

In this chapter, you will learn what social and behaviour change (SBC) means, where the concept originates, and how it is different from similar-sounding concepts and abbreviations.

THE KEY TERMS USED IN THIS CHAPTER

- **Determinants** are the factors that influence whether a person practices a given behaviour or not.
- **Barriers** are the factors that prevent a person from practicing the desired behaviour.
- **Social and Behaviour Change (SBC)** is a process involving individuals, communities or societies that enables them to adopt and sustain positive behaviours.
- **Target group** consists of people targeted by an intervention (e.g. women of reproductive age).
- **Priority group** consists of people who are expected to practice a given behaviour (e.g. mothers of children aged 0 - 5 months who should breastfeed exclusively) as well as those who are supposed to ensure that someone else practices a behaviour (e.g. parents of children who should ensure that the children attend school). One target group usually includes different priority groups.

Let us consider how we may have traditionally thought about promoting better nutrition in the communities we work with. Most likely, the familiar approach tries to educate the priority group members about how to grow nutrient-rich crops and how to prepare nutritious meals. It has perhaps been taken for granted that making people "aware" of a problem and of a "solution" would translate into action. However, think about your own experience: Does the fact that you know that you should be doing something (for example, exercise regularly) result in you actually doing it? If you are like most people, it most likely hasn't. Of course, improved awareness is not entirely useless, and in the 1970s to as late as through the 1990s, **Information, Education, and Communication (IEC)** was the way to go about trying to achieve change in people's behaviours. You may have come across many flipcharts, training manuals, or even radio programmes from the past, and most of them are perfectly sound in their content (see example below).[1] But as extensive evidence has shown, increasing knowledge, awareness or even attitudes without addressing other determinants of human behaviour does not usually translate into long-term action.[2] Having certain knowledge is just one of many factors that influence people's ability and willingness to practice a given behaviour.



1 Singapore's Health Promotion Board

2 Darnton A. (2008) An overview of behaviour change models and their uses, retrieved from this site
Christiano, A. and Neimand, A. (2018) Stop raising awareness already, retrieved from this site
Kelly, M. and Barker, M. (2016) Why is changing health-related behaviour so difficult?, retrieved from this site
Seimetz, E. et al. (2016) Effects of an awareness raising campaign on intention and behavioural determinants for handwashing, retrieved from this site

Behaviour Change Communication (BCC) thus emerged as a more strategic use of communication with an explicit focus on behaviour change (i.e. not just, for example, on increasing people's awareness). While this was not a common practice, at least some of the BCC interventions made the effort to employ a more systematic process, beginning with defining the desired behaviours and the people who should practice them, formative research identifying the key barriers to practicing these behaviours, development of the key messages, and subsequent communication planning, implementation, monitoring and evaluation. They also took greater advantage of behaviour change theories that were built across disciplines over decades, including marketing, economics, public health, behavioural science, behavioural economics, psychology, medicine, and anthropology.

BCC efforts have largely focused on individual behaviour change. However, a growing understanding that behaviour change is not just a matter of an individual's decisions and abilities resulted in an expansion of the approach to become **Social and Behaviour Change Communication (SBCC)**. SBCC is guided by a recognition that people's behaviour is influenced by a range of external 'influencers', such as the opinions and attitudes of their family members and friends, local culture, the economic situation in their area, availability of resources, (lack of) services provided by the private sector, government policies, extent to which a government supports its citizens, and many other factors that are beyond an individual's control. BCC was changed to SBCC because it was increasingly clear that a long-term change in people's behaviours often cannot be achieved without shaping the social and environmental factors that influence these behaviours.

All the approaches described above can easily create an impression that behaviour change is primarily about communication – about beautiful posters with catchy content, attractive TV shows and spots, well-designed mobile phone messages, informative counselling sessions or large community events. However, is this the conclusion we should make? Let's have a look at some of the factors that frequently prompt people to practice the desired behaviours:

- wide availability of agricultural inputs in the local shops
- readily accessible affordable financing options to purchase various products and services
- willingness of poor people to visit health facilities when they are treated with respect
- HIV/AIDS counselling services for youth being offered in a place that ensures privacy
- presence of companies offering the construction of affordable latrines
- availability of the water required to grow nutritious crops during the dry season

As you can see, achieving such an "enabling environment" was not about displaying nice posters or sending mobile phone messages. Often, to facilitate the desired change, **we have to do much more than just "communication"**.

The recognition that communication is important but not enough by far lead to the last "C" of SBCC getting dropped, resulting in **Social and Behaviour Change (SBC)**. Throughout this publication, SBC is understood as a process involving individuals, communities or societies that enables them to adopt and sustain positive behaviours. It does so by identifying the various factors that influence people's behaviour and addressing these by using those approaches that are most likely to be effective. The following chapters will provide you with practical guidance on how to do so in the course of your interventions.

AN EXAMPLE OF SOCIAL AND BEHAVIOUR CHANGE RELATED TO NUTRITION

Orthodox Christianity, the major religion in Ethiopia, encourages its followers to fast 200 – 250 days a year. The fasting prohibits the intake of animal-source foods. This represents a problem especially among pregnant and lactating women, who have an increasing demand for energy and nutrients and are thus vulnerable to nutritional inadequacy.[3] Fasting is not entirely an individual choice: it is very deeply entrenched in the cultural norms, encouraged by an influential church authority without whose explicit support, it would be impossible to change. Tackling this barrier to improved nutrition required a change at a level higher than that of the individual. GIZ and other stakeholders therefore focused their efforts on the Ethiopian Orthodox Church. As a result of the collaboration, in late 2017, the Church made a declaration relieving pregnant and lactating women from the fasting obligations, encouraging a diversified diet particularly for young children and other initiatives to improve nutrition in the country.

3 Karle, Ch. (2017) Fasting among Orthodox Christians in Ethiopia: The symbolic and nutritional significance of the fast for reproductive women, retrieved from this site

Chapter 2
What Influences Behaviour Change

In this chapter, we will look at why people (do not) adopt and maintain various behaviours. We will take advantage of the most useful behaviour change theories as well as practical lessons learned generated in the course of the behaviour change programming of various agencies.

THE KEY TERMS USED IN THIS CHAPTER

- **Motivators** are the factors that encourage a person to practice the desired behaviour.
- **Barriers** are the factors that prevent a person from practicing the desired behaviour.
- **Target group** consists of people targeted by an intervention (e.g. women of reproductive age).
- **Priority group** consists of people who are expected to practice a given behaviour (e.g. mothers of children aged 0 – 5 months who should breastfeed exclusively) as well as those who are supposed to ensure that someone else practices a behaviour (e.g. parents of children who should ensure that the children attend school). One target group usually includes different priority groups.

WHAT CAN WE LEARN FROM BEHAVIOUR CHANGE THEORIES

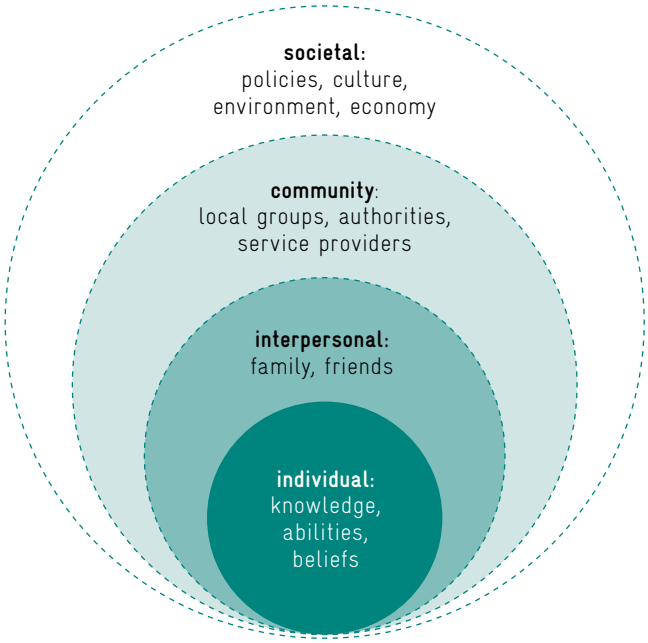
There are a large number of useful theories and models that aim to explain human behaviour change across different contexts. Some of the most prominent are: The Health Belief Model, Theory of Planned Behaviour, Socio-Ecological Model, The Stages of Change Model, Exchange Theory, Diffusion of Innovations Model, Theory of Gender and Power, Fear Management Theory, Social Learning Theory, Social Cognitive Theory, and Communication Theory. If you are interested in a comprehensive overview of the various theories and models, have a look at the Overview of behaviour change models and their uses (2008; Darnton, A.). In this chapter, we will introduce you to two practical models / theories that are frequently used in development interventions.

THE SOCIO-ECOLOGICAL MODEL

The Socio-Ecological Model is a theory-based model for understanding the various factors that on several different levels influence people's behaviours. It covers the essence from most of the other models regarding the individual level and adds in the socio-ecological aspect, acknowledging the great impact community, society, policy, natural environment and other factors have on individuals' behaviours. According to the Socio-Ecological Model, our behaviour is determined by a range of personal and external factors at the following levels:

- **Individual level** includes a person's knowledge, skills, self-confidence, life experience, socio-economic status, age, health, and other factors.
- **Interpersonal level** includes a person's partner, family, friends or the closest classmates/colleagues.
- **Community level** includes various local-level groups and institutions (e.g. presence of a saving group or of a school), local authorities (e.g. traditional leaders) and providers of commercial and public services (shops, health facilities, transportation).

- **Societal level** includes factors at the highest level that an individual is least able to influence, such as government policies, budget allocation, culture, religion, media, the economy and the environment.



Source: Adapted from Schmied, P. (2017) Behaviour Change Toolkit

The model clearly shows that the individual level, involving a person's knowledge, motivation, and skills, is just one out of several factors that determine whether a person practices the desired behaviour. It highlights **the importance of the "social" aspects of social and behaviour change**, helping us to look at the issues we address from a broader and more realistic perspective. Let's have a look at several examples:

- In Northern Laos, mothers-in-law often have a much greater influence on childcare than do the mothers. Interventions focusing exclusively on mothers would be likely to bring only limited results.
- In many countries, vegetable seeds are frequently sold in packages that contain much larger quantities than the average farmer needs or can afford. Negotiations with producers to sell seeds in smaller packets would make them more affordable.
- In rural Cambodia, health facilities closed in the early afternoon, making it difficult for women who worked in factories or needed urgent help to access the required healthcare.
- "Social" factors are sometimes the "enemies of change" but they can also support a change. For example, Islam has precise rules for various hygiene practices that for some people can be a powerful motivator. Another example: In rural Zambia, groups of men with more progressive attitudes towards helping their wives with domestic chores have motivated other men to follow their example.

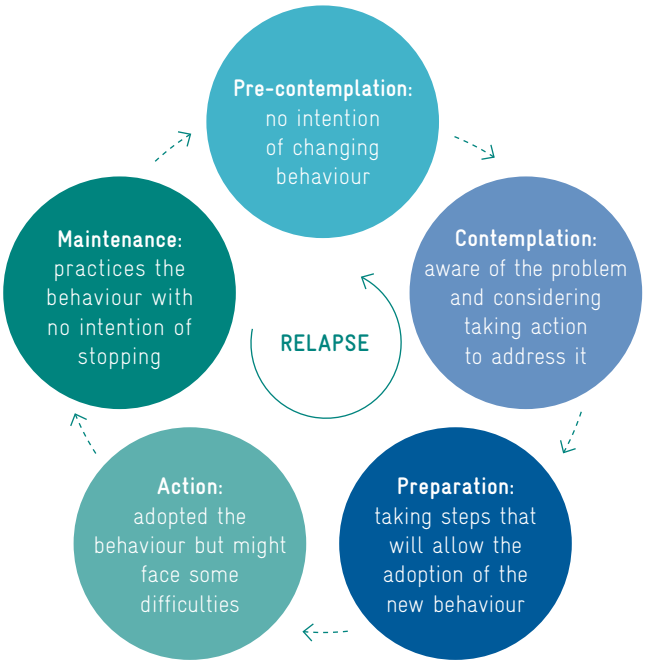
AN EXAMPLE OF USING A BROADER VIEW

Click on the links below to see examples of three interventions whose strategy engaged stakeholders at several levels of the Socio-Ecological Model:

- People in Need's Community Livestock Market Development project funded by the European Union worked on improving the food security and livelihoods of poultry farmers through systematically engaging a wide range of the market and government actors at several levels.
- The GIZ's Fit for School programme focuses (amongst others) on reducing the risk of diseases caused by poor hygiene, water and sanitation. It uses an approach involving stakeholders at all the levels of the education system – students, parents, school staff and relevant authorities.
- Save the Children's ENGINE programme funded by USAID, worked with Ethiopian stakeholders from the grassroots to the national level to improve the nutrition of young children and mothers.

STAGES OF CHANGE MODEL

How does behaviour change happen? This is a question that the scientists Prochaska and DiClemente tried to answer more than 35 years ago through their Stage of Change Model. According to the model, **when adopting a behaviour, people go through several different stages**. As the illustration shows, they range from a 'pre-contemplation' stage, when a person has no intention of changing her/his behaviour, to a 'maintenance' stage, when the person routinely practices the behaviour and does not intend to stop. At the same time, as the spiral shows, the person can relapse anytime and move from one stage to any of the previous stages (e.g. from the action stage to the contemplation stage).



Let's illustrate this model with the example of mothers giving children drinks that are not high in sugar:

- **Pre-contemplation stage:** The mother does not see any problem with her children getting obese. The children appear happy when they receive sugary drinks and other 'treats' and so she is also happy.
- **Contemplation stage:** The mother is aware of the risks related to child obesity and of the connection between giving sugary drinks and weight gain but does not yet take any action with regard to it.
- **Preparation stage:** The mother is determined to reduce the amount of sugary drinks her children drink but she is afraid that they will be unhappy. She is also not sure whether she can offer good alternatives.
- **Action stage:** The mother has largely replaced the sugary drinks with healthier drinks.
- **Maintenance:** The mother routinely gives non-sugary drinks to her children and the children accept them.

An important part that is missing in this story is the risk of relapse: at any point, the mother can decide that it is not worth the hassle. Alternatively, her husband can force her to start giving the children the (sweet) drinks they want. In such a case, her 'stage of change' can slip, for example, from the action stage to the contemplation stage – knowing about the problem but not taking any steps to address it.

As you can imagine, **people that are in different stages of change require different types of support**. For example, a person who does not see a problem in her/his current behaviour is likely to need very different support from a person who is determined to change her/his behaviour but is unable to overcome some of the obstacles s/he faces. Interventions that are designed without understanding the stage that most of their priority group members are in, are less likely to be effective simply because they might be providing a different type of support from what people need.

Working out the proportion of your priority group members in the various stages of change is not difficult – you can assess it during your baseline survey by gauging people's:

- **Awareness:** Are they aware of the problem?
- **Attitudes:** What are their attitudes towards the desired behaviour?
- **Practices:** Do they already practice the behaviour properly (e.g. exclusive breastfeeding until 6 months) or partially (e.g. exclusive breastfeeding until 4 months)?[4]

4 Schmied, P. (2017) Behaviour Change Toolkit, retrieved from this site

Photo: GIZ/Mehret Haile

THE 11 KEY FACTORS THAT INFLUENCE HUMAN BEHAVIOUR

The following eleven factors, often called 'determinants', were identified as those that influence whether we adopt and sustain a given behaviour or not.[5] They are frequently used in assessments that aim to understand which factors prevent people from practicing the desired behaviours (and on the other hand, what could motivate them to practice these behaviours). The main reason why so many of them include the word 'perceived' is because **what matters most is not what we think about these determinants but how the priority group members perceive them** (for example, what THEY think the positive or negative consequences of a given behaviour are).

If you are interested in learning more about these determinants, take advantage of the examples and guidance available in the training manuals Practical Guide to Conducting a Barrier Analysis and Designing for Behavior Change: For Agriculture, NRM, Health and Nutrition. Notice how many determinants cannot be addressed through communication only (such as posters, awareness-raising sessions, radio shows) as they require a much broader range of solutions.

5 This overview was prepared based on explanations in the two publications recommended above as well as the author's programming experience.

1 - Perceived self-efficacy
is about an individual's belief that s/he can do a particular behaviour given her/his current knowledge, abilities, self-confidence or resources. For example, farmers growing vegetables for household consumption might not feel confident that they can deal with the pests that affect their crops.

2 - Perceived social norms
is about the perception that people who are important to an individual think that s/he should (not) do the behaviour. For example, husbands might be concerned that their friends will laugh at them if they start helping with 'women's tasks' at home (e.g. collecting water, feeding children). A mother who observes a local celebrity breastfeeding her child may perceive that people living the life she aspires to approve of breastfeeding.

3 - Perceived positive consequences
are about the positive things a person thinks will happen as a result of performing a behaviour. These may be, for example, health-related (e.g. "feeding my child an egg every day will help her to grow well") or may go beyond health (e.g. "feeding my child an egg every day will help her to be smart and sharp in school"). They can also be much less 'rational', such as positive feelings of comfort, peace of mind or feeling good about oneself.

4 - Perceived negative consequences
are about the negative things a person thinks will happen as a result of performing a behaviour (including negative feelings such as disgust, fear or uncertainty). For example, caregivers might be concerned that if young babies receive only breastmilk, they will be hungry or thirsty.

5 - Access
is about the extent to which the priority group members feel that the goods (e.g. fertilizers, soap) or services (e.g. animal vaccinations) required to practice the behaviour are available. Access is affected by barriers related to costs, distance, language, culture and gender. For example, members of ethnic minorities might find it difficult to access those government extension services provided in a different language from their own.

6 - Cues for action or reminders
are about the extent to which the priority group members think it is difficult for them to remember 1) to do the behaviour or 2) how to do the behaviour. For example, stickers can remind caretakers of the steps involved in preparing an oral rehydration solution to prevent dehydration.

7 - Perceived vulnerability
(also referred to as susceptibility or risk) is about a person's perception of how vulnerable s/he feels with regard to the problem. For example, a mother's opinion on how likely it is that her child could become undernourished.

8 - Perceived severity
is about a person's belief that the problem (which the behaviour can prevent) is serious. For example, women may think that it is not a problem if their children are obese as some other children in their community are also chubby. Others may underestimate the threat that malaria poses for children.

9 - Perceived action efficacy
is about a person's belief that practicing the behaviour is effective in avoiding or addressing the problem. For example, a poultry farmer might not believe that vaccinating his chickens will be effective in reducing their mortality.

10 - Policy
is about laws, regulations and rules (both formal and informal) that make it more difficult or easier to practice the desired behaviour. For example, the Baby-Friendly Hospital policy forbids the sale of baby formula at health facilities and thus helps promote exclusive breastfeeding.

11 - Culture
is the set of history, customs, lifestyles, values, and practices within a self-defined group. It may also be associated with ethnicity or lifestyle (e.g. youth culture). As opposed to the social norms, culture includes a much broader spectrum of people. An example of a culture-related determinant is a belief that girls are destined to marry young and become housewives and thus do not need much education.

WHAT ELSE DO WE KNOW

In the past decades, practical programming experience alongside thousands of studies have generated valuable lessons learned, the application of which can make a big difference to the impact of our interventions. The following pages therefore share with you some of the most useful insights that are worth considering when designing and implementing development programmes.

THE (IR)RATIONALITY OF OUR DECISION-MAKING

Traditionally, behaviour change interventions have been based on providing people with the rational arguments related to the advantages of practicing a given behaviour. The assumption was that once people understand these advantages (and gain the required skills), they will adopt the desired behaviours and continue using them in their everyday lives. However, is this really the way our minds and lives work? Do we always decide based on what is rationally correct? The existing research as well as practical experience show that humans often do not decide to practice a certain behaviour in a well-calculated, planned or even conscious manner.[6] The drivers of human behaviour can be divided into two very different groups:

- A more **automatic, cue-driven system** (called 'System 1') that uses familiar behaviour patterns (e.g. our habits), signals from the environment, and simple decision rules to guide behaviour. It is fast, impulsive, intuitive, automatic, frequent, emotional, and subconscious. For example, answering what 2+2 is, picking up a favourite drink in a shop, and anything that you learned in the past and now do without thought.
- A more **conscious, goal-directed system** (called 'System 2') that uses decision-making to direct behaviour towards emotionally and motivationally valued outcomes. It is effortful, calculating, logical, less frequent, and conscious. For example, making a decision about changing a diet.

Now, for behaviours that people perform infrequently, newly, or in different settings, people tend to use the 'conscious system'. However, **behaviours that are performed frequently in the same setting are better predicted by habit strength**, which belongs to the 'automatic system' – people doing things as they get used to doing them.

Habits are automatically triggered by context cues, such as physical settings or preceding actions that remind people to practice the behaviour (handwashing after defecating is a good example of this). If these 'reminders' are not consistently present in the environment, the desired habit will not occur unless motivation is extremely high.[7]

A greater understanding of the automatic system has led to an increasing use of the **nudging techniques** that aim to alter our environment so that when the automatic system is used, the resulting choice is the most positive and desired outcome.[8] 'Nudges' are frequently described as "… any aspect of the choice architecture that alters people's behaviour in a predictable way without forbidding any options or significantly changing their economic incentives. To count as a mere nudge, the intervention must be easy and cheap to avoid. Nudges are not mandates. Putting fruit at eye level counts as a nudge. Banning junk food does not."[9] By using nudges, we are trying to increase the likelihood that a person chooses an option that brings positive social or environmental benefits. Practical examples of nudges include:

- a system where farmers are offered the possibility of purchasing a voucher for fertilizers immediately following the harvest (when they have the money), at a regular (not-subsidised) price, with free delivery later in the season[10]
- promotion of saving accounts where for a period of six months people cannot withdraw the deposited money (increasing the amount of money they save in the long-term)
- a system sending an SMS reminder to HIV/AIDS positive people to take the required drugs (in order to increase adherence to the treatment, increase its effectiveness and decrease the costs)[11]

6 Ariely, D. (2009) Predictably Irrational; Thaler, R. and Sunstein, C. (2008) Nudge: Improving decisions about health, wealth, and happiness; World Bank (2015) Mind, Society, and Behaviour, retrieved from this site
7 Wood, W., et al. (2005) Changing circumstances, disrupting habits
8 Campbell-Arvai, V. et al. (2014) Motivating sustainable food choices: the role of nudges, value orientation, and information provision
9 Thaler, R., and Sunstein, C. (2008)
10 Duflo, E. et al. (2009) Nudging farmers to use fertilizer: theory and experimental evidence from Kenya, retrieved from this site
11 World Bank (2015)

BEHAVIOUR CHANGE WITHOUT BEHAVIOUR CHANGE COMMUNICATION

Nudging Handwashing among Students in Bangladesh

This study shows how a low-cost and replicable intervention introducing nudges that remind children to wash their hands, increased handwashing rates from 4% (photo on the left) to 74% (photo on the right).

Photos: see this link

In international development, the lessons learned about the 'automatic system' were used primarily in the public health sector. For example, research conducted in rural Bangladesh has shown that the consistent physical availability of soap at a designated place has been found to be critical to the formation of a new handwashing with soap practice.[12] A repeated message resulting from similar research has been that **the easier you make something** (such as washing hands with soap), **the more likely is it that people will do it**. This can work in a reverse way when you take the sensory cues away. For example, banning visual displays of cigarettes at point-of-purchase reduces impulse/habitual cigarette purchases.[13]

These principles can be extensively and creatively applied in the context of food security and nutrition interventions as well. What matters most is that in addition to the rational drivers of behaviour change our interventions also focus on the automatic, cue-based drivers of behaviour change – for example, by trying to make the desired behaviours more habitual, intuitive, easier to practice, and appealing.

MAKING A CHANGE IN FAMILIES' DIETS EASIER

Another useful insight is that instead of creating a new, desired behaviour "from nothing" it can be more effective to attach the behaviour to an existing behaviour that is already established in people's daily practice. For example, in Ethiopia, instead of proposing completely new recipes, GIZ suggested adding a healthy ingredient (e.g. an egg or green vegetables) to a traditional dish. This approach is likely to be much more acceptable than coming up with completely new recipes.

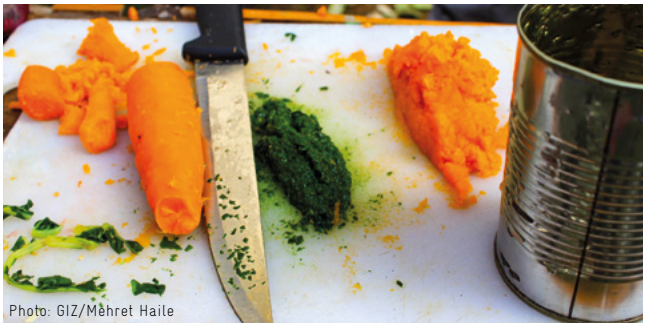


Photo: GIZ/Mehret Haile

12 Luby, S.P. et al. (2009) Household characteristics associated with handwashing with soap in rural Bangladesh, retrieved from this site
13 Wakefield, M. (2008) The effect of retail cigarette pack displays on impulse purchase, retrieved from this site, retrieved from this site

USE YOUR EVIDENCE, NOT ASSUMPTIONS

Development practitioners frequently ask: "What is the most effective way of changing people's behaviour?" The idea behind this question is that there is a certain 'magical' approach that will convince people that the desired behaviour is worth practicing. However, the true 'behaviour change magic' does not happen through glossy posters or clever messages. It happens when we thoroughly assess how people feel about their existing behaviours, how they perceive the behaviours we promote, and what exactly is preventing them from adopting these behaviours. The better the understanding of this we have (and use), the more likely it is that our intervention will succeed. Despite this fact, it is not uncommon that development practitioners design interventions based on their own assumptions instead of on evidence of why things are as they are.

When preparing and implementing behaviour change interventions, be humble and curious – try to research your topic well and only then come up with the solutions. As much as possible, pre-test your activities among smaller groups of target group members, adapt them based on the initial experience, and only then scale up (read related guidance at the end of chapter 3.4).

"The true behaviour change magic happens when we thoroughly understand **how people feel** about their existing behaviours, **how they perceive** the desired behaviours, **what exactly is preventing them** from adopting these behaviours and then **we use these insights** to tackle the identified barriers."

PEOPLE ARE NOT EMPTY VESSELS

The traditional approach to behaviour change has been that development practitioners 'educate' people about the benefits of certain behaviours and 'teach' them how to practice these behaviours. While it is true that people sometimes lack the required knowledge or abilities, they should never be treated as empty vessels into which development interventions pour their information and skills. In every community, there are people who have found ways to overcome the issues development interventions (and people in their everyday lives) tackle. As much as possible, **ensure that your strategy and activities take maximum advantage of people's current knowledge and skills** and focus primarily on helping them to address the gaps. Approaches such as the Positive Deviance or Trials of Improved Practices can give you the methodological support you might need.

PROMOTE THE BENEFITS BUT ALSO ADDRESS THE COSTS

Aid agencies are usually good at explaining the benefits of the desired behaviours. What they often forget to address are the financial as well as non-financial "costs": the things that people lose when they stop practicing the previous behaviour (such as pleasure gained from consuming tasty fast food; or its easy availability) and the negative consequence of adopting the new behaviour (e.g. difficulty eating with friends who prefer fast food, more time and money spent on accessing healthier foods). **It is important that your strategy focuses both on maximising the perceived benefits and reducing the perceived costs** – otherwise people might quite rightfully (often even unconsciously) decide that the change you propose is not worth it. If the costs cannot be reduced, then your behaviour change activity should increase the perception that the cost is worth the benefit gained.

FREQUENCY AND CONSISTENCY OF YOUR COMMUNICATION IS KEY

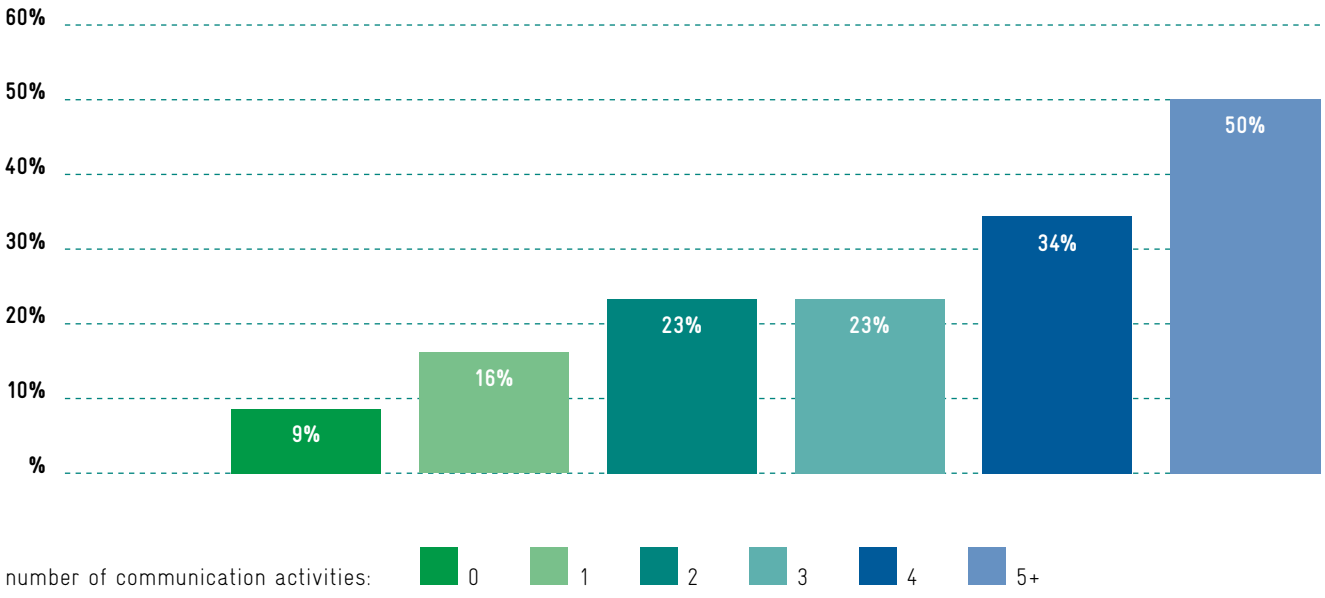
Repetition, consistent communication and nudging are essential in making behaviours that are not yet "habitualized" persist. Always think of how you can ensure that your messages reach people as frequently as possible and ideally even after your intervention is over. Using a mix of different communication channels (such as radio, community events, etc.) and especially engaging members of the target groups into being voluntary 'agents of change' (as does, for example, the Care Group approach) can increase the likelihood of your communication bringing the desired change.

INTENSITY MATTERS

The example below[14] is from Alive & Thrive's sentinel surveillance data in Ethiopia, where one of the key messages was to feed children (6 -23 months of age) an egg every day. This message was delivered through multiple activities: through face-to-face interactions with health extension workers, volunteers, religious leaders, and during community meetings; by media (radio, road shows at markets); and during cooking demonstrations with mothers and fathers. The numbers across the bottom of the chart represent the number of these different Alive & Thrive activities to which a mother was exposed (not the number of times they were exposed to a single activity).

As you can see, multiple contact points matter. Of women who were exposed to only 1 of these activities, 16% fed a child an egg. Compare that to the women who were exposed to 5 or more different activities, half of which then fed an egg to their child. The conclusion is clear: intensity matters. Alive & Thrive found similar outcomes in most of its evaluations, for different behaviours and in a variety of countries – **the greater the variety of ways in which a mother was reached, the more likely it was that she adopted the behaviour**.

% of 6 to 23-month-olds who consumed eggs, by number of behaviour change communication activities to which their mothers were exposed



14 Alive & Thrive (2016) Understanding factors driving nutrition behavior change: the experience of Alive & Thrive

Chapter 3
Social and Behaviour Change in GIZ's Programming

This chapter provides you with practical steps that you can take in order to increase the effectiveness of your behaviour change interventions. Each step is accompanied with examples and links to the most useful resources providing more detailed guidance.

THE KEY TERMS USED IN THIS CHAPTER

- **Motivators** are the factors that encourage a person to practice the desired behaviour.
- **Barriers** are the factors that prevent a person from practicing the desired behaviour.
- **Formative research** is a process using largely qualitative methods to help us understand what influences people's behaviour and how we can tackle the identified barriers.
- **Target group** consists of people targeted by an intervention (e.g. women of reproductive age).
- **Priority group** consists of people who are expected to practice a given behaviour (e.g. mothers of children aged 0 – 5 months who should breastfeed exclusively) as well as those who are supposed to ensure that someone else practices a behaviour (e.g. parents of children who should ensure that the children attend school). One target group usually includes different priority groups.

OVERVIEW OF THE KEY STEPS INVOLVED IN SBC PROGRAMMING

STEP 1:
SELECT THE DESIRED BEHAVIOURS

✓ define the problem and its causes
✓ select the behaviours that tackle the problem / its causes
Expected output: selection of a limited number of behaviours that 1) are most likely to be effective in addressing the given problem and 2) are most feasible to adopt, from the priority group's point of view.

STEP 2:
SPECIFY THE PRIORITY GROUPS

✓ select the priority group
✓ specify it and collect additional information
Expected output: clear profiles of the people who should practice the desired behaviours.

STEP 3:
UNDERSTAND THE BARRIERS AND MOTIVATORS

✓ define what information you need
✓ check which information is already available
✓ conduct formative research
Expected output: a solid understanding of why some people do not practice the desired behaviours and what could motivate them to do so.

STEP 4:
ADDRESS THE BARRIERS AND STRENGHTEN THE MOTIVATORS

✓ define what exactly needs to change
✓ design activities to address the barriers and motivators
✓ ensure adequate capacities of the implementing team
✓ find the right partners
✓ prepare SBC messages and materials
✓ pilot, adapt, scale-up
Expected output: SBC activities are implemented (and hopefully, the barriers are addressed).

STEP 5:
EVALUATE AND SHARE

✓ assess the quality and effectiveness of the SBC activities
✓ share your best (but also bad) practices with practitioners and key decision-makers
Expected output: knowledge of what was achieved and which approaches should (not) be replicated in the future.

In the previous two chapters, you could see that there are many factors that influence people's behaviour, and each of them can be tackled in many different ways (depending on the local context, available resources, etc.). Therefore, it is not possible to prescribe solutions that could be 'copy pasted' from one context to another. What can be recommended are practical tools, tips, and guidance that can help you design and implement a SBC strategy in a way that is more likely to achieve the desired change. And that is exactly what this chapter is about.

Before we start describing the various steps involved in designing, implementing and evaluating SBC strategies and activities, let us highlight several considerations that can make your job much easier.

TOOLS FOR DESIGNING SBC STRATEGIES

Behaviour change interventions are likely to be much more effective if they are based on a clear strategy. Online you can find various tools and guidance on how to design a SBC strategy. Although they differ in name, most of them cover more or less the same points: they describe who exactly is supposed to follow which behaviours, what is preventing them from doing so, what may motivate them to adopt the behaviours, what needs to be done to address the barriers, what environmental cues or supports can be put in place, and other essential information. Examples include:

- **The Designing for Behaviour Change (DBC)** framework is most likely the easiest tool used for developing behaviour change strategies. As the template below shows, it requires the user to:
  - state the desired behaviour
  - describe who should practice the behaviour and who influences them
  - identify the barriers and motivators
  - based on the findings define what needs to change (also called the 'bridges to activities')
  - design activities to achieving these changes

The Designing for Behaviour Change (DBC) Framework

Desired Behaviour	Priority and Influencing Groups	Barriers and Motivators	Bridges to Activities	Activities
Indicator:				Indicators:

Learn more about this tool in PIN's Behaviour Change Toolkit or DBC guides in various languages.
See also the database of DBC frameworks for various behaviours.

- **The Behaviour Centred Design framework** developed by the London School of Hygiene & Tropical Medicine (LSHTM) is a more sophisticated approach to behaviour change that is relevant primarily to larger interventions or interventions that focus on a very small number of behaviours (e.g. large-scale campaign promoting exclusive breastfeeding). See a brief example of a nutrition programme in Indonesia using this framework. For guidance visit LSHTM website.

- **The RANAS approach** is a method for designing and evaluating behaviour change strategies that target and change the determinants of a specific behaviour in a given population. Compared to the DBC framework, is it more comprehensive but also more demanding to use (see guidance).

THE CONTENT OF SBC STRATEGIES

The content of social and behaviour change strategies depends of course on the target behaviours, identified barriers, proposed behaviour change activities, etc. but it is also equally influenced by the tool that you use (see examples above). At the very minimum, **a SBC strategy should cover:**

- background information about the intervention, including the problems it aims to address
- exact definition of each behaviour (see chapter 3.1 below)
- description of the priority group members and the 'influencers' (see chapter 3.2)
- the barriers and motivators to practicing the desired behaviour (see chapter 3.3)
- the changes that need to happen for the barriers and motivators to be addressed (see chapter 3.4)
- the behaviour change activities that are expected to minimise the barriers and maximise the motivators – including the actions the 'influencers' can take to support the priority group to adopt the behaviour (see chapter 3.4)
- the key messages that should be promoted by some of the SBC activities (see chapter 3.4)
- the indicators for measuring the progress and effectiveness of the activities (see chapter 3.5)
- detailed implementation plan that specifies who will do what, and by when

See the following **examples of SBC strategies**: South Africa's national Hand Hygiene Behaviour Change Strategy and a shorter Nutrition SBC Strategy for Kyrgyzstan.

REALISTIC TIME FRAMES AND BUDGETS

When you design a new SBC intervention, be realistic about what can you achieve within the time frame, budget, and with the human resources you have. Ensure that you:

- focus on only a limited number of the most impactful and feasible behaviours (see chapter 3.2)
- allocate the resources required to conduct a baseline and formative research (see chapter 3.3)
- do not prepare your budget in too detailed a way so that you can accommodate any costs needed to address newly identified barriers

WORKING WITH WHAT IS ALREADY THERE

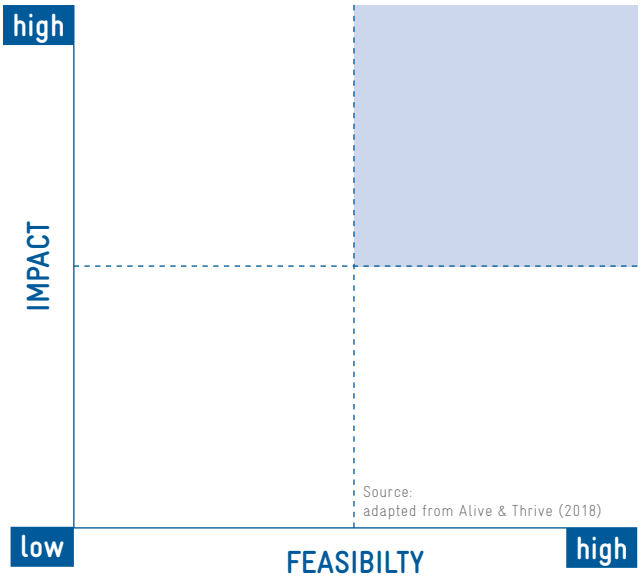
It is likely that in the country where you work there are at least several other NGOs, UN agencies and government institutions that have promoted the same behaviours that you intend to promote. This represents a great opportunity as it means that there are likely to be many SBC communication materials prepared, training curriculums developed, people trained, studies conducted, failures and best practices experienced (and hopefully also recorded). Finding them might require some effort to be spent on sending e-mails and having meetings. However, building on existing best practices and resources is certainly better than wasting your time and the taxpayers' money on reinventing the wheel.[15]

15 Schmied, P. (2014) Integrated Programming for Improved Nutrition, retrieved from this site

Chapter 3.1
Select the Desired Behaviours

The first step when designing a behaviour change strategy is to define the key problem the intervention aims to address, understand its main causes, and then **identify the behaviours that are likely to be the most effective in addressing these causes**. The question of course is: "How can I know which behaviours are likely to be effective?" When thinking about the potential effectiveness of a behaviour, we should **consider two main criteria**: the extent to which the behaviour can address the given problem (i.e. its potential **impact**) and how easy or difficult the behaviour is to practice from the priority group members' point of view (i.e. its **feasibility**). The aim is to **select behaviours with the greatest impact and feasibility** – those that are in the top right corner of the chart on the right.[16] Let's now have a look at how to do so.

Selecting the Desired Behaviours



SPECIFY THE BEHAVIOUR

When defining the desired behaviour, it is important that everyone understands it in the same way. For example, "mothers consume nutritious diet" can be understood in many different ways. Ensure that the definition of your behaviour always includes:

- who is supposed to practice the behaviour
- an active verb in the present tense saying what the priority group is supposed to do
- further details about the behaviour, such as frequency, time, duration or place

For example: "Mothers of children 0 - 23 months eat iron-rich foods at least three times a week." This way, it will be easier to ensure that your colleagues, partners, community workers and the priority group members have the same, correct understanding of the desired behaviour.

GO FOR SMALL DOABLE ACTIONS

A small doable action is something small that the priority group members feel they can do. For example, instead of asking people to "feed their children nutrient-rich meals", interventions should **promote a few smaller doable actions**, such as adding eggs to children's porridge or giving them a nutritious fruit as a snack. Whether a certain action is easily doable or not should always be decided based on the feedback from the priority group members (i.e. not on what we think). Approaches such as the Trials of Improved Practices or Positive Deviance can help you with identifying doable actions.

16 Adapted from Alive & Thrive (2018) Choosing the small doable action: data for high impact and feasibility, retrieved from this site

IDENTIFY THE POTENTIAL IMPACT

The potential impact of a behaviour should be considered in two ways:

1) Room for Improvement: What proportion of the priority group members already practice the behaviour? If a behaviour is already very common, promoting it will not make much difference.[17]

2) Impact on Addressing the Problem: To what extent is the behaviour effective in addressing the given problem (e.g. child undernutrition) / achieving the goals of your intervention?

ROOM FOR IMPROVEMENT

The extent to which the priority group members practice the given behaviour(s) can be identified from the data provided by your baseline survey. If this is not available, take advantage of the surveys conducted by the local health authorities and NGOs or disaggregated data from the latest Demographic Health Survey.

IMPACT ON ADDRESSING THE PROBLEM

The extent to which a behaviour is likely to address a given problem can be identified in two main ways:

- **Existing Scientific Evidence:** The results of many research initiatives showing the impact of various behaviours are freely available at different websites, such as the www.3ieimpact.org. Some results are also summarized under specific themes – for example, the Essential Nutrition Actions and the Essential WASH Actions (both are sets of practices that contribute to the reduction of child malnutrition).

Examples of Essential Nutrition Actions (ENA)	Examples of Essential WASH Actions (EWA)
• exclusive breastfeeding • nutritionally adequate complementary feeding • increased protein, calorie and micronutrient intake during pregnancy For a full list of ENA and associated behaviours, review Part I of WHO's overview.	• handwashing with soap and flowing water • use of improved latrines • hygienic handling & safe storage of food • separating children from animal faeces For a full list of EWA and associated behaviours, see page 14 of the EWA guide.

- **Implementers' Previous Experience:** After reading the previous paragraph, you might easily say: "OK, but what if I can't find any scientific evidence that is relevant to my context?" The fact is that in some sectors, such as health, there is much more evidence available than in others, such as agriculture. Alternatively, there might be a research study on what worked in one area but you are not sure whether it would also work in your context. In such instances, your best bet is to invest in reviewing the experience of actors who tried to promote the same behaviours in a similar context. These can be government institutions, extension workers, staff of NGOs and UN agencies, and the private sector actors (e.g. sellers of agricultural inputs). Ask them about what worked best (and why), what did not work well (and why) and what their recommendations would be. If you cannot do so when developing the proposal, integrate it in the time plan for the initial months of your intervention.

17 Alive & Thrive (2018)

ASSESS THE FEASIBILITY

There are many behaviours that can be highly effective in addressing a given problem, however, the priority group members find them difficult to practice. For example, certain types of animal products have a high nutrient content; however, if not many people can afford them, promoting their consumption is not likely to bring the desired change. Therefore, it is very important that through your formative research (see chapter 3.3) you **identify how feasible the considered behaviours are from the priority group's point of view**. Do they feel that they are doable? Remember that translating a more demanding aspiration (e.g. children consuming nutritious meals) into smaller doable actions can significantly increase the feasibility of what you are asking the priority groups members to do.

Behaviours that are more difficult to adopt / promote are those that:

- require complex skills
- do not deliver immediate benefits
- require more time, money or labour
- require resources that are not easily available
- go against the social norms
- are done frequently
- require many people
- involve multiple steps[18]

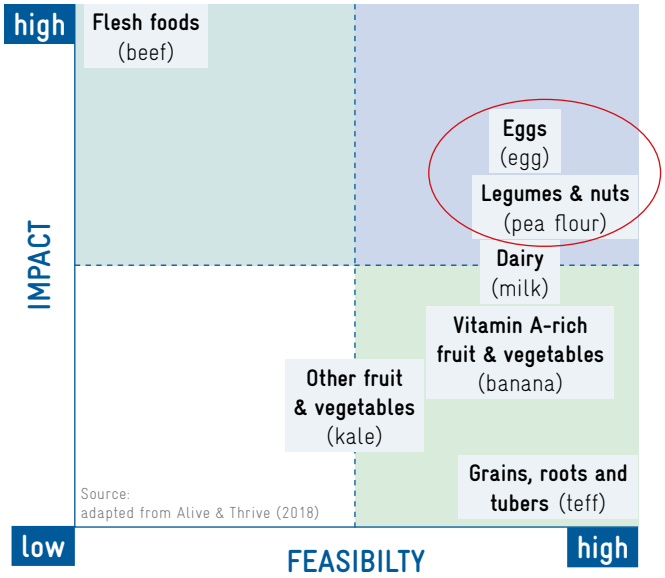
SELECT THE DESIRED BEHAVIOURS

At this point, you should be able to select behaviours that are likely to have the greatest impact and feasibility. Keep in mind that the most successful nutrition programmes are those that **focus on a few behaviours only** – it is not realistic to do everything at once. In the example below, the two promoted behaviours / small doable actions were adding eggs and pea flour to children's meals.[19] For a nice explanation of how these behaviours were selected, watch this useful video.

Additional criteria that you might want to consider include:

- the extent to which you can influence the behaviour within your intervention's budget, timeframe, mandate, and human resources
- the extent to which you have (or can acquire) the expertise required for enabling people to adopt the given behaviour
- the extent to which the behaviour is already addressed by other actors operating in the same area
- the extent to which the support to the behaviour is in line with the government's strategies

Selecting Small Doable Actions for Improved Child Nutrition



18 FSN Network (2013) Designing for behavior change: for agriculture, NRM, health and nutrition, retrieved from this site
19 Adapted from Alive & Thrive (2018)

Chapter 3.2
Specify the Priority Groups

The next step is to specify for each desired behaviour the **"priority group"** – these can be either:

- the people who are expected to practice a given behaviour (e.g. mothers of children aged 0 - 5 months who should breastfeed exclusively); or
- those who are supposed to ensure that someone else practices a behaviour (e.g. parents of children responsible to ensure that the children attend school)

It is important to understand the **difference between a "priority group" and a "target group"**. While target groups are all the people targeted by an intervention (e.g. women of reproductive age), "priority group" includes only those who are expected to practice a given behaviour (e.g. mothers of children aged 0 - 5 months). One target group can include many different priority groups.

The more specific definition of the priority group(s) you have, the more likely it is that your SBC activities will be effective. For example, a priority group "farmers" might include both wealthy farmers, focusing on cash crop production, as well as smallholder farmers, growing only enough to feed their families. Similarly, a priority group "women" might involve both teenage girls living in the rural areas as well as adult women living in towns. As you can imagine, these groups are likely to have quite different characteristics and needs. They are also likely to be differently affected by the problem your intervention tackles. In the world of SBC communication, the process of dividing a large population (e.g. farmers) into smaller groups is called "segmentation". For useful examples and guidance on **segmentation**, visit this website.

Designing your SBC activities will be much easier and effective if in addition to having a clear definition of the priority group members you also learn (and most importantly: use) about their age group, gender, literacy (very important for your communication activities), residence, ethnic group, religion, their attitudes towards the behaviour, what they care about, and any gender-related considerations that impact adoption of the behaviour.

If you have evidence of who significantly influences whether the target population practices the given behaviours (the "influencers", such as mothers-in-law), specify these; otherwise identify them in the next step.

"The more **specific definition of the priority group(s)** you have, the more likely it is that your SBC activities will be effective."

Chapter 3.3
Understand the Barriers and Motivators

Once you know what the priority groups are, the next step is to conduct a relatively simple study ("formative research") which will enable you to understand **what is preventing priority group** members from practicing the desired behaviours (the 'barriers') and **what could enable and motivate them** to adopt the behaviours (the 'motivators').
Examples of the most important information on each of the desired behaviours include:

- What is the proportion of priority group members who (do not) practice the desired behaviour?
- What do they perceive as the positive and negative consequences of practicing the desired behaviour?
- What makes it difficult for them to practice the behaviour?
- What could make it easier to practice the behaviour?
- How easy or difficult is it for them to access the resources required to practice the behaviour?
- Who approves and who disapproves of them doing the behaviour?
- To what extent do they think that they are affected by the problem the behaviour tries to address?
- What are their attitudes towards the desired behaviour? To what extent do they think that it is effective in addressing the given problem?
- Are there any cultural or government rules that make it difficult to practice the behaviour?
- Are there any specific gender-related norms that make it more difficult for women or men to practice the behaviour?
- In the opinion of the priority group members, what would need to be done to tackle the key barriers?
- What could best motivate the priority group members to adopt and keep practicing the behaviour?
- What positive emotional „hooks" may be meaningful? What do the priority group members care about?

Additional information might be required depending on:

1) **The SBC approach / tool you use:** At the beginning of chapter 3, you were introduced to several approaches and tools for designing SBC strategies, such as the DBC framework, Behaviour Centred Design framework, and the RANAS model. While the easiest of these tools requires only the most essential inputs (such as the desired behaviour, priority group, and the key barriers & motivators), the more sophisticated ones will require you to provide a range of additional information.

2) **The SBC theory you use:** The previous chapter has described behaviour change theories that can help you design more effective SBC interventions. If you decide to use a SBC theory, formative research and the project's baseline survey are the right moments to collect the information you need to be able to apply it in the context of your intervention. For example, in the case of the Stage of Change model, you should be interested in the proportion of priority group members that are in the respective stages of change. In the case of the Socio-Ecological model, you should be interested in which factors at the four key levels influence the priority group members' ability and willingness to adopt and practice the desired behaviours.

If you are interested in more guidance on **what topics should be covered by formative research focusing on maternal and child nutrition**, take advantage of CARE, USAID or WHO/UNICEF's guidance materials.

IDENTIFYING THE 'INFLUENCERS'

During the formative research, identify those people who either encourage or discourage the priority group members from practicing the desired behaviours. For example, a mother may be responsible for exclusively breastfeeding her baby, but if the father and other family members are not helping her with the household workload, and feed the baby other foods despite the mother's protestations, your SBC activities must also focus on these 'influencers' and offer them ideas of specific actions they may take in support of the mothers' behaviour. The "influencers" may be identified by asking the priority group members about who approves and who disapproves of them doing the behaviour.

FORMATIVE RESEARCH METHODS

At this point, you know what type of information you need and the obvious question is: "How do I get this information?" Formative research usually takes between 3 to 6 weeks and is best conducted in the initial stage of a programme, after you have collected the baseline data. Baseline data is often collected using the knowledge, attitudes and practices (KAP) survey that provides **quantitative** insights into the proportion of priority group members that (do not) practice the desired behaviours, their awareness of the problem, attitudes towards the behaviours and other data that can be collected using quantitative surveys (i.e. it provides answers to the question "How many?", "How often?", etc.).[20] In order to gain more **qualitative** insights (providing answers to the questions "Why?", "How?", "In what way?" etc.), **you can take advantage of the methods listed below**. Remember that no matter what methods you use, it is critical that you 1) provide an opportunity for the priority group members to share their opinions about the desired behaviours and 2) actively use their opinions in the design of your SBC activities.

- **Review of Secondary Resources:** Before you start conducting your own research among the priority group members, ask the NGOs, UN agencies, and government stakeholders operating in the same area whether they already have some of the information you are interested in. It can save you time and enable you to explore the main topics in more depth.

- **The Barrier Analysis** is a quantitative/qualitative survey that asks people a series of questions aimed at identifying which of the 11 behavioural determinants (see chapter 2) have the biggest influence on whether people (do not) practice the given behaviour. The Barrier Analysis study uses the Doer/Non-Doer methodology that consists of interviewing 45 people who already do the behaviour (Doers) and 45 people who have not yet adopted the behaviour (Non-Doers). The points where the Doers and Non-Doers' responses differ significantly reveal which barriers/motivators are the most important. For example, if a large proportion of Doers believe that drinking filtered water protects their children from diarrhoea but only a few Non-Doers think so, we know that belief in the effectiveness of filtering drinking water is a factor we need to focus on. The focus of the Barrier Analysis is always on the way the priority group members perceive things, irrespective of whether we think that it is right or wrong.[21]
  See available guidance.

- **Key Informant Interviews** are semi-structured interviews with people who are likely to provide useful insights into the topics you want a good understanding of. These can be, for example, people who already practice the behaviours, those who do not, extension workers, staff or NGOs and institutions working on the given topics (e.g. Department of Health), local authorities, etc. Remember that the opinion that counts the most is that of the priority group members, as they are the ones who are expected to practice the desired behaviour(s). Key informant interviews are suitable when you need to research sensitive issues that people may not want to discuss in a group; when you do not want the responses to be influenced by what others say; when you need to clarify the results of your quantitative survey; when you want to generate ideas for your intervention; or pre-test communication messages and materials.[22]
  See available guidance.

20 The Demographic and Health Survey is also a very useful source of quantitative information on nutrition and health topics.
21 FAQs on Barrier Analysis, retrieved from this site
22 CARE (2014) Formative Research Guide, retrieved from this site

- **Trials of Improved Practices** (TIPs) is a formative research method that is used for assessing the acceptability and feasibility of a newly introduced behaviour through asking some of the priority group members to practice it and then using their experience. The procedure consists of a series of visits in which a field worker and the priority group member analyse the current practices, discuss what could be improved, and together reach an agreement on which of the specific practices (that the implementing organisation plans to promote) the person would like to try over a trial period. At the end of the trial period, the field worker together with the person assesses her/his experience together, including: what the person did, how and why, how s/he felt about it, what was easy, what was difficult, what the response of other people (family members, friends) was, whether she would recommend the same practice to a friend, etc. The results are used for refining the design of the SBC strategy and activities. TIPs is especially useful for testing behaviours that are used by very few (if any) people.[23] See available guidance.


Photo: People in Need

- **Customer Journey Mapping** is a formative research technique helping us understand people's experience in using (or trying to use) certain services, such as those provided by local health facilities, agriculture extension workers, government institutions or commercial service providers (e.g. vets, microfinance institutions). Primarily through interviews and observations, it analyses both the physical and emotional "journey" a person goes through when accessing / using a service (sometimes also a product). It aims to understand the main barriers to accessing and using a given service, its weaknesses (but also strengths), opportunities for improvement, and other factors that might influence people's use of the service.
  For example, if the behaviour you promote is "pregnant women go for antenatal health check to a health facility", you would be interested in how easy it is to get to the facility; whether the opening hours suit the women's schedules; how long they have to wait there; what is required to be examined (the individual steps/the process – e.g. get an appointment? pay a fee?); how they feel about going to the facility / waiting there / receiving the health check; what they think about the health staff's behaviour; how useful they think the service is; etc. There is no fixed methodology – the key is to understand the entire "journey" through the person's experience.[24] For more guidance and examples (from a high-income country; however, also highly relevant to low-income contexts), read this guide for practitioners.

- **Focus Group Discussion** (FGD) is a discussion among 6 to 8 people around a specific topic that is facilitated by a moderator (another person takes notes). It is useful for exploring people's opinions, perceptions and feelings about topics that are not too sensitive and people do not mind discussing openly. FGDs are commonly used to clarify the results of quantitative surveys, gain people's feedback on various programming ideas, and to pre-test SBC messages and materials. The questions should be open ended (e.g. starting with "Why …" or "How …"), worded in a way that cannot be answered with a simple "yes" or "no" answer. Be aware that using FGDs is not as easy as it might seem. They require a very skilled moderator who is able to stimulate the discussion and elicit responses that truly represent people's feelings and thoughts. Coding and analysing the collected information can be a time-consuming task that requires a special skill set. See available guidance.


Photo: Petr Schmied

23 Manoff Group (2005) Trials of Improved Practices (TIPs): Giving participants a voice in program design, retrieved from this site
24 Schmied, P. (2018) Behaviour change know-how for your everyday work

- **Observations** is a research method involving observing what people do and how, in their natural environment. The researcher records what s/he sees (this can also be done using a checklist that focuses on specific topics / practices). They can be used, for example, to explore people's food hygiene behaviours, agricultural practices, childcare practices, the cleanliness of the places where young children spend their time, etc. Observations can provide information that the implementing organisations did not think of earlier and can help with increasing the relevance of the behaviour change activities. See available guidance.

- **Seasonal Calendars** are used to understand seasonal patterns of change, such as the changing availability of resources (e.g. certain types of food, income, water), accessibility of various services (e.g. due to road conditions, market supply, etc.) or the prevalence of certain diseases (such as diarrhoea). They are also useful for identifying the best timing of SBC activities (for example, promoting certain behaviours only when people are most likely to have the resources required to practice them, or avoiding having overly time-consuming activities when people are busy). The calendars are usually prepared by the priority group members (e.g. smallholder farmers, mothers of young children) or other community members who are likely to be able to provide the required information (e.g. extension workers, sellers). See guidance on page 60 of CARE's Formative Research Guide.

- **Other Participatory Methods:** There are dozens of other participatory methods that can provide you with useful insights into the determinants of people's behaviour, such as daily activity charts, division of labour charts and various ranking techniques. For more information and detailed guidance, explore CARE and IHAA's guides.

Chapter 3.4
Address the Barriers and Strengthen the Motivators

At this point, you know which behaviours you should promote (and why), who is expected to practice them and what barriers prevent people from doing so. This chapter will show you the next steps you should focus on.

DEFINE WHAT EXACTLY NEEDS TO CHANGE

Before you start thinking about (re)designing the SBC activities based on the results of your formative research, define first what exactly needs to change in order for the barriers and motivators to be addressed. For example, if one of the findings is that first-time mothers are not sure how to deal with engorged breasts, the desired change is to "improve mothers' abilities to prevent their breasts from becoming engorged." All your SBC activities that tackle this barrier should then be designed in a way that directly contributes to achieving this desired change. This approach helps you ensure that each of your SBC activities directly tackles one or more of the identified barriers (i.e. avoiding a situation where you have activities that might sound nice but do not respond to the findings of your formative research). According to the methodology used by the DBC framework (see beginning of chapter 3), these changes should always be defined in one of the following ways:

increase / decrease / improve / reduce / reinforce … +	**the perception that …** (or) **the availability of / access to…** (or) **the ability to…**

For example:
- Increase the availability of the desired vegetable seeds.
- Improve the ability of caregivers to correctly prepare oral rehydration solutions.
- Increase the perception that husbands approve of feeding children protein-rich food 3 times a week.

The required changes are defined this way because changing people's perceptions, abilities, and the availability of / access to certain resources and services are the three main ways to address the barriers. **Define them without having specific activities in mind**, so that you are able to consider different pathways to achieving the required changes.[25]

DESIGN ACTIVITIES TO ADDRESS THE BARRIERS AND MOTIVATORS

At this point, you should have all the information you need to design the SBC activities. As was explained at the beginning of chapter 3.4, it is important that you **ensure that each activity directly addresses a specific barrier / motivator** (try to select a behaviour change activity that can address several different barriers/motivators). Avoid selecting a certain activity / approach just because it 'looks nice', such as mobile phone messaging or cooking demonstrations.

SBC activities aim to enable people to adopt the desired behaviours by lowering the barriers and maximizing the motivators (that were identified through formative research). Barriers can be about people's **perceptions** (e.g. "it is too expensive, it takes too much time, it would not work, my husband does not approve, I am not at risk"); lack of the required **abilities** (e.g. an ability to prevent or overcome common breastfeeding difficulties); and poor **availability** of / **access** to the required services, products and resources (e.g. money, time, water, food).
Barriers and motivators are most commonly addressed by a combination of some of the following approaches and activities:

- **Peer Education** is a process where people that have something in common, such as age (e.g. youth) or interest (e.g. mothers of young children) share information, experience and skills. The thinking behind peer education is that people are more likely to trust and follow people they see as being like them. They are also more comfortable discussing more sensitive issues, such as sexual health, with them. The Care Groups approach (see text box) uses peer education in the nutrition, maternal and child health, agriculture and other sectors. Click here to access useful guidance.

THE CARE GROUPS APPROACH

A Care Group is a group of voluntary, community-based educators who are supported to regularly visit 10 - 15 of their peers, sharing with them what they know on the given topic while supporting their peers to make changes to their behaviours. Detailed guidance and examples are available at this website.

- **Counselling** can be a highly effective (though time-consuming) technique that enables people to receive individual advice that is tailored to their situation and needs. It can be provided as part of a government extension system (e.g. breastfeeding counselling provided by community health workers), by trained peers (e.g. as a part of home visits) or market actors (e.g. sellers of agricultural inputs providing advice to their clients). The people providing counselling need to have very good counselling skills and understanding of the given topic. For guidance, explore the counselling resources at this website.

25 FSN Network (2013); Schmied, P. (2017)

- **Trainings** (as well as **awareness-raising / education sessions**) are one of the most popular activities of development interventions. This might be because it is expected that if people attend a training, they acquire useful knowledge and skills and start practicing the desired behaviour. However, this is often not realistic as lacking knowledge and skills usually are not the only (or even the main) barrier people face. Trainings are most likely to be effective if:
- one of the main barriers people face is a lack of skills / knowledge;
- the trainings follow the principles of adult learning (i.e. are participatory, take advantage of what people already know, use real-life situations, involve lots of practice); and
- have follow-up support (e.g. refresher training, personal visits) that helps people use what they learned.

Therefore, if you organise a training, pay maximum attention to the methodology and the trainers' skills. For practical guidance, read PIN's guide How to Deliver a Workshop or Training.

- **Positive Deviance** is an approach based on the observation that in any community there are people who manage to find better solutions to certain problems (e.g. undernutrition) than their peers, despite facing similar challenges and having the same resources. The practices that these 'positive deviants' adopt are very likely to be replicable and are therefore worth identifying and promoting as a part of the SBC strategy (ideally with the active participation of the 'positive deviants'). Learn more about the approach by watching this video or exploring guidance materials.

- **Entertainment education** events, such as theatre, folklore music or games, are another way of communicating your messages in an enjoyable and culturally sensitive manner. Their disadvantage can be relatively high costs (unless they are disseminated by mass media and reach many people).


Photo: GIZ/Michael Jooss

- **Participatory Demonstrations:** Most people learn best when they can observe how things are done and especially when they can practice them themselves. That is why participatory demonstrations that actively engage people in practicing what they heard / saw can be a very effective strategy for increasing people's skills and confidence as they can actually practice the promoted behaviours (e.g. cook more nutritious meals, build a low-cost handwashing station or apply organic pest control measures).


Photo: GIZ/Jorg Boethling

THEATER PLAYS FOR BETTER NUTRITION

In rural parts of Myanmar, traditional beliefs on dietary practices during and after pregnancy continue to prevail. These beliefs about mothers' and children's diets are mostly propounded by influencers in the women's direct environment, such as grandmothers and mothers-in-law. The infotainment play, developed jointly by GIZ's FNS project and a professional theatre group, aimed to tackle some of the most harmful practices. The play, performed by local actors, centred around a local family struggling with nutrition and hygiene challenges. Through performances on modest stages from village to village, the actors spoke of the healthy diets required during pregnancy and in the first years of a child's life, and at the same time engaged their audience through mutual conversations. A recording of the play is available at this link.

Approaches to Influencing the Influencers

This guide has highlighted the impact various 'influencers', such as fathers, grandmothers, peers, authorities, and others can have on people's ability and willingness to adopt a new behaviour. They can influence a person's decision-making power, availability of time required to practice a behaviour, and access to and control over the required resources. While some can be great 'agents of change', others can make it very difficult for the priority group members to adopt the desired behaviours. Formative research can help you identify who the influencers are and what change needs to happen to ensure that they are not the 'barriers' to the desired change (see chapters 3.3 and 3.4). The following resources can help you design **effective strategies for engaging the influencers in achieving the desired change**:

- Men Care's great guidance on **engaging men** in improving child health (access here)
- Alive & Thrive's strategies to **involve fathers in child feeding** (access here)
- the Nurturing Connections guidance on engaging the community members in **challenging harmful gender norms** and improving communication between spouses (video, guidance)
- GENNOVATE's tips for exploring **gender dimensions of household nutrition** (access here)
- Engaging Grandmothers to Improve Nutrition training module on increasing the positive impact grandmothers have on maternal and child nutrition (access here)
- PATH's training on **mobilizing community leaders** for improved nutrition (access here)
- see **examples** of interventions and research from Mozambique, Senegal, and Rwanda

Photo: GIZ/Michael Jooss

- **Community Engagement:** There are dozens of approaches that engage people in addressing a challenge faced by a community as a whole, such as Community Led Total Sanitation or Community Management of Natural Resources. They usually involve a range of participatory processes, such as community dialogue and planning, which are expected to result in the community members taking the lead in addressing the given challenge.

- **Social Networks** can be both formal and informal groups of people who share a similar interest, such as to save money (and/or take loans), access agricultural inputs and services, sell produce, or receive advice from their peers. As much as possible, work with already existing (even very informal) groups. If you need to establish a new group, ensure that: 1) the members see a clear incentive and benefits; 2) the group's rules, activities and plans are driven as much as possible by its members; 3) people voluntarily decide whether they want to join or not (i.e. the membership is not decided by the project); and 4) each group starts with smaller, easier activities that provide tangible benefits and only scales them up when its members are ready.

- **Strengthening of Extension Services:** Government extension services have multiple advantages: potential to reach a large number of people, ability to address a wide range of barriers (related to self-efficacy, negative consequences, access, etc.), and long-term presence in the communities. Among the most common weaknesses that a SBC intervention might want to address are their effectiveness and coverage: 1) extension workers having a good understanding of things but not being able to share it effectively with others (due to poor training and facilitation skills, lack of training materials, etc.); and 2) extension services reaching only a fraction of people who need them (due to a lack of resources, poor management but also gender inequality and other factors).


Photo: People in Need

- **Mass Media Communication:** Radio, television, newspapers, billboards, Internet and other forms of mass media are able to reach very large populations. Another advantage is that they can transfer not only facts but also emotions – a powerful motivator.[26] They require having a partner with a solid technical background, such as an experienced radio station or a social marketing agency. Opinions vary regarding the extent to which billboards, radio shows and other mass media can influence people's practices; however, there are some positive examples (explore this website, watch a brief TV spot, and learn from Alive & Thrive's experience with using radio drama). **Mass media is likely to be most effective when they encourage people to take a very specific, not overly complicated action**, such as taking a child to a health facility when s/he experiences the symptoms of an illness. If you decide to use mass media, **ensure that you first have the following information**:
- who exactly are the priority group members (the better you define them, the more relevant and effective your communication can be)
- the type of mass media they follow
- when they follow the media (time of a day, occasions, etc.)
- what type of information would they find most useful (considering their needs and desires)
- what types of messages are likely to be most easy-to-remember and actionable (remember that it is likely that the priority group members might only have limited time or attention when seeing / hearing your message)
- how can you make the priority group members feel that the messages are relevant for people like them and that they can be applied to their lives

26 Schmied, P. (2017)

MEDIA CAMPAIGN FOR OPTIMAL NUTRITION

GIZ's Nutrition Sensitive Agriculture Project in Ethiopia has designed a large-scale media campaign aiming to support and encourage women and men in adopting a range of optimal nutritional practices (such as production and safe consumption of nutrient-rich foods). To ensure that the campaign is well-adapted to the local context, GIZ collaborated closely with the Tigray Bureau of Agriculture. Among the main communication channels were billboards, TV and radio spots for reaching large numbers of the priority group members. The campaign also developed learning videos on improved nutrition to be used as training tools by the government's agricultural Development Agents, nutrition-related games for children as school teaching materials, and printed materials for interpersonal communication during the training of parents. The campaign was also supported by influential people from Ethiopian society – see the example of the Nutrition Song with Nutrition Ambassador and singer Mahlet.

- **Social Media,** such as Facebook, Snapchat or YouTube, offer not only very well-targeted communication (e.g. based on age, gender, location, etc.) but also the opportunity to engage their users in more interactive communication 1) with each other and 2) with professionals capable of providing relevant advice (e.g. on how to deal with certain pests affecting crops). Social media is also a good way to create an "enabling environment" by creating the impression that "everyone" thinks a certain way or does a certain thing. When considering which social media channel to use, first get reliable data on the proportion of the priority group members who use what most regularly.
- **Mobile Phone-Based Communication:** SMS, voice messages, and various applications are increasingly used to enable people to (remember to) practice the desired behaviours. With more than two thirds of the world's population owning a mobile phone[27] (and over half using smartphones), this type of communication presents many opportunities. The two main considerations that should be taken into account for this option are 1) the extent to which receiving a message or information in an app is likely to contribute to the desired change in people's behaviours; and 2) the technological (and financial) requirements of setting up such a system (often they are quite high).

Illustration: People in Need

27 GSMA, Unique mobile subscribers, retrieved from this site

- **Market-Based Approaches:** Poor people are not always able to adopt (or continue practicing) certain behaviours simply because they lack access to the products and services they require to do so, such as seeds to grow vegetables, construction materials to build latrines, or veterinary services to vaccinate animals. Alternatively, sometimes these products and services are available but people are not able to afford them.[28] Market-based behaviour change approaches engage and support the market players (such as service providers, suppliers, sellers and policy-makers) to increase the demand for and/or supply of affordable products and services that people need to adopt various behaviours. You can gain understanding of this approach through a brief video and explore it further by reading two brand new guides on increasing poor people's access to and demand for essential products and services.

- **Nudging** techniques aim to alter a person's environment so that s/he is more likely to choose an option that brings positive social or environmental benefits (for example, to follow pictures of footprints leading from a toilet to the handwashing station). For more information, watch this brief video.

- **Advocacy** is an approach that focuses on influencing the practices and decisions of policy makers, service providers, and other stakeholders that have a major influence on people's abilities and willingness to adopt various behaviours. Examples of advocacy-related changes include: advocating the producers of vegetable seeds to supply them in smaller quantities and more affordably; advocating the government to enforce a ban on the advertising of cigarettes; or advocating relevant ministries to increase the budget for the provision of certain services. Guidance on preparing and implementing advocacy campaigns is provided at this website. For an example of an advocacy campaign, read about GIZ's collaboration with the Ethiopian church at the end of the first chapter.

Photo: Petr Schmied

- **Direct Provision of Inputs and Services:** For decades, one of the most common approaches to addressing barriers, especially related to access, was aid agencies and governments donating the goods and services needed by beneficiaries in order for them to practice the desired behaviours. Common examples are soap, seeds, agricultural equipment, solar panels, trainings, etc. While this approach can deliver (usually short-term) positive results, it often does not address the underlying reasons for why poor people cannot access these goods and services. It is also characterised by limited sustainability, inability to reach significant scale and the (very real) risks of contributing to dependency and distorting the markets.[29] This approach should therefore be only used in the contexts where alternatives are not possible or very difficult (e.g. in areas with extremely weak market supply, in emergencies, etc.).

28 PIN (2018) Market-Based Approaches, retrieved from this site
29 PIN (2018) Good Practice Guide: Enabling poor people's access to essential products and services, retrieved from this site

ENSURE ADEQUATE CAPACITIES OF THE IMPLEMENTING TEAM

The process of designing the SBC strategy and activities is likely to be much easier and more effective if the **members of the implementing team have at least a basic understanding of social and behaviour change**, including the main misconceptions that surround this topic. Therefore, consider asking the programme staff (including those from the partner organisations) to:

- read this guide and discuss together the points they found most interesting and relevant to their work
- take one of the on-line SBC courses recommended at the end of this publication
- actively participate in collecting and analysing the formative research data to have first-hand experience with how the priority group members perceive the main barriers

If your programme has a strong behaviour change focus, **consider having (at least a part-time) SBC expert on board** – for example, for consultations, methodological support, access to useful resources, etc.

FIND THE RIGHT PARTNERS

Implementing social and behaviour change interventions often requires a wide range of expertise, including a very good technical understanding of the given topic (e.g. child nutrition), ability to conduct formative research, the know-how required for developing effective communication messages and materials, capacities to implement more demanding communication activities (e.g. radio shows) and activities that are not based primarily on communication (such as working with the local private sector on improving the target population's access to certain products or services). As you can imagine, it might not be realistic for the implementing team members to have all this expertise.

Therefore, your aim should be to **identify partners and allies that can complement the competencies that the implementing team offers**. These can be, for example, government institutions (e.g. Department of Agriculture), commercial service providers (e.g. consultants, social marketing agencies), mass media (e.g. radio stations that your target group members listen to most), private sector actors capable of addressing some of the identified barriers (e.g. national suppliers and local sellers of agricultural inputs), NGOs offering certain expertise or operating in your target areas, and other stakeholders. While the collaboration with some stakeholders might already be agreed when developing the programme proposal, others might be contracted / partnered in the course of the programme implementation.

When selecting your contractors, partners and allies, **consider the following criteria**:

- How well do they understand the topic they are supposed to be working on?
- How convincing are the samples of their previous work?
- What do the referees say?
- To what extent do you sense that they care about doing their work well?
- Do they have sufficient personnel to implement their responsibilities within the given period? (keep in mind that successful stakeholders might have many other commitments)
- When discussing their roles, are they unnecessarily stuck on some ideas (e.g. certain solutions) or are they quite flexible and open-minded?
- What is the technical / methodological quality of the solution they propose?
- To what extent and why are they interested in working with you?

PREPARE SBC MESSAGES AND MATERIALS

SBC messages are the main information you communicate to the priority groups using various means, including printed, audio and video materials. They should be simple, easy to understand and remember, and address the barriers/motivators revealed by the formative research. When developing the messages and materials, **keep the following good practices in mind**:

- **Engage Experienced People:** Designing communication messages and materials can be a very time-consuming task. Engaging people who specialise in design, (social) marketing, radio programmes, photography, etc. can make your work considerably easier.

- **Avoid Reinventing the Wheel:** SBC messages should always be based on what was revealed by the formative research conducted among the priority group members targeted by your intervention (i.e. you should avoid using general messages). However, when it comes to designing SBC communication materials, you can often adapt already existing ones, saving time and money. It is very important that any adaptations you make are based on the findings of your formative research – do not assume that because some materials (and messages) worked in one context they will also work in your context. Take advantage of this guidance on adapting SBC communication materials.

- **Collaborate with Relevant Government Stakeholders:** SBC messages and materials often need to be approved by various government stakeholders. Engaging them in the development of new materials can make the required approval easier.

- **Use Creative Briefs** – short documents that guide the implementing staff and especially the creative professionals in the development of the desired materials (e.g. radio show, slogans, posters). This helps with ensuring that everyone understands the tasks in the same way and reduces the risk of potentially costly misunderstandings. It clarifies the objectives, the priority group(s), focus of the key messages and the intended effects the materials should have. The process of developing the brief should be very participatory, engaging the programme staff, creative professionals, and the staff of key partner organisations. Read more in How to Write a Creative Brief.

- **Pre-Test** any drafts of the communication messages and materials among the priority groups, so that you understand their points of view. Resist the temptation to rely primarily on the opinions of experts or of your colleagues – the messages and materials were designed for the priority group members and they are the best 'judges' of how good they are. Learn more in this guidance.

- **Keep Literacy in Mind:** If you work in a context where many people are illiterate, ensure that the messages in your communication materials can be understood even without reading the text. You can also prefer the use of verbal communication (through face-to-face communication, radio shows).

- **Do Not Overestimate the Power of SBC Communication Materials:** Posters, leaflets, billboards, SMS or voice messages, various handouts and other communication materials can be quite fun to design, be attractive, and involve lots of creative thinking. This sometimes results in development practitioners investing a disproportionate amount of time and money in their preparation, even though they might be less effective in changing people's behaviours than more personal communication approaches, such as counselling, participatory demonstrations, etc. Therefore, do your best to design effective materials but ensure that this is not at the expense of more important activities.

For more guidance, explore:

- Introduction to SBC Messages and Materials
- How to Design SBC Communication Messages
- Simply Put: A Guide for Creating Easy-To-Understand Materials
- Guidance on How to Integrate Gender Into SBC Communication
- Evaluation of IEC Materials

Example of GIZ/HKI poster promoting the purchase of nutritious foods:

The ANF4W food poster below used by GIZ and Helen Keller International (HKI) in Bangladesh was a great tool to give away to families as take-home reminder material after sessions. It tells people that nutritious foods can be found locally, and that it is easy to make a well-balanced plate of food by just picking an item from each coloured box. HKI's research has repeatedly found that although nutritious food may be available and accessible, **the perception of nutritious food as expensive and unattainable for the poor**, as well as culturally-embedded food preferences, influence households in having less diverse diets. Locally available fruits and vegetables are often seen as less nutritious and are associated with lower social/economic status, as they are cheap and not imported. The same design principle was also used for GIZ's Nutrition Sensitive Agriculture Project (NSAP) in Ethiopia.

PILOT, ADAPT, SCALE-UP

Having a well-researched and thought-out SBC strategy is essential; however, this strategy should not be taken as a rigid plan that must be made and then blindly executed. Instead, it should be understood as the direction that the implementers (to the best of their knowledge and thinking at the time) believe is the best but that should be revised in the light of new findings and lessons learned. Therefore, one of the key recommendations is that instead of immediately launching full-scale implementation, you **first pilot your approach** (or selected activities) in a small part of the target areas, rapidly **review** its strengths and weaknesses, **adapt** it using these lessons learned, and only then **scale it up** to the remaining areas. This way, instead of learning about the weakness when it is too late (e.g. the activities are largely implemented or you do not have the resources to make a change), you will identify them at a time when you can still set it right.

Practically speaking, such piloting does not have to 'delay' the implementation by more than a few months and therefore can be easily **integrated in the timeframe of your intervention**. Of course, not all activities / approaches can be piloted within such a period but it is still better to pilot some than none. When reviewing the feasibility and expected effectiveness of your approach / activities, it is recommended that you:

- prepare simple checklists (see examples) monitoring whether an activity (e.g. cooking demonstrations) is implemented as it was intended; consider using tablet / mobile phone-based checklists that allow you to access real time data
- organise group interviews with the target group members, assessing their perceptions about the extent to which the activities were useful in addressing the identified barriers and motivators
- consult the frontline workers (e.g. extension workers, field officers, community volunteers) on what they see as the main strengths and weaknesses, what could be done better and how, etc.
- if resources allow, conduct a quantitative survey focusing on the key SBC communication indicators, perceived usefulness of the activities and any changes in people's knowledge, beliefs, attitudes toward the behaviour, self-efficacy, and perception of social norms

Throughout the entire implementation process, **ensure that all stakeholders are aware that you are actively seeking new ideas on how the programme can be made more effective**, even if it involves the need to point out various weaknesses and suboptimal decisions made in the past (not everyone is comfortable doing so as it can be perceived as criticising the work of others). Having such a 'learning culture' embedded in your team can make a big difference in the effectiveness of its work.

Chapter 3.5
Evaluate and Share

The implementers of SBC interventions often spend a lot of time, energy, money and other resources on trying to enable the priority group members to adopt the desired behaviours. Naturally, among the main questions they have in mind are "To what extent have we managed to address the main barriers?", "Did we already achieve any change in people's behaviour?" and "To what extent are such changes likely to last?" All these questions should be answered by your programme's M&E system – there is no need to have any special M&E plan to measure behaviour change. This chapter provides you with essential tips on what such a system should cover.

WHAT AND WHEN SHOULD WE MEASURE

The tips on what should be measured are divided according to the four main stages of the intervention:

Baseline Survey should focus on collecting the following data:

- data required by the programme indicators
- data on the proportion of the priority group members who (do not) practice the desired behaviours (disaggregated by gender and other relevant criteria)
- other data required for understanding the stage of change most people are in (see chapter 2.1), such as their awareness of the problems, knowledge about desired behaviours, attitudes towards the behaviours – e.g. perceived effectiveness and perceived difficulty in practicing the behaviours
- data regarding the priority groups' access to the inputs required to do the behaviour

Ongoing Monitoring should assess:

- the quality of the SBC activities (primarily by using checklists (see examples), collecting feedback from the participants, and observations)
- the effectiveness of SBC communication activities against the most common SBCC indicators
- the extent to which the programme is on track to meet its output-level milestones
- the reasons why some people do not participate in the behaviour change activities
- the reasons why some people do not adopt the promoted behaviours
- the suggestions of the frontline workers, target group members and other 'grassroots-level' stakeholders on what could be improved and how to make the programme more effective

Mid-Term Review should cover:

- the extent to which the programme is on track to meet its indicators (in the case of longer-term interventions, invest in a representative survey measuring the extent to which people started adopting the promoted behaviours)
- the extent to which the key barriers identified during the initial formative research were addressed
- the priority group members' perceptions of which factors still make it 1) difficult and 2) easier to adopt the promoted behaviours
- the strengths and weaknesses of the behaviour change strategy
- the extent to which the programme uses the data from ongoing monitoring to improve the quality and effectiveness of the monitored SBC activities
- the extent to which the programme addresses the main pre-conditions for the sustainability of the promoted behaviours (see examples in Annex 12 of the Behaviour Change Toolkit)
- recommendations of the key stakeholders on how the intervention could become more effective

Endline Survey should focus on:

- the extent to which the programme indicators and objectives were met and the reasons for (not) achieving them
- any other changes in people's behaviours that were not captured by the official indicators
- the extent to which the key barriers identified during the initial formative research were addressed
- the extent to which the main pre-conditions for sustainability were met
- intended as well as unintended impacts of the intervention (both positive and negative)
- the extent to which the recommendations from the mid-term review were used

The following overview provides examples of indicators that are commonly used to measure the results of nutrition-related interventions. For more indicators, including those for agriculture, WASH, health, education, gender and other topics, visit www.indikit.net.

Examples of Child Nutrition Indicators	
Prevalence of Acute Undernutrition	% of children aged 6 - 59 months with a weight for height ‹ –2 Z scores (and/or bilateral oedema)
Prevalence of Stunted Children	% of children aged 6 - 59 months with a height for age ‹ -2 Z scores
Exclusive Breastfeeding	% of infants of less than 6 months of age who received only breast milk during the previous day and night
Breastfeeding Difficulties	% of women of reproductive age who know how to effectively address at least X out of X [specify numbers] most common breastfeeding difficulties
Solid, Semi-Solid or Soft Foods	% of infants aged 6 to 8 months of age who received solid, semi-solid or soft foods during the previous day or night
Minimum Dietary Diversity	% of children 6 - 23 months of age who received foods from ≥ 4 food groups the previous day or night
Minimum Acceptable Diet	% of children 6 - 23 months of age who received a Minimum Acceptable Diet the previous day and night
Gender Ratio for MAD	ratio of boys and girls aged 6 - 23 months who received a Minimum Acceptable Diet (MAD) the previous day and night
Perceived Agreement of Influencers	% of [specify the target group members] who think that their [specify the influencers] agree with them following the promoted child nutrition practices
Examples of Maternal Nutrition Indicators	
Prevalence of Acute Undernutrition	% of women of reproductive age with a MUAC ‹ 210mm
Awareness of Appropriate Diet	% of women of reproductive age aware of at least X out of X [specify numbers] promoted dietary practices
Minimum Dietary Diversity – Women	% of women of reproductive age (15 - 49 years) who ate foods from ≥ 5 food groups the previous day or night
Consumption of Iron-Rich Foods	% of pregnant and lactating women who consumed an iron-rich food the previous day or night
Consumption of Vitamin A Rich Foods	% of pregnant women who consumed a vitamin A rich food the previous day or night

Examples of Nutrition-Sensitive Agriculture Indicators	
Farm Diversity Score	the average number of crop types grown by the target households during the last [specify the name of the season]
Production of Nutrient-Rich Crops	% of households which in the past 12 months grew at least X out of X [specify numbers] promoted nutrient-rich crops
+ indicators related to measuring dietary diversity listed above	
Examples of Nutrition-Related Gender Indicators	
Household Decision Making Index	average score on Household Decision-Making Index
Men's Participation in Household Chores	% of men substantially participating in at least X out of X selected household chores[30]

USING AND SHARING WHAT WE LEARNED

Monitoring and evaluation (M&E) are primarily about learning. It is important that we keep in mind that **learning makes most sense when we actively use the knowledge we gained**, this means when we translate the M&E findings into practical recommendations and actions that further increase the impact of the development work that we (or any other stakeholders) are doing. Therefore, we should never be content with just checking the latest monitoring data or with reading the evaluation report. Our main question should always be: "So what? What does the data mean for the work that we are / will be doing? What kind of actions should we – or anyone else – take as a result of the findings?"
Especially in the case of the final evaluations, it is easy to say "Okay, our job is done, let's move on." However, this means that most of the – often very useful - lessons generated in the course of the programme implementation can easily get lost. As a result, other people and organisations might be unnecessarily 'reinventing the wheel'. As much as possible, include in your programme proposal various activities that focus on sharing your best practices (that can be replicated), key findings, and practical recommendations with stakeholders that are able to use them (such as relevant government departments, donors, UN agencies, NGOs working in the same sector, but in many cases also the communities you worked with). Make sure to also share your unsuccessful practices or negative unintended consequences to help others avoid the same mistakes (among development workers, these are often more appreciated than the usual "success stories").

It will not only **enable others to be more effective in their work but also strengthen the image of your work** – people will see you as someone who understands the given topic and is capable of sharing useful know-how with others. There are many ways in which you can share. For example, **you can share through**:

- organising in-depth technical workshops for practitioners that focus on discussing a given topic, for example, what does (not) work in nutrition-sensitive agriculture and why
- meeting donors or policy makers and providing them with your view on what works for addressing a given problem, where the key gaps are, and what actions they should consider
- publishing your formative research results including practical recommendations (see example)
- discussing the findings of your evaluations with the target group members, seeking their feedback on the validity and accuracy of the findings, and discussing how to ensure that the changes last
- sharing and discussing experiences and learning with colleagues and partners in the working groups of GIZ's Sector Network Rural Development (SNRD) in on-site workshops, webinars
- sharing your experience and any publications on the IDA (Integrated Digital Applications) platform and/or on the SNRD-web site (e.g. SNRD Africa)

30 IndiKit – Guidance on Relief and Development Indicators, retrieved from this site

A Little Bonus for You

Have you enjoyed reading this guide? Are you keen to learn more about social and behaviour change?
We prepared a selection of the very best resources for you – take a few minutes to explore what they offer!

- **Three Myths of Behavior Change:**
  Excellent TED Talk tackling the main behaviour change myths.

- **Choosing the Small Doable Actions:**
  A brief video showing how to select the most effective behaviours.

- **Communications and Behaviour Change:**
  A great introduction to SBC with many examples drawing on psychology and behavioural economics.

- **Behaviour Change Toolkit:**
  A practical and easy-to-read toolkit nicely complementing this guide.

- **How-to Guides:**
  Dozens of helpful mini-guides on almost any aspect of SBC communication activities, including initial preparations, design of SBC messages and materials, M&E, and more.

- **www.behaviourchange.net:**
  Website providing guidance on various formative research methods (including questionnaire templates) and approaches for addressing the identified barriers.

- **www.indikit.net:**
  The most comprehensive on-line guidance on the use of SBC and other project indicators. Also includes several brief M&E guides and checklists in multiple languages.

- **Behavior Change in Nutrition-Sensitive Agriculture:**
  On-line course for people who want to get a better understanding of SBC in the context of agricultural projects.

- **Social Norms, Social Change:**
  This UNICEF-supported on-line course will deepen your understanding of social norms and their impact on social and behaviour change.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