PROSAF
BEHAVIORAL CHANGE COMMUNICATION LESSONS LEARNED REPORT

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For:
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List of Acronyms

ABPF	Benin Family Planning Association (Association Beninoise de Planification Familiale)
BCC	Behavioral Change Communication
CLUSA	Cooperative League of USA
DDSP	Department of Public Health
E-E	Entertainment education approach
IEC	Information, education, and communication
KAP	Knowledge, attitudes and practices
NGOs	Non-governmental organizations
PATH	Program for Appropriate Technology in Health
PLWHAs	People living with HIV/AIDS
PROSAF	Benin Integrated Family Health Project (Promotion Intégrée de la Santé Familiale dans le Borgou)
URC	University Research Corporation, LLC
USAID	United States Agency for International Development

Executive Summary

The *PROSAF*[1] *Behavioral Change Communication (BCC) Lessons Learned Report* shares insights with BCC implementers and decision-makers in Benin as well as the wider donor community. The report satisfies a project milestone and provides information about the project's guiding principals and selected, successful, BCC interventions and supports to enable other implementers to replicate or adapt them. The project's BCC interventions have helped the primary beneficiaries, specifically the people of Borgou/Alibori, to significantly improve their health knowledge, attitudes, and practices.

In the course of contributing substantially to behavioral change results, PROSAF has learned lessons that continue to inform BCC implementation. The lessons learned include a set of guiding principles: maximize beneficiary participation, serve as coaches and catalysts for change, design interventions that fulfill the beneficiaries' prerequisites for behavioral change, adjust the interventions according to findings from continual monitoring and lay the groundwork for sustained BCC gains. Although none of these lessons is revolutionary, one lesson deserves special attention: **design interventions that fulfill the beneficiaries' prerequisites for behavioral change.** This lesson leads to recognition that **social approval** is a core prerequisite for behavioral change among people living in collectivist societies.

Some of the lessons learned by PROSAF during implementation are represented by highly effective BCC interventions and supports developed with project partners as well as a few activities adapted from other implementers. Selected interventions and supports are presented here with brief guidelines to enable others to use and adapt the activities. The interventions and supports presented here include a participatory rapid monitoring method, community media for entertainment education, print materials, and participatory IEC supports and activities. The **participatory rapid monitoring approach** merits special attention as an innovative method for ensuring feedback and intervention quality.

This report reflects the main BCC lessons learned for the PROSAF project. The insights gained have helped project staff realize the importance of using interventions that reach an entire community simultaneously, such as community media, to ensure social approval for healthy behaviors. Beneficiaries need opportunities for learning information and becoming motivated through group reflection about the relative merits of new behaviors. The project also learned the value of developing change agent and beneficiary capacity to develop and carry out participatory IEC. This process assists community groups to reinforce, clarify and recall new behaviors and attitudes. For maximum effectiveness, all interventions need to be integrated and implemented within a comprehensive BCC strategy.

[1] PROSAF is the acronym for the Benin Integrated Family Health Project (Promotion Intégrée de la Santé Familiale dans le Borgou) that is financed by the United States Agency for International Development (USAID) under contract 680-C-00-99-00065-00. The opinions expressed in this document are those of the authors and do not necessarily represent the views of USAID. PATH provides technical assistance for the behavior change communication (BCC) activities described in this report.

Introduction

PROSAF[2], the Benin Integrated Family Health Project, is a five-year[3] USAID-funded project which contributes to USAID/Benin's strategic objective of increasing the use of family health services and prevention measures within a supportive policy environment. The project works in the departments of Borgou and Alibori in northern Benin. PROSAF works in partnership with the Department of Public Health (DDSP) and with community radio stations, community media, non-governmental organizations (NGOs) and community volunteers. The project encompasses five major components: (1) Planning and Coordination, (2) Increased Access and Quality Assurance, (3) Training, (4) Behavior Change Communication (BCC/IEC)[4], and (5) Community Mobilization. PROSAF is a consortium led by University Research Corporation (URC) and includes Association Beninoise de Planification Familiale (ABPF), Cooperative League of USA (CLUSA), and Program for Appropriate Technology in Health (PATH). PATH provides technical assistance for the behavior change communication (BCC) activities described in this report.

The purpose of this report is to share relevant lessons learned by the PROSAF project with BCC other implementers and decision-makers in Borgou/Alibori, in Benin, and the wider public health community. The intent is to provide information about the project's guiding principals and selected, successful approaches and interventions to enable other implementers to replicate or adapt them. This report satisfies PROSAF Milestone 30: *Lessons learned report based on PROSAF's experiences in behavior change and communication produced.*

The authors acknowledge with gratitude the participation of the many people of Borgou/Alibori who helped the project team better understand how to encourage and enable them to adopt healthier practices, the many change agents who served as coaches and catalysts and the many collaborating partners in Benin and BCC colleagues worldwide whose successes have inspired and guided the project team.

1 PROSAF Family Health Behavioral Change Results

In conjunction with the DDSP and other collaborators, PROSAF has helped the primary project beneficiaries, the people of Borgou/Alibori, to significantly improve their health knowledge, attitudes and practices (KAP). BCC interventions have contributed to these successes along with health system improvements and enhanced social mobilization activities that have brought user-friendly services and products closer to the people. To assess the magnitude of these changes, PROSAF has conducted two department-wide KAP surveys, a baseline in 2000 and a follow-up in 2002. Progress towards the knowledge and behavioral targets set by USAID has been substantial, with three end-of-project targets already achieved by 2002: knowledge of three contraceptives, knowledge of STI symptoms and use of exclusive breastfeeding. Important gains were recorded in the percentage of the public informed about family health behaviors and the percentage of the public engaging in appropriate health behaviors (see table and chart below).

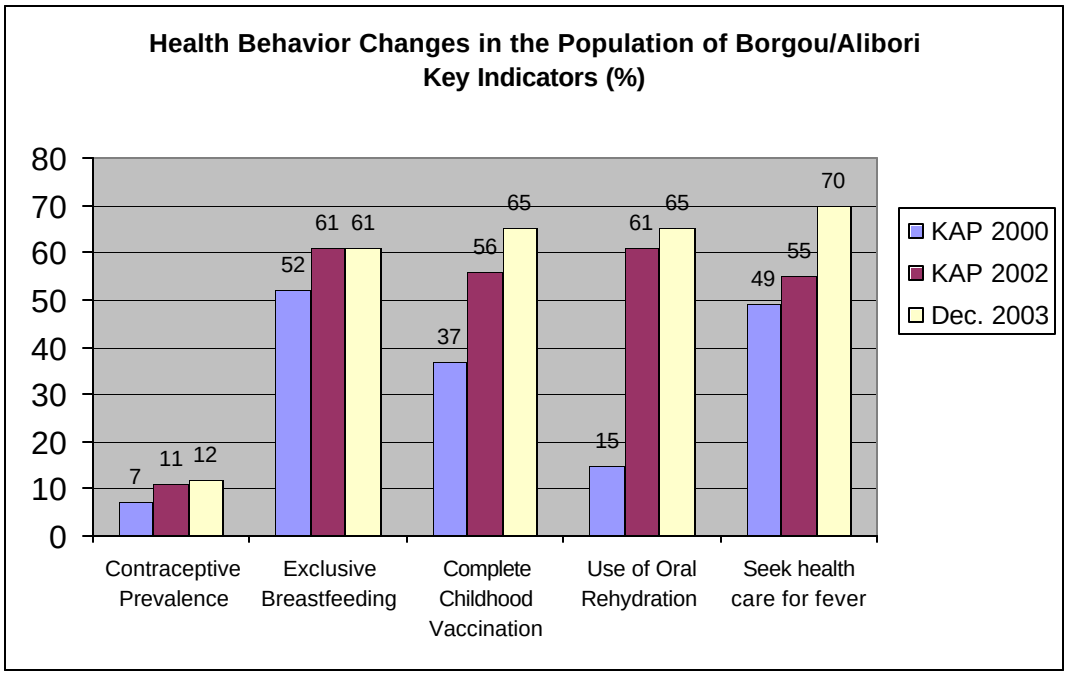
[2] *Promotion Intégrée de la Santé Familiale dans le Borgou* (PROSAF) is financed by the United States Agency for International Development (USAID) under contract 680-C-00-99-00065-00. The opinions expressed in this document are those of the authors and do not necessarily represent the views of USAID.

[3] January 1999 to January 2004, with a phase II contract to begin in early 2004.

[4] For the purposes of this report, *Behavioral Change Communication* (BCC) is synonymous with information, education and communication (IEC). Both IEC and BCC enable people to change their behaviors, and both employ similar multi-media methods. The report authors recognize, however that BCC places greater emphasis on attaining behavioral change within a given social and economic environment.

Changes in Health Knowledge: Percentage of the Population (%)			
Indicators	**KAP 2000**	**KAP 2002**	**End of Project Objectives (12/03)**
Reproductive Health Indicators			
Three modern contraceptive methods (Women)	6	25	25
Two symptoms of STIs for their own sex (Women and Men)	W: 6 M: 23	W: 32 M: 40	W: 30 M: 40
Two means of reducing the risk of HIV infection (Women and Men)	60	W: 47 M: 56	W: 75 M: 75
Child Health Indicators			
One danger sign for ARI requiring Health Center visit (Mothers of children under 3 years old)	66	72	80
*Three means of preventing diarrhea among children (Mothers)		14	80
*One way of preventing diarrhea among children (Mothers)	69	76	80
Sleeping under a bed net protects against malaria (Women and Men)	55	W: 59 M: 76	70
**During the project, this indicator changed from knowledge of one method to knowledge of three methods of preventing diarrhea.*			

Behavior and knowledge gains linked to PROSAF interventions implemented in 2003 after the most recent KAP survey have not been studied; they will be recorded in the KAP survey scheduled for September 2005. The deficits related to fever and malaria, complete childhood vaccination and knowledge of ways to avoid the risks of HIV/AIDS infection were addressed in multi-media interventions that were initiated after KAP 2002.



Who are our beneficiaries?

Primary beneficiaries = *Priority Groups* (the groups we target for change)

Secondary beneficiaries = *Change Agents* (health workers, staff and volunteers associated with radios, community media and NGOs)

2 Lessons Learned: PROSAF Guiding Principles for BCC

In the course of achieving the behavioral change results outlined above, PROSAF learned lessons that continue to guide the project's BCC implementation. These lessons emerged from a central behavioral change communication principle--the success of BCC projects and interventions depends upon the attitudes and actions of the beneficiaries. PROSAF has also drawn upon the prevailing BCC theories[5] to guide project work, while remaining grounded in the realities of the beneficiary population. The low level of health indicators was a prime rationale for selecting Northern Benin as the site for this major USAID/Benin health project. In addition, the low level of literacy, the multiplicity of local languages and the rapidly modernizing traditional cultures constitute challenges that shaped the project's communication approaches. In light of lessons learned, PROSAF staff has sought to maximize beneficiary participation and serve as coaches and catalysts for change. The project has also designed interventions to fulfill beneficiary behavioral change prerequisites, revised the interventions to integrate findings from monitoring, and laid the groundwork for sustained BCC gains.

PROSAF Guiding Principles for Family Health BCC

⇐ Maximize beneficiary participation by understanding and responding to their perspectives and capabilities

⇐ Serve as coaches and catalysts for change by providing target groups with opportunities to satisfy their prerequisites for behavioral change:

- Information
- Motivation
- Social approval
- Self-efficacy (confidence in one's own ability to carry out the behaviors) which includes for some behaviors:
  - Skills
  - Service and product accessibility

⇐ Select channels and design interventions that maximize the capacity of the priority groups to fulfill their outstanding behavioral change prerequisites

⇐ Monitor and modify interventions continually on the basis of feedback

⇐ Assure BCC sustainability by substantially increasing the KAP of the public, building change agent capacity and linking change agents to funding sources

[5] The Communication Initiative website (www.comminit.com) provides access to sections on communication theory and strategy that describe the diversity of approaches to communication for change as well as sources for other publications on these topics.

The guiding principles outlined in the table above form PROSAF's BCC lessons learned and are key components of a successful BCC strategy. Although none of these lessons is revolutionary, one lesson deserves special attention: **design interventions that fulfill the beneficiaries' prerequisites for behavioral change.** By taking the perspectives of the beneficiaries and asking what they require to make a behavioral change decision and act on that decision, PROSAF BCC staff arrived at a list that differs in emphasis from the prevailing theories:

- Information
- Motivation
- **Social Approval**
- Self-efficacy (confidence in one's own ability to carry out the behaviors) which for many behaviors depends upon:
    - Skills
    - Service and product accessibility

The central role of social approval for people in collectivist societies as distinct from Western individualist societies[6] is highlighted in this list. Social approval is often incorporated into a communication theory under the rubric of an *enabling environment* that also includes service and product accessibility as well as government and community approval. The PROSAF experience has demonstrated that individuals do not seriously consider major behavioral changes without assurance that their reference group (family, community members and/or peers) is also considering and/or approving the change. Fear or discomfort at being disloyal to the group/community and singled out as different inhibits absorption of information and one's ability to assess the advantages and disadvantages of new behaviors.

2.1 Maximize beneficiary participation

The success of any BCC strategy or activity depends on the engagement of the primary beneficiaries, or priority group, addressed by the project or intervention. BCC change agents can and do assist these priority groups to change their knowledge, attitudes, skills and practices. Change agents are the secondary beneficiaries. A change agent is an implementer at any level and, more specifically, one who is in contact with the priority group. BCC change agents include community volunteers, health workers, and staff and volunteers associated with radios, community media and NGOs. Change agents facilitate change, but only the priority groups can themselves effect the behavioral change. As the proverb goes, *you can lead a horse to water, but you can't make him drink.* Because the priority groups are active subjects responsible for stopping harmful behaviors or initiating healthy ones, their perspective and participation is key.

How can implementers ensure effective beneficiary participation? To persuade beneficiaries to seriously consider new perspectives on their health, project activities need to generate trust. If intervention messages respect the beneficiaries' right to their own beliefs, while simultaneously introducing new information, it is easier for people to consider different perspectives. The reasons why people engage in harmful practices need to be taken into account as well. Many unhealthy, harmful or risky behaviors that health interventions seek to change offer enticements to people (e.g., pleasure, income or economic savings, convenience, etc.). Project staff need to recognize the benefits of the behavior in the traditional setting and the extent to which these benefits still apply to the population in current, modernizing environments.

[6] Hofstede, Geert. 1997. Cultures and Organizations: Software of the Mind. McGraw-Hill International (UK) Limited, p. 51. Geert compares individualist and collectivist societies as follows: "*Individualism* pertains to *societies in which the ties between individuals are loose: everyone is expected to look after himself or herself and his or her immediate family. Collectivism* as its opposite pertains to *societies in which people from birth onwards are integrated into strong, cohesive in-groups, which throughout people's lifetime continue to protect them in exchange for unquestioning loyalty.*"

Facilitating beneficiary participation demands particular time, attention and effort. A variety of approaches enable beneficiaries to participate in developing and implementing BCC interventions. Project implementers should remember that many of the change agents are members of the beneficiary public with a particular skill, including popular and traditional performers, local language radio animators, NGO staff and community volunteers. Participation may be limited to input from participants in focus group discussions and in-depth interviews. In the case of community theater, PROSAF found that valuable beneficiary input could be incorporated through the actors using a participatory rapid monitoring tool to obtain feedback and integrating new ideas into their performance. PROSAF also found that extensive pretesting and use of draft IEC supports with the public before finalizing materials allowed for greater input from beneficiaries. In addition, the project staff worked with community members to create participatory IEC supports and messages, including songs and games, that the beneficiaries use naturally and with enjoyment during their everyday life. Community volunteers also created informal skits and presented them in their neighborhoods with the assistance of a few friends, followed by discussions about feasible actions arising from the issues addressed in the skits. Thus a spectrum of techniques to encourage and ensure participation from beneficiaries may be used.

2.2 Serve as coaches and catalysts for priority groups

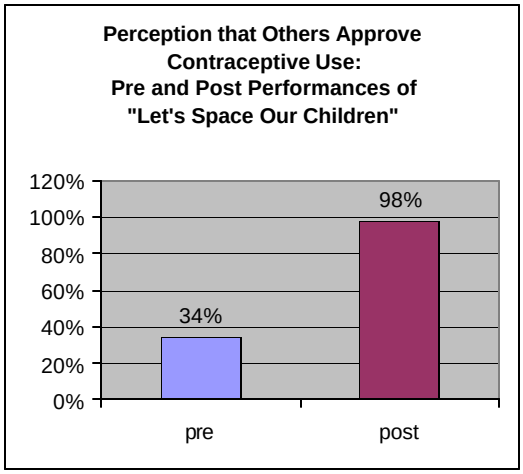
BCC specialists and change agents cannot change people; however, they can coach people and serve as catalysts for change. They function as coaches in the sense that a coach shares the interests of his or her team. A good coach provides guidance and direction and is constantly available to help improve the team's capacity to win through persuasion and skill building. A BCC specialist is a coach, who brings in outside expertise, synthesizes and translates worldwide lessons learned, and recommends relevant best practices to his or her team of change agents and the priority groups they are assisting to make healthier behavioral choices. BCC specialists and change agents use their wider experience to provide stimulus for change by ensuring that the decision-making and needs of priority groups are met in a timely manner.

Priority Group behavioral change prerequisites. When BCC experts acknowledge that beneficiaries hold the power to change, they must ask what beneficiaries need and want in order to decide to change and to act on their decision. What are the prerequisites for behavioral change? People need many things to successfully act on behavioral change decisions: information, motivation, social approval and confidence that they can successfully carry out the change.

Although **knowledge** is not sufficient to make people change, it is necessary to convince people of the need for behavioral change. Program implementers must keep in mind the beneficiaries' perspective, using information they already have as the starting point. Starting where they are, program implementers can identify and focus on essential messages and problems. They should avoid requiring beneficiaries to learn information not necessary for carrying out the healthier behaviors. For example, while it is nice to be well informed about the names and purpose of each childhood vaccination, confidence in the health system and a sense of when to seek vaccinations is more important. Parents do not need to know the name of each vaccine but they do need to know the childhood vaccination calendar.

Without **motivation** people will not make an effort to change their behaviors. Individuals need to be convinced of the benefits of new practices. Once convinced of the theoretical need to change, they still have to weigh any negative consequences or social-economic costs of adopting a new practice, and decide that the benefits outweigh the costs. For example, each mother weighs the long-term benefits of spending her time and money to take her child to his or her fifth vaccination session against the immediate pressure to be working in the fields or caring for older children and her husband. BCC implementers need to help mothers and family members weigh these costs and benefits to help motivate people to adopt change.

Social approval is essential for people living in collectivist societies to initiate a new behavior or change their attitudes towards a new behavior. They have been socialized to conform to the accepted social norms and to fear being singled out from their reference group. Particularly for sensitive reproductive health behaviors, people have often not fully considered the benefits of the behaviors. Discussion of sensitive topics may be taboo, or raising a controversial topic may make an individual susceptible to scorn or accusations of immoral behavior. Community drama can provide opportunities for group reflection and assessment of behavioral choices that bring about social approval of the recommended behavioral changes. During a performance, the entire community watches the hero and other characters change their attitudes as they acquire more knowledge and see the appropriate behaviors modeled. The audience agrees with the hero and realizes that everyone else approves. Thus the community's attitudes change and simultaneously community members change their perception of community attitudes so that they feel free to initiate new behaviors. PROSAF found this to be true for a play called *Let's Space Our Children*, when before the performance only 34% of audience members polled stated that they thought others approved of contraceptive use, and after the performance 98% of the *same* audience members said others approved of contraceptive use.



Self-efficacy, confidence in ones own ability to successfully carry out a new behavior, is the ultimate prerequisite for actually trying out a behavior. Self-efficacy includes having the skills necessary to carry out a behavior, and an enabling environment that makes the behavior possible. A main feature of the environment is the availability, affordability and access to services and products used in carrying out the behavior. For some health behaviors, people need to learn new **skills** to carry out the recommended behavior. They need to be able to interpret a chloroquine dosage chart, use a condom correctly, seek treatment for a sexually transmitted infection, wash their hands effectively with minimal water, etc. Skill-based practices are best promoted by demonstrating or modeling the behaviors and by providing opportunities for coaching and practice. The more self-confidence people acquire in their performance, the more likely they are to try out and maintain the behavior.

Services and products are essential to perform many health practices. BCC professionals may not be responsible for services and product supply, but they are responsible for advocating effectively for availability and accessibility at optimal cost and proximity to priority groups. Promotion of contraceptives, treated bed nets, clean birth kits or potable water is inadequate and wasteful if the services or products are not available. Access to contraceptives is often a barrier for adolescents because of provider attitudes or regulations. Similarly, government regulations may prevent community distribution of contraceptive and malaria pills, thereby severely limiting their accessibility for people living long distances from health facilities.

2.3 Select channels and design interventions that maximize the capacity of the priority groups to fulfill their outstanding behavioral change prerequisites.

Multi-media interventions can assist the greatest proportion of the population to fulfill their behavioral change prerequisites (information, motivation, social approval and, self-confidence). The three major communication channels (mass media, community media and interpersonal communication) each offer special features that contribute to effective communication. Hybrid media including cassettes and CDs can be categorized as a fourth channel that replicates and enhances the communication effects of the major channels. Research carried out by health and development communicators has established that a multi-media approach increases communication effectiveness. Some channels have the power to reach more people per intervention, while other channels stimulate greater behavioral change among a smaller group of individuals. Behavioral change communications strategies seek to maximize their use of the particular qualities of each channel and to mix the channels together to reinforce their effect.

Radio is an especially effective mass media for developing nations. Radio has by far the greatest reach; it provides information to the greatest number of people while overcoming language, literacy and financial barriers. Radio also helps ensure message penetration by providing the most cost-effective frequency – the average number of times a person is repeatedly exposed to a message. Radio information and messages can also serve to motivate and advise the public on product sources and prices. The capacity of radio to build skills is rather limited because listeners may misinterpret the oral directions. For audience participation and feedback, only a small portion of the radio audience may have the literacy skills necessary to participate in phone-in and write-in programs.

Radio dramas and public forum offer virtual community media and interpersonal communication opportunities and have the potential to increase the perception of social approval of a new behavior. A popular radio program can convince the majority of listeners that their peers are also listening and agreeing with the healthier behaviors being promoted. Television has a significantly reduced reach in rural areas; however, it can reach a large percentage of people in urban areas who also may maintain social networks with relatives in rural areas. In addition, television is more powerful because it models behaviors and skills in a visual form more easily imitated by the public.

The special power of **community media** (theater, griots/praise-singers, choral groups and orchestras) is their capacity to unite a community to reflect together on difficult behavioral change issues and to assist the community as a whole to approve the recommended behavioral changes. Each audience member realizes that everyone present is learning the new information, motivation and skills for the behaviors and,

more importantly, that everyone is responding positively to the rationales for the healthy changes being dramatized by the actors. The audience members perceive widespread social approval for the recommended behaviors, thereby freeing individuals to carry out new behaviors without fear of being singled out. Thus, community media performances can overcome or complement the skill building and social approval deficiencies of radio and fulfill all the behavioral change needs of a community simultaneously. PROSAF worked with the *Troupe Bio Guerra* to develop a participatory rapid monitoring approach to collect immediate audience feedback (see next section) that helped improve the scope and effectiveness of community theater content.

In comparison to mass media, the proportion of individuals reached by community media is much smaller, and opportunities for repeat performances are severely constrained. These limitations can be overcome by disseminating the performances via the mass media and via **hybrid media** such as audiocassettes, videocassettes, CDs, video CDs and DVDs. These small media can be used for interpersonal communication sessions and for personal use by individuals in their homes. Large screen projection of these small media has the advantage of replicating the social impact of community media without requiring the presence of the performers.

Interpersonal communication (group discussions and home counseling visits as well as health information songs and poems) assists individuals and small groups to overcome barriers to behavioral change. Volunteers and community facilitators help people clarify their misunderstandings, misconceptions and personal values. Interpersonal communication also provides for more effective skill and confidence building. Demonstrations can be tailored to the group and individuals can receive advice and encouragement as they practice skills and participate in self-esteem building activities. Once health information songs and poems become integrated into daily life, beneficiaries share them and remind people of information and attitudes, thereby informally promoting healthy behaviors. All forms of interpersonal communication help participants acquire the perception of group approval of the behavioral change; however, given the small number of people involved, this approval does not automatically translate to the perception or the reality of societal approval.

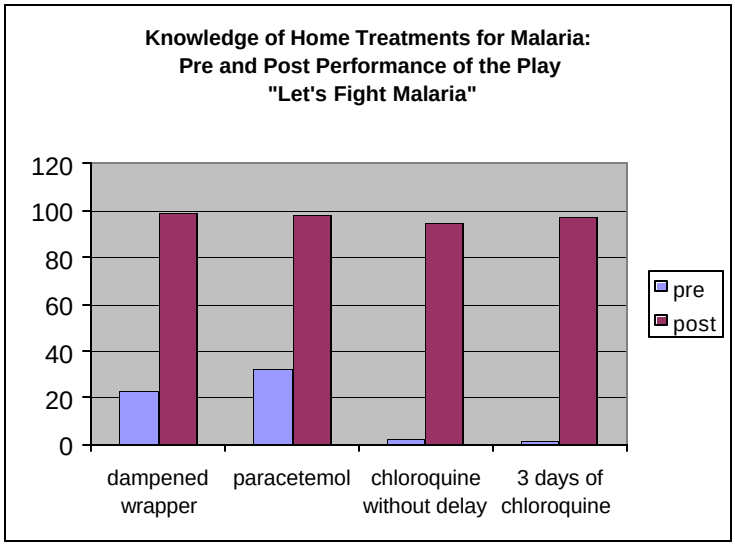
Like the other communication channels, using one of the hybrid media productions often enhances interpersonal communication effects. They can serve as the trigger for group reflection and discussion. These small media can be prepared with a high level of communication and health content expertise. They can compensate for high turnover and variable technical competency among community facilitators and volunteers, but their utility is limited by local equipment costs and possible widespread lack of electricity.

2.4 Continually monitor and modify interventions

Continual monitoring--checking on the responses, desires and abilities of the beneficiaries--contributes significantly to relevance, quality and effect. Monthly service statistics provide immediate feedback on the effectiveness of interventions and are particularly energizing for health staff and other change agents when they are collected before and after a campaign. Radios can use quiz games to attract listeners' interest and provide immediate feedback on listeners' comprehension. Community theater groups can also use participatory, rapid monitoring tools such as pre-performance and post-performance surveys.

2.5 Assure BCC sustainability

The sustainability of BCC is assured by substantially increasing the knowledge, attitudes and healthy practices of the population, building the capacity of change agents and fostering continued sources of funding. Some of the priority group gains in knowledge, attitudes, skills and practices will inevitably be lost; however, their gains will often not fall back to the pre-intervention or pre-project level. Once people have benefited personally from using the new behavior on a regular basis, the majority will seek to maintain that behavior after the end of the project without continuous project-based stimulus. Moreover, the greater the percentage of people who have adopted a particular attitude or behavior, the greater the likelihood that people around them will assume the same behavior. By modeling the new behaviors and their benefits, satisfied users constitute powerful advocates after the end of a project. Once the new behavior becomes a social norm, conformity with the new behavior becomes easier than conformity with the previous behavior.



Although enhanced change agent capacity to implement BCC activities and to coach other implementers will carry over to post-project activities, few BCC campaigns are feasible without funds. Change agent capacity is built through training and through funded experiences. Because of high personnel turnover in government or in civil society organizations, sustainability requires personnel with capacity to train and retrain change agents. Over the long run, IEC supports that are user friendly and durable will last longer and help more change agents and their beneficiaries. With sustainability in mind, PROSAF has initiated promotion of participatory IEC supports and activities that are cost-free once the population has taken ownership of them (see section 3 below).

Post-project continued funding of excellent interventions using the project-trained change agents is a major challenge that must be addressed to avoid underutilization of the expertise acquired. The most viable options include preparing non-governmental change agents to seek national and international donor funds and assisting health zones and departments to integrate BCC interventions within their work plans. To the extent that these approaches are successful and have been monitored to confirm their success, a greater proportion of the BCC activities will be sustained.

3 Selected Best Practices with Implementation Guidelines

Some of the lessons learned by PROSAF during implementation are represented by highly effective BCC interventions and supports developed with project partners as well as a few activities adapted from other implementers. This section presents selected examples of these interventions and supports with brief guides to facilitate replication by others. The interventions include participatory rapid monitoring, community media for entertainment education, print materials and participatory IEC supports and activities. The **participatory rapid monitoring approach** merits special attention as an innovative method for ensuring feedback and intervention quality.

Selected Best Practices with Implementation Guidelines

⇐ Participatory Rapid Monitoring of *Spacing Our Children*
⇐ Community Media for Entertainment Education
- Theater: *Let's Fight AIDS: Let's Not Reject Sabi*
- Griot: *Health Stories and Messages*

⇐ Print Materials for BCC/IEC Support: *Malaria Counseling Cards and Flyers*
⇐ Participatory IEC Supports and Activities
- Songs: *Mosquitoes and Malaria*
- Kinetic Messages: *The Vaccination Hand*; *The HIV Mime*
- Participatory Activities: for the public and for training
- Skill Building with Models: wooden penises and chloroquine pills

3.1 Participatory rapid monitoring

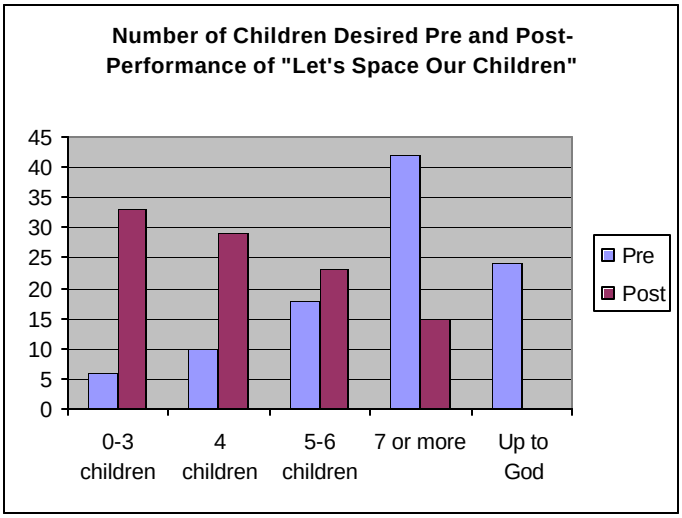
PROSAF developed an approach for monitoring community performances that relies on the performers and/or animators administering a pre- and post-performance questionnaire and facilitating post-performance discussions with the audience. These quantitative and qualitative tools provide immediate feedback for improving intervention quality and timely data about the effect of the drama. While focus groups, pre-testing, and KAP surveys greatly improve the pertinence of BCC materials and interventions, they may or not be feasible for use in a community theater program. Field trials during the first 15 performances of a play can generate substantial improvements in the final the script. Monitoring audience response during this period is essential. Using the audience feedback improves the play's relevance for the audience and can enhance the play's effect. Continuing the participatory rapid monitoring throughout the tour of the play enables the actors and producers to demonstrate immediate effect without relying on expensive audience surveys or waiting for the results of KAP surveys.

Working with the *Troupe Bio Guerra* community theater group, PROSAF developed and refined participatory rapid monitoring techniques. The actors facilitate post-performance discussions to learn audience ideas and language to feedback into the plot and to reinforce the effect of the play by providing a forum for collective knowledge and values clarification. After each performance, the actors form five discussion groups that segment the audience by age and sex: married men, unmarried men, married women, unmarried women and elderly men. These groupings allow younger women and men whose husbands' and fathers' would otherwise be in the same group to voice their opinions, express their concerns and ask questions in a more comfortable environment.

Qualitative data collected from the small groups is corroborated by quantitative pre- and post-performance survey data. Five actors administer a one-page KAP questionnaire to a convenience sample of audience members. Each actor interviews three members of his/her post-performance discussion group. A tour of major villages in five communes suffices to provide about 300 respondents per sex or age segregated target group, thereby ensuring an adequate sample.

Although questionnaires are excellent monitoring tools, their limitations should be acknowledged. The actors possess minimal training in research, surveys and group animation techniques, and have variable levels of education. PROSAF progressively modified the questionnaires in response to issues that arose and also verbally translated each survey into Bariba language for most interviewees. Some respondents were interviewed in the presence of other villagers whose presence may have influenced their responses. In addition, the actors' involvement in the message delivery increased potential investigator bias. Nevertheless, the data is reliable for monitoring purposes, and for reassessing the intervention and modifying it to increase effectiveness. Moreover, the large percentage increases in KAP are indicative of strong trends that constitute a baseline for future planning.

The example of monitoring *Let's Space Our Children.* PROSAF's experience with a play called *Let's Space Our Children* demonstrates that the results of participatory rapid monitoring energize and encourage the actors to improve their performances and to better model new behaviors. Without monitoring the effects of each performance and discussion group, the play would have focused mainly on use of condoms for birth spacing. Audience members began volunteering heartfelt testimonies thanking the actors for making them realize that they could and should limit their children. Tabulation of preliminary survey results from one village confirmed that local audiences were receptive to explicit family planning messages. Consequently, the actors transformed the key message of the play from birth spacing to limiting number of births. They modified the play's plot and content to more strongly promote five modern contraceptive methods available locally.



Computer tabulation of the survey results revealed almost 100% immediate recall of the new information about contraceptives. The data also demonstrated that the play had a dramatic impact on reducing the desired family size cited by audience members before and after the play. The graph above serves as an advocacy tool to support the use of drama and to encourage health workers to promote contraception. Data like this show that clients have an unmet need for contraception to both limit family size and space births.

3.2 Community media for entertainment-education

Introduction to entertainment-education. PROSAF has adopted the *entertainment-education* (E-E) approach to take advantage of its effectiveness in introducing controversial issues and in generating social approval for new behaviors. "*Entertainment-education* is the process of purposely designing and implementing a media message both to entertain and educate, in order to increase audience members' knowledge about an educational issue, create favorable attitudes, and change overt behavior."[7] E-E has the power to inform, dramatize the process of attitudinal change and model the desired behavior, as well as to generate discussion about taboo topics. Three character types are usually featured in E-E performances: positive and negative role models who share or reject the values and behaviors being promoted and transitional characters whose attitudes and behaviors change and who eventually adopt the positive behavior.[8]

Live performance is particularly effective for its emotional impact.[9] It brings people into direct emotional contact with new information and ideas, making them more accessible and less controversial. When an audience member follows events in a story, he or she may see more clearly how issues connect to his or her own life. Through this identification with story characters, one can examine controversial content without risking being singled out and stigmatized.

Community drama uses live performance to assist people to reflect on the impact of their current social norms[10] (their socially approved attitudes and behaviors) on their family's health and well being. Live performance brings together entire communities of people—villagers, people living in the same urban neighborhood, teenagers attending the same school, etc. By identifying with story characters and their transformations, individual spectators realize that the benefits of the promoted values and behaviors outweigh the costs. More importantly, they realize that their peers are also responding positively to the drama. Community drama provides beneficiaries with social approval of the desired behavioral changes as well as the information and motivation for these changes. In addition, it provides opportunities for vicarious self-efficacy. The spectators watch and identify with characters that model the desired behaviors and overcome problems in carrying out these behaviors.

The example of *Let's Not Reject Sabi.* PROSAF technical staff worked with a skilled, well-loved community theater troupe to develop an educational play called *Let's Fight HIV/AIDS: Let's Not Reject Sabi.* The griot opens the play with a brief synopsis and asks the audience to heed the "Abstain, Be Faithful or Use a Condom" advice of the medical doctor. The play dramatizes the life of Sabi, the transformational hero, and the consequences of his irresponsible sexual behavior. The reactions of Sabi's dramatic foils, two apprentices aspiring to his status, help the audience realize that they themselves are

[7] Singhal, Arvind and Everette M. Rogers. 1999. *Entertainment-Education*. Mahwah, New Jersey: Lawrence Erlbaum Associates, Publishers, p. 9.
[8] Singhal and Rogers 1999: 133.
[9] Brooke 1996: 2. The discussion in this paragraph cites Pamela Brooke, *Traditional Media for Gender Communication*
[10] Examples of social norms include social expectations that a man assume responsibility for the health of his family including decisions about expenditures on health, that children obey and respect their elders and that a "real" man act on his "right and need" to have multiple sexual partners.

not so different from Sabi and other people living with HIV/AIDS (PLWHAs). They learn that one act of unprotected sexual intercourse with an infected partner can suffice to contract HIV/AIDS. With the help of the positive hero, Sabi's childhood friend, the characters change their attitudes towards PLWHAs and carry the audience along with them. The griot closes the play by returning to the stage to remind the audience of the AIDS messages.

Griot Tamborou's scenario:
Removing mosquito breeding sites

" I extend my greetings to my friend Jean. When I went to his house, I didn't even know where to put my feet. Rusty sardine cans, broken jars and even sewage were scattered everywhere. I could scarcely breath, so I carefully tiptoed away. My friend, would you be surprised if malaria kills everybody in that house? You shouldn't be, because for mosquitoes that place is a paradise where they can hatch and invade the house. Jean did not understand why his children had fever.

Dear village delegate or chief *(he kneels down before the village official)* you must see to it that everybody gets rid of all uncovered containers that can hold water. That's where mosquitoes breed and hatch their eggs, and they are the same mosquitoes that give us malaria. Do you want your children to continue to die from malaria? »

Griots as change agents. In West Africa, *griots* (oral historians) are the traditional chroniclers of lifetime events. They inform, instruct and educate with their songs and parables accompanied by drumming. Griots are the memory of a community; they know and teach each generation the facts and deeds of past generations. When touring to promote health messages, griots use anecdotes and humorous stories that make people laugh. At the same time, they create different scenarios, describing real-life situations so each spectator identifies with the situation. This enables people to both personalize the problem and reflect on it together as a community. In many ways, griots are change agents par excellence.

The example of the Griot Tamborou of Bembereke. A griot and his drummer offer many of the features of a drama troupe without the added costs of a larger cast of characters and a public address system. Griots are trusted members of the community who often travel to neighboring villages and attract large audiences. In the simplest form, the griot can sing songs with health messages. He can also teach a health song to the public or demonstrate a health game or practice.

PROSAF developed an effective awareness raising performance with the Griot Tamborou from Bembereke. He performed twice a day, in one village in the morning and another in the evening. Upon his arrival, his companion took a tour of the village beating his tam-tam to announce the griot's presence in the village and to indicate the public place chosen for the performance. During that time, the griot started his animation with traditional songs. When enough people had gathered, he started his performances. At the end of each performance, he organized a discussion, including opportunities for "skill-building".

More sophisticated work with griots involves using their praise-singing talents to tell a dramatic story that leads their audiences to reflect on the need for behavioral change. PROSAF worked with a local griot to develop *The Song of Sabi*, a praise-song in which the griot Tamborou sings the story of Sabi, a handsome and popular man who has many sexual partners. When he has symptoms of a sexually transmitted infection, he tries the traditional healers to no avail and ultimately after the stillbirth of his child he seeks treatment for himself and his wife at the health center.

3.3 Print materials for BCC/IEC support

In societies where the majority of beneficiaries are non-literate or minimally literate, print materials are most useful for recall of information and messages through the use of pictures and a limited amount of text. Both the text and the illustrations usually require a change agent to assist the non-literate beneficiary in interpreting the material. Most health messages require first year secondary school literacy.

Print materials in local languages offer a partial solution if the population is literate in their own language. These materials are useful even if only a small proportion of villagers are literate in the local language because these persons are often respected persons to whom other people turn for advice. Literacy training for community volunteers assists them in their activities while at the same time empowering them to use local language print materials as a source of new knowledge. A layout with clear separation between text and illustration allows community volunteers and beneficiaries with minimal literacy to learn to interpret the illustrations without being hindered by their inability to fully interpret the text.

Each type of print material has its particular advantages. **Posters** have a relatively long life; they usually stay on the walls of health centers, schools and public buildings until the walls are repainted. **Flip charts** and **counseling cards** rely on change agents to interact with the beneficiaries and help them understand the messages and their rationale; they can be quite durable. Their effective life depends upon their continued use by the health workers or other change agents. **Flyers** are distributed to beneficiaries who often are careful to save them; however, low-literate beneficiaries have to seek assistance of someone else in the family or neighborhood to interpret the flyer. The same applies for **information booklets**. They can nonetheless be valuable resources for information recall.

The cost of print materials varies enormously. The number of copies to be printed and distributed influences the cost effectiveness of the materials. Substantial economies of scale are available with large print runs. If the unit cost of printing 50,000 flyers is $0.04 (21 CFA) the unit cost of printing 5,000 may be almost twice as high at $0.07 (40 CFA). PROSAF printed malaria flyers and counseling cards in large runs, resulting in beautifully designed, well-illustrated materials at a reasonable cost. Further cost reductions can be made by using only one or two colors, including black as one of the colors. To make full color images, the printer has to print the image four times using blue, red, and yellow ink that combine on the page to make secondary colors. Thus, the number of colors used affects cost. PROSAF kept the cost of printing the *Child Health Booklet* by restricting it to one color, light brown, for both the text and images. While a full color booklet would have been more pleasing to the eye and somewhat easier to interpret, it would have been more costly. Since beneficiaries have no access to an alternative source of the health booklet information, there was no need to increase the costs to attract the audience. During pre-tests, both non-literate and literate users declared that they would like to purchase

the booklet for themselves and their families. Paper is another major cost consideration. An offset printer uses large sized paper and prints multiple copies on a single sheet. Ensuring that the materials being produced fit on the selected paper without wastage can reduce costs.

Developing print materials. Print materials are best developed with the participation of all stakeholders: counterparts in the ministry and department of health, partners, donors, beneficiaries and graphic artists. Their full participation during one or more materials development workshops and their review of modifications after each stage of successive pre-tests ensures that the materials benefit from multiple perspectives. This approach also increases the number of organizations that use the final product so that it reaches a wider public and so that the printing costs can be kept at a minimum.

Using computer-assisted design. The development of print materials using computer-assisted publishing software and techniques increases the speed at which designers of print materials can prepare enhanced layout options and quality for text and illustrations. This approach facilitates the use of local artists to create locally appropriate images. It also permits rapid preparation of draft materials for comments by stakeholders.

3.4 Participatory IEC supports and activities

Participatory IEC includes health songs, mimes and games created by the beneficiaries themselves. This approach has a long tradition that is beginning to receive more theoretical support. Participatory IEC refers to educational supports and activities that stimulate participatory learning[11] and are created or disseminated by community facilitators and volunteers with minimal coaching from experts. They may incorporate messages that are disseminated by the beneficiaries themselves in the course of their daily lives or are shared among participants of smaller groups. In addition to songs, people can learn to communicate messages kinetically using their bodies. PROSAF staff and partners developed a game called the *Vaccination Hand*, which creates a visual representation of the childhood vaccination calendar and enables beneficiaries to use their fingers to recall a related poem (see below). The participatory activities used by trainers and facilitators constitute another form of IEC. They lead participants in many interactive activities that illustrate messages and serve as triggers for group reflection. They also teach beneficiaries essential skills using supports such as a wooden penis model for demonstration of correct condom use. The *HIV Mime* was developed in Uganda for children to enact to explain how HIV causes AIDS, and has been adapted worldwide. The participatory activities used by trainers and community facilitators during group sessions constitute another form of IEC. They lead participants in many interactive activities that illustrate messages and incite group reflection.

[11] Aubel, Judi. Simple, participatory health education materials to promote learning about CDD and ARI: songs, stories & games. Report of the Health Education Materials Development Workshop, Luang Prabang, May 20-31, 1996.

Songs that communicate health messages have been developed in many parts of the world in local languages and sometimes in national languages. To enable the priority groups to easily learn the health song and sing it with pleasure outside a workshop setting, the lyrics are usually set to the music of a well-known traditional song comparable to *Silent Night* or *Row Row Row Your Boat.* Creation of a song can be virtually cost-free within a workshop setting where participants develop the song as part of the warm-up activities. The Mosquitoes and Malaria song (see box) was developed in Bariba by PROSAF staff and the local *Troupe l'Oeil du Septentrion* as the finale for a play entitled *Let's Fight Malaria.*

Mosquitoes and Malaria

Solo: What brings malaria?
Choir: The mosquitoes.
Solo: Let's avoid the situations
Choir: Where malaria kills children.

Solo: To fight malaria
Choir Let's buy mosquito nets
Solo: Husband and wife
Choir: Under the mosquito net
Solo: Children and pregnant women
Choir: Under the mosquito net
Solo: Always
Choir: Under the mosquito net
Solo: Everywhere
Choir: Under the mosquito net.

Solo: To keep fighting malaria
Choir: Keep our environment healthy
Solo: What brings malaria?
Choir: The mosquitoes.

Catchy health songs are frequently underused because of the programmatic planning and other costs involved in widespread dissemination. In addition, ease of integrating the songs into daily life depends partially on being a member of the culture familiar with the original song.

Kinetic messages are a form of participatory IEC that offer additional opportunities for involving beneficiaries in the dissemination of their own IEC supports. PROSAF experimented successfully with the *Vaccination Hand* as a memory tool to help mothers and family members recall the childhood vaccination calendar so that children would be brought for their vaccinations on time. During PROSAF activities, community volunteers, health workers and parents were taught how to recite a poem and count off the necessary vaccination visits on a child's hand as a kinetic-oral reminder.

The Vaccination Hand Poem

I need 5 vaccination sessions against terrible childhood sicknesses.
Immediately at my birth, give me my first vaccination.
Immediately after my coming out at 42 days, give me my second vaccination.
At two and a half months, give me my third vaccination.
At three and a half months, give me my fourth vaccination.
And then when I'm nine months old, give me my fifth vaccination.
Bravo! I have completed all my vaccinations before my first birthday!

Participatory activities. Interactive activities for workshops and group IEC sessions constitute another powerful form of participatory IEC. A facilitator usually leads an interactive activity during a group session, based on the precept that adults learn more effectively when they participate actively in their own learning. People generally remember 10% of what they have read, 50% of what they have seen and heard, and 90% of what they have said while doing something.[12] Three examples of activities are outlined below.

[12] Knowles, Malcolm. *The Modern Practice of Adult Education: Andragogy vs. Pedagogy*. Englewood Cliffs, NJ: Prentice Hall, 1970.

- **HIV mime.** This mime can be used in workshops, group awareness-raising sessions and in classrooms to help people understand how HIV attacks the immune system in stages. The beneficiaries act out the mime themselves and then participate in a facilitated discussion of its meaning to ensure that all beneficiaries have fully understood.
- **HIV/AIDS transmission dance.** PROSAF worked with local griots to adapt the well-known HIV/AIDS *Wildfire* transmission game into a dance appropriate for African culture. The dance helps people personalize their risk of HIV/AIDS by making them realize that handsome, beautiful and healthy people can be living with HIV and that most people with HIV do not realize they have the virus. The dance demonstrates graphically how the epidemic can spread very rapidly.
- **Family size game.** This energizing game helps participants realize that people have been reducing their actual and desired family size progressively over the past several generations. The game contributes to participant recognition that their peers approve of family limitation and can be used as a rapid focus group to assess participant attitudes towards family size.

Some games are best used in a workshop setting, particularly if they require props or are intended for training change agents including trainers, facilitators and service providers.

- **The Pebble Survey.** Participants take part in an anonymous mini-survey with five questions. Results are calculated immediately and used as the basis of group reflection. The game is very effective in eliciting honest responses from participants about sensitive subjects like their personal sexual behavior. It is also useful with non-literate participants because it allows many participants to reply to true/false questions simultaneously even though they are unable to read the questions and answer sheets.
- **The Blind Walk.** Participants take turns playing the blind person and playing the blind person's guide. The experience helps people realize that each of us can in some situations be unable to function well without assistance and to realize the responsibility we have for the people who rely on our services.

Skill building with IEC supports in the form of models builds participant skills while taking advantage of the recall value of "saying something while doing it." Demonstrating correct condom use with a penis model and condom raises awareness; however, few people feel confident enough to imitate the behavior themselves. To gain confidence, participants need to practice, ideally more than one time, requiring large numbers of wooden penises and condoms for large groups.

PROSAF also had excellent results with the use of wooden models of chloroquine tablets to help people understand how to read a chloroquine dosage chart for children. A facilitator helped the group understand the significance of illustrations of babies and children that represent different ages. Then they learned to interpret the symbols for the three days of medication. One by one participants come forward and select the combination of whole, half and quarter (large) wooden tablets that corresponds to the dosage for the first, second and third day of treatment. By the time participants have determined the correct dosages for three age groups, virtually all participants can confidently interpret the dosage chart.

Conclusion

This report details the main behavioral change communication lessons PROSAF has learned during five years of intense project activity. The project shares the guiding principles and examples of effective BCC interventions, as well as the implementation guidelines, with the intention that other implementers can

adapt and learn from these insights. To ensure social approval for healthy behaviors, project implementers need to make greater use of interventions like community media that reach the entire community simultaneously. Beneficiaries need opportunities for learning information and becoming motivated through group reflection about the relative merits of new behaviors. To assist groups at the community level to reinforce and apply new behaviors and attitudes, project implementers also need to develop change agent and beneficiary capacity to carry out participatory education approaches, in the context of a well-defined BCC strategy with clear goals.

Behavior change communication is an interactive process. Attaining targeted behavioral change is never enough; beneficiaries also need help maintaining new practices. Maintenance calls for additional BCC interventions, well-trained change agents and sustainable IEC activities and supports. As beneficiaries satisfy their BCC prerequisites for a particular health behavior, they open themselves to the possibility of satisfying prerequisites for other health behaviors. BCC is an iterative process for both the beneficiaries and a process for the change agents. BCC implementers must continue to build on experiences with beneficiaries and continue learning from partners in Northern Benin and worldwide.