FEDERAL DEMOCRATIC REPUBLIC OF ETHIOPIA

Ministry of Health

National Hygiene and Environmental Health Communication Guideline

Advocacy ,Social Mobilization ,Behavior Change Communications

November 2016

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Operational definitions

Attitude: is a cross cutting factor. Personal dispositions towards a particular subject or situation; how we generally feel about a situation. This is a concept from the individual level theories in the Graphic: Concepts of Selected SBCC Theories

Barrier: is a difficulty or obstacle that can stop people from performing desired behaviors to the identified problem.

Behavior change communication (BCC): is a researched based, consultative process of addressing knowledge, attitudes, and practices through identifying, analyzing, and segmenting audiences and

participants in programs and by providing them with relevant information and motivation through welldefined strategies, using an appropriate mix of interpersonal, group, and mass media channels including participatory methods.

Campaign: is goal oriented recognizable attempt to inform, persuade or motivate change within the intended audiences; linked series of activities using different media with mutually supportive messages.

Channel: is the medium used for communication. The three categories of communication channels are interpersonal, mid-media, and mass media. Interpersonal channels include direct communication with an individual or group of individuals. Mid-media channels reach a group of people within a distinct geographic area or reach a group that shares common interests or characteristics. Mass media channels are those which can reach large audiences quickly.

Cohort: is a group of people sharing a common characteristic.

Control: Scientists investigate the effect of various factors one at a time in an experiment and keep control for study. Control group do not receive treatment and represents population before treatment or if no treatment. They are kept for comparison purpose.

Communication objective: Communication objectives are ways to address barriers to achieve desired change in policies, social norms, or behaviors. They are audience specific and contribute to program objectives.

Communication strategy: is a comprehensive document that guides and links decisions on intended audiences, communication objectives, channels and materials based on analysis and integrated by a strategic approach.

Community: is a group united around a shared characteristic or concern or a group of people located n the same area.

Conceptual framework: is a diagram of a set of relationships between factors that are believed to impact or lead to a target condition. It is the foundation of project design, management, and monitoring.

Crosscutting factors: These are represented in the triangle of influence in the socio ecological model.These factors are put into four large categories: information, motivation, ability to act, and norms which SBCC interventions may be able to modify to generate change.

Data sources: The resources used to obtain the data needed for M&E activities. These sources may include, among many others, official government documents, clinic administrative records, staff or provider information, client-visit registers, interview data, sentinel-surveillance systems, and satellite imagery.

Determinant: Are factor that cause changes in behavior such as media exposure, education etc.

Diffusion of innovation: is a process by which an innovation is spread in a given population over time.Under the right conditions, innovations (new services, products, best practices) can be successfully introduced/communicated and adapted at the individual, community, and organizational level.

Ecological: In this context, ecological means the relationships between individuals and their environments.

Environment: is the physical, emotional, or social contexts that shape community and individual attitudes and behaviors.

Epidemic: denotes significantly high incidence of disease occurrence in a population.

Evaluation: is a process that attempts to determine as systematically and objectively as possible the relevance, effectiveness, and impact of activities in light of their objectives.

Experiment: is an empirical method that arbitrates between competing hypotheses. Experimentation is used to test existing theories or new hypotheses in order to support them or disprove them. Any study in which a treatment is introduced is an experiment. It looks for cause and effect relationships.

Experiments vs non-experiments: An experiment is any study in which a treatment is introduced.However, a non-experimental study does not introduce a treatment but is exploratory in nature.

Focus group discussion: is discussion in which a small group of people, usually 8 to 10, talk about a topic of common interest to all the participants. These group discussions take place under the guidance of a facilitator and are used to collect research data or test materials.

Formative research: is the research conducted during the planning process that allows programplanners to obtain insight into the knowledge, attitudes, and practices of the situation. This researchhelps to form, plan and develop communication programs and determine audiences and strategies.

Framework: is an open set of tools for project planning, design, management, and performance assessment. Frameworks help to identify project elements (goals, objectives, outputs, and outcomes),their causal relationships, and the external factors that may influence success or failure of the project.

Goal: is a broad statement of a desired, long-term outcome of a program. Goals express general program intentions and help guide a program‘s development. Each goal has a set of related, more specific objectives that, if met, will collectively permit program staff to reach the stated goal.

Incidence: is the number of new cases of infection within a specified period of time.

Independent variable: are factors that researchers control or manipulate in order to determine the effect on behavior.

Indicators: are quantitative or qualitative measures of program performance that are used todemonstrate change and that detail the extent to which program results are being or have been achieved. Indicators can be measured at each level: input, process, output, outcome, and impact.

Information: is a crosscutting factor. People need information that is timely, accessible, and relevant.When looking at information consider the level of knowledge held by that person or group, .g.,aboutmodern contraceptives and their side effects.

Informal communication: is a communication networks that fall outside of established systems for conveying information, e.g. information communicated over drinks at the bar or by the communal pipe

stand.

Information Education and Communication (IEC): a process of providing information and education to individuals and communities to promote healthy behaviors that are appropriate to their context.

Impact: is the anticipated end results or long-term effects of a program. For example, changes in ealth status such as reduced disease incidence or improved nutritional status.

Impact evaluation: is a set of procedures and methodological approaches that show how much of the observed change in intermediate or final outcomes, or ―impact,‖ can be attributed to the program.Itrequires the application of evaluation designs to estimate the difference in the outcome of interest between having or not having the program.

Input: are the resources going into conducting and carrying out the project or program. These could include staff, finance, materials, and time.

Interpersonal communication: is a face to face exchange of e.g.; information, education, motivation,or counseling.

Intervention: is a set of complementary program activities designed to achieve program goals.

Learning: is a process of mastering or internalizing values, knowledge, skills through socialization, formal instruction, or experience.

Message: is a brief, value based statement aimed at an audience that captures a concept. Messages must be personally appealing and discuss only one/two key points. The information in the message should be new, clear, accurate, and complete, culturally appropriate, and include specific suggestions of what people can do.

Metric: is the precise calculation or formula that provides the value of an indicator.

Model: it draws upon multiple theories to try to explain a given phenomenon.

Modeling: is a process where people learn not only from their own experiences but also by observing others actions and the benefits that they gain through those actions.

Monitoring: is the routine process of data collection and measurement of progress toward program objectives. It involves tracking what is being done and routinely looking at the types and levels of resources used; the activities conducted; the products and services generated by these activities, including the quality of services; and the outcomes of these services and products.

Monitoring and evaluation (M&E) plan: is a comprehensive planning document for all monitoring and evaluation activities within a program. This plan documents the key M&E questions to be addressed: what indicators will be collected, how, how often, from where, and why; baseline values, targets, and assumptions; how data are going to be analyzed and interpreted; and how/how often reports will be developed and distributed.

Multivariate analysis (MVA): refers to any statistical technique used to analyze data that arises from more than one variable. This essentially models reality where each situation, product, or decision involves more than a single variable. In design and analysis, the technique is used to perform trade studies across multiple dimensions while taking into account the effects of all variables on the responses of interest.

Objectives: are significant development results that contribute to the achievement of goals and provide a general framework for more detailed planning for specific programs. Several objectives can contribute to each goal.

Outcomes: are the changes measured at the population level in the program's target population, some or all of which may be the result of a given program or intervention. Outcomes refer to specific knowledge, behaviors, or practices on the part of the intended audience that are clearly related to the program, can reasonably be expected to change over the short-to-intermediate term, and that contribute to a program's desired long-term goals.

Output: are the immediate result obtained by the program through the execution of activities (e.g.,number of commodities distributed, number of staff trained, number of people reached, or number of people served). Good process monitoring of outputs from activities (if mutually supportive) can lead to program outcomes and hopefully have impact!

Population: is set of all cases of interest. For example: All currently married women aged 15-49 in a district.

Pretesting: is a type of formative evaluation that involves systematically gathering intended audience

reactions to messages and materials before the messages and materials are produced in final form.

Prevalence: is the proportion of persons in a population who have a particular disease or condition.

Process: is set of activities in which program resources are used to achieve the results expected from

the program (e.g., number of workshops or number of training sessions).

Process evaluation: is a type of evaluation that focuses on program implementation. Process evaluations usually focus on a single program and use largely qualitative methods to describe program activities and perceptions, especially during the developmental stages and early implementation of the program.

Qualitative method: it helps build an in-depth picture among a relatively small sample of people on a specific issue. Questions are asked in an open-ended way and the findings are usually analyzed as

data is collected. Information gathered should not be described in numerical terms, and generalization about the intended audience cannot be made.

Quantitative method: are things that are either measured or counted, or questions are asked according to a defined questionnaire so that the answers can be coded and analyzed numerically by asking a large number of people identical (and predominantly close ended) questions.

Randomization: is true experiment that involves assignment to treatment groups based on random selection. All participants have equal chance of being chosen for experimental group or control group

Reliable: Results those are accurate and consistent through repeated measurement.

Risk: is an increased probability of being affected.

Risk factors: are conditions associated with increased likelihood of a particular disease or condition, e.g. individual behaviors, lifestyle, environmental exposure or hereditary characteristics.

Routine data sources: are resources that provide data collected on a continuous basis, such as information that clinics collect on the patients utilizing their services.

Sample: subset of the population used to represent the population.

Situation analysis: is a systematic review of social, cultural, political, and behavioral data aimed to identify internal and external determinants of a situation, such as immediate and underlying cause and

effects.

SMART (objectives): specific, measureable, attainable, realistic, time bound

Social and behavior change communication (SBCC): is an evidence -based, consultative process of addressing knowledge, attitudes, and practices through identifying, analyzing, and segmenting

audiences and participants in programs and by providing them with relevant information and motivation through well-defined strategies, using an appropriate mix of interpersonal, group and mass media channels, including participatory methods.

Social change intervention: are activities directed at changing conditions within the social environment.

Strategy: is a coordinated and comprehensive set of activities aimed at achieving an objective.

Theory: is a systematic and organized explanation of events or situations. Theories are developed from a set of concepts (or ―constructs‖) that explain and predict events/situations, and provide explanations about the relationship between different variables.

Theory of Change (TOC): is a ―concrete statements of plausible, testable pathways of change that can both guide actions and explain their impact

Tipping point: is the dynamics of social change where trends eventually become permanent change. They can be driven by a naturally occurring event or a strong determinant for change, such as political will that can provide the final energy to ―tip over‖ a situation to change – they are events that prompt change.

Tools: are instruments (e.g. worksheet, checklist, or graphic) that assist or guide practitioners in the understanding and application of concepts in their programmatic work.

Trend: is a pattern in frequencies of disease incidents or prevalence over time, within or across various subgroups.

Triangulation: is the use of multiple data sources or methods to validate findings, discover errors or inconsistencies, and reduce bias.

Valid: a term used to describe an objective, methodology or instrument that measures what it is supposed to measure.

Variables: a trait or characteristic with two or more categories. Categories should be mutually exclusive (Each participant belongs to one and only one category) and exhaustive (Variable has a category for each participant).

PREFACE

In arriving at the decision to develop a National Hygiene and Environmental Health Advocacy , Social Mobilization and Behaviour Change Communication Guidelines , Hygiene and Environmental Health Case team of the Federal Ministry of Health (FMOH) , in collaboration with key sector stakeholders recognized the importance and timeliness of behavioral changes in a sustainable was as one of the disease prevention intervention to complement the recent community mobilization approaches such as Community Led Total Sanitation and Hyguenes (CLTSH).

For hygiene and environmental health programs to deliver a positive yieldrequired health benefits at community and individual level, this requires to designed, implemented and monitored integrated manner. This is what precipitated the need to develop this guideline targeting at translating elements of the National Health Communication and Promotion Strategy with aim of to bridge existing gap of hygiene and environmental health behaviors.

This guideline developed , under the auspices of National Hygiene and Environmental Health Task Force, the Communication Technical Working Group (TWG) teamed from key relevant stakeholders including Government, Development Partners, and Non-Governmental Organizations has made remarkable efforts through continuous consultative workshops and need assessment at national and regional levels, this helped to arrive at the appropriate guideline which drove the process of integrating Advocacy , Social Mobilization and BCC within existing relevant national policies , procedures and strategies destined to deliver hygiene and environmental health services.

The satisfaction of all who made inputs into developing this important document will not only be that they have made inputs, but that the guideline will be implemented as set out frameworks , with innovation and flexibility depending on the situation on the ground.

At the end of the day, this policy document should help to standardize progressive implementation of an integrated Advocacy, Social Mobilization and BCC interventions. The guidelines promotes and encourage concerted and coordinated efforts among key stakeholders engaged in hygiene and environmental health sectors, as well as serve as a tool to enhance the effectiveness of service delivery by relevant stakeholders in promoting positive hygiene and environmental health behaviors in urban , per urban and urban settings.

Abbreviations

BCC	behavior change communication
CLTSH	Community-Led Total Sanitation
EDHS	Ethiopia Demographic and Health Survey
FOAM	Focus, Opportunity, Ability and Motivation (for Handwashing with soap)
HWWS	Handwashing with soap
IPC	Interpersonal Communication
KAP	knowledge, Attitudes and Practices
M&E	Monitoring and Evaluation
MoH	Ministry of Health
NGO	Non-Governmental Organization
OD	Open Defecation
PHAST	Participatory Hygiene and Sanitation Transformation
RWSSH	Rural Water Supply, Sanitation and Hygiene
SaniFOAM	Focus, Ability and Motivation (for sanitation behaviors)

SNV	Netherlands Development Organization
UNICEF	United Nations Children's Fund
WASH	Water, Sanitation and Hygiene
WSP	Water and Sanitation Program of the World Bank

Table of content

Lists of tables and figures

Section I: Introduction

1.1. Overview

Ethiopia has made significant progress over the past few years in increasing access to improved water, sanitation and hygiene (WASH) among rural, per urban and urban population. This progress has been made possible through the guidance and efforts of Government of Ethiopia as well as investment, expertise and programmatic implementation from donors and civil society working in the sector. Despite remarkable accomplishments in the past decades in terms of improving access and utilization of basic latrines, proper hand washing practices and household water storages and treatment at the household level, Ethiopia stood among the lowest coverage of these basic facilities. Poor sanitation, hygiene and insufficient access to improved technology options remain major issues. Improving hygiene and environmental health status for rural, peri-urban and urban in Ethiopia requires a multi-pronged approach that puts equal emphasis on the behavioral as well as technological aspects of hygiene and environmental health.

In this context, behavior change is critical to continued progress, and it is one of the key objectives of the Government of Ethiopia. *The National Guidelines for Advocacy, Social Mobilizations, and Behavior Change Communication for Hygiene and Environmental Heath is developed, hereafter referred to as the National Hygiene and Environmental Health Communication Guidelines*.

The guideline recognizes a ranges but largely interlinked environmental health and hygiene behaviors are linked in clusters, either one behavior is leading to others or severalinterrelated behaviors reinforcing one another. For instance, families investing in sanitation are motivated to keep their facilities clean; consequently they may adopt personal hygiene behaviors such as handwashing with soap.

Like any other behavior change interventions this document also recognized creating an effective supportive and enabling environment through the well-organized Advocacy and Social Mobilization to bring sustainable behavior changes throughout the nation. This is proven by the designing approaches of communication guidelines. The guideline designed to address a step by step approaches where by the closing perception gaps knowledge, bring attitudinal changes and sustainably practicing new set of behaviors. In order to achieve this the guideline provide a frameworks through which each segments of audiences proved the required skills and develop capacity at institutional , communities , family and individuals.

Therefore, this guidelinesis mainly designed to provide the necessary guidance for professionals to increase their understanding in determining target audience, understanding their gaps anddesign effective integrated behavioral change communication programs through build on advocacy and social mobilization as a tool to create enabling environment.

This document therefore intended to serve as a quick reference tool for practitioners to develop a well harmonized Advocacy, Social Mobilization and BCC campaigns at national, regional, community and individual levels to address a gap pertaining to hygiene and environmental health behaviors.

1.2. Theoretical Models

1.2.1. The Socio Ecological Model

Sustained national economic development; improving road and communication infrastructures; improved literacy rate, particularly girl's education; industrialization (increase in local production of drugs and equipment, local manufacturers of food, etc.); and urbanization among others are recognized as opportunities in the analysis of the national context used for the planning process of

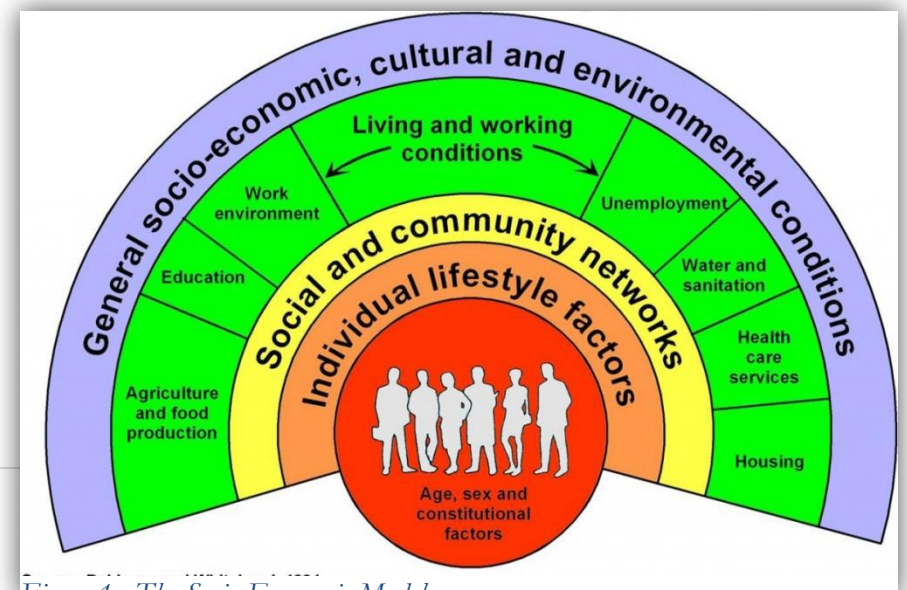


Figure 1 : The Socio Economic Model

the HSDP V.[1] Evidence shows that improvements in health status of population follow with progress in socio-economic developments which in turn contributes to empowering citizens to sustain gains. This implies that health is much more than mitigating illnesses as is frequently referred to. The World Health Organization (WHO) defines health as "...a complete state of physical, mental and social well-being and not merely the absence of disease or infirmity". In 1986 this definition was expanded to better define health. To reach a state of complete physical, mental and social well-being, an individual or group must be able to identify and to realize aspirations, to satisfy needs, and to change or cope with the environment. Health is, therefore, seen as a resource for everyday life, not the objective of living.

The Social Ecological Model is a comprehensive public health approach that not only addresses an individual's risk factors, but also the norms, beliefs, and social and economic systems that create the conditions for child maltreatment to occur. *Individual level influences* are biological and personal history factors that increase the likelihood of an individual becoming a victim or perpetrator of violence*Interpersonal relationship level influences* are factors that increase risk as a result of relations with peers, intimate partners, and family members. A person's closest social circle – peers, partners and family members – have the potential to shape an individual's behavior and range of experience (Dahlberg et al., 2002). Interventions for interpersonal relationship level influences could include family therapy, bystander intervention skill development, and parenting training (Powell et al., 1999).*Community level influences* are factors that increase risk based on community and social environments in which an individual has experiences and relationships such as schools, workplaces, and neighborhoods. Interventions for community level influences are typically designed to impact the climate, systems and policies in a given setting. *Societal level influences* are larger, macro-level factors that influence child maltreatment such as religious or cultural belief systems, societal norms, and economic or social policies that create or sustain gaps and tensions between groups of people. Interventions for societal level influences typically involve collaborations of multiple partners to change laws and policies related poor hygiene and environmental health practices.The guideline frameworks developed on the basis of social ecological models to leverage influences at individual, interpersonal relationship and social mobilization approaches concurrently.

[1]HSTP, final draft, May 2015

1.2.2. The Ecological Model

The guideline also built on key ecological models' assumption in that health and well-being are affected by *interaction* among multiple determinants including biology, behavior, and the environment. Interaction unfolds over the life course of individuals, families, and communities. An ecological *approach* to health is one in which multiple strategies are developed to impact determinants of health relevant to the desired health outcomes.

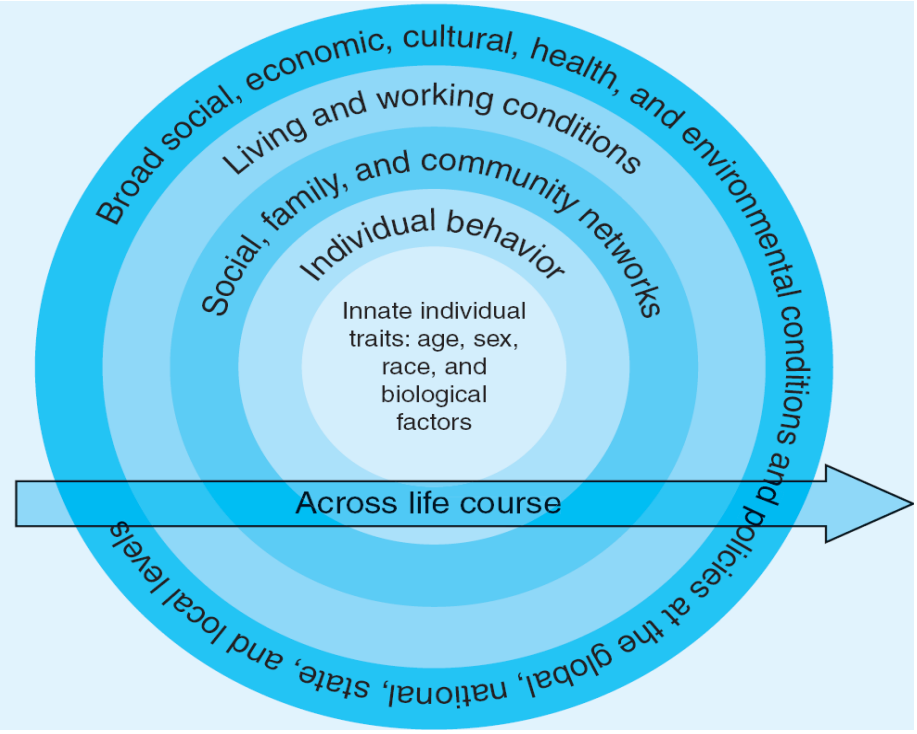


Figure 2 : The Ecological Model

Source: Adapted from: U.S. Department of Health and Human Services, Advisory Committee.

Physical conditions and behavior affect the health and social welfare of others, and it obviously affected by the physical environment. Public health experience has demonstrated that interventions conducted on multiple levels of the model are more effective than those focusing solely on one level. The guideline largely benefited especially model's concept of understanding each set of behaviors and developing highly contextualized communication approaches in the process of acquiring required health behaviors.

Ecological Model	Primary Intervention	Communication Support
National , regional and woreda	Policies, laws, treaties, "movements," emergencies.	Advocacy to create or maintain policy or law; national and state specific reinforcement advertising; Incentive programs; package warnings and labels; government educational campaigns; social mobilization.
Living and working Conditions	Environmental conditions; hours; policies.	Citizen or worker advocacy (multimedia) to improve conditions; awareness and promotion campaigns for improved facilities, services; state or local lead education campaigns; private-sector advertising.
Social, community, Family	Social norms; elimination of social disparities;provision of community health and social services;cultural "rules" for group behavior.	Grass roots campaigns; radio, TV, Internet, printor locale- (e.g., church, bar) based social marketingor promotional campaigns; opinion leadersand role models; psas; health fairs, small mediaeducational materials; reinforcement of normsthrough group processes.
Individual behavior	Acquisition of beliefs, attitudes, motivation, self-efficacy, products, and services through socialmarketing, behavior change communications,paid advertising, or psychological counseling.	Multimedia decision aids; educational materials; guidelines; promotional advertising; reinforcementthrough home, healthcare providers,community.

1.2.3. People and Places Model

The People and Places Framework Maibach,Abroms, and Marosits have developed a framework to diagram the processes of communication and marketing in terms of their potential for social impact they call the People and Places Model of Social Change. Speaking very plainly, they view the ecological model as people in environments or places, "What about the people, and what about the places, needs to be happening in order for the people (and the places) to be healthy?" Forces that affect people at the individual, social network, or community/population level are referred to as "people fields of influence."

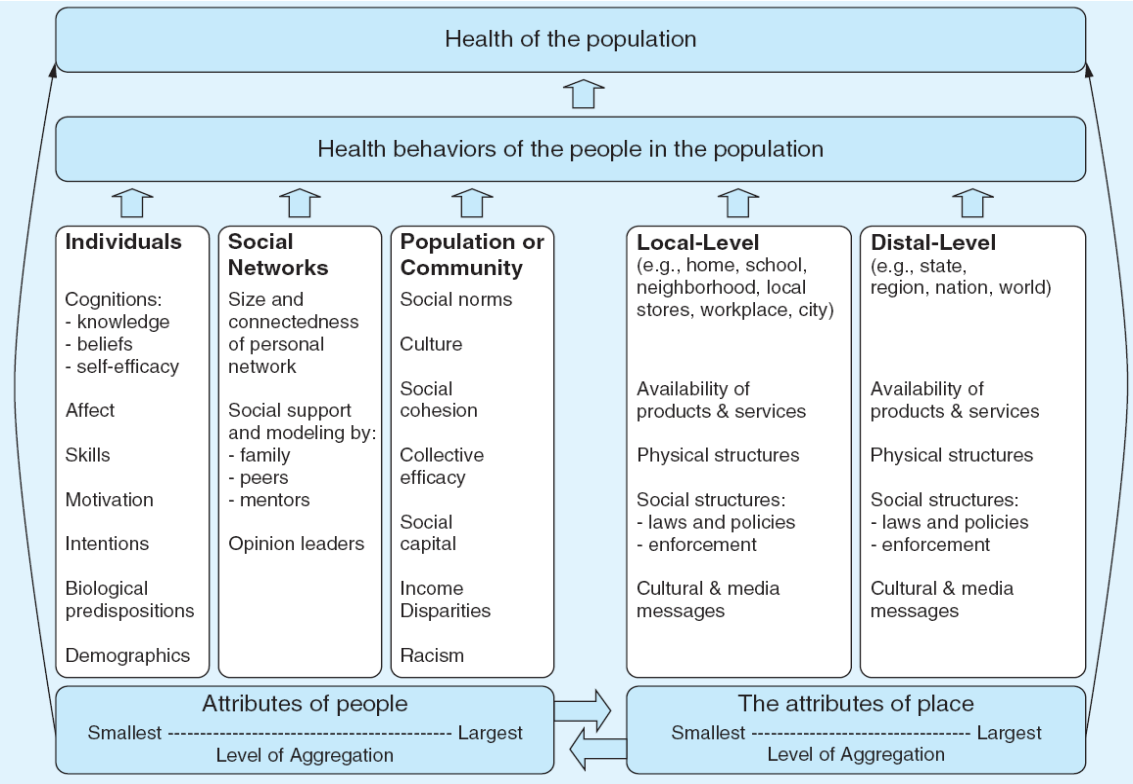


Figure 3 : People and Places Model

Source:Maibach, E.W.,Abroms, L.C.,Marosits, M. Communication and marketing as tools to cultivate the public's health: a proposed "people and places" framework. BMC Public Health; 2007, 7. Http://www.biomedcentral.com/1471-2458/7/88.

Forces that are linked inextricably to a local level or higher administrative level are referred to as "place fields of influence." The People and Places Framework (PPF) suggests that organization

marketing and business-to-business approaches and policy (legislative, corporate) advocacy are more effective at bringing about change in place fields of influence. Social marketing and health communication, which promote voluntary behavior change based on information,motivation, and self-efficacy, among other psychological processes, are more effective at changing people fields of influence.

It is in view of this the guideline utilized on this model the importance of fuller understanding of the problem to be addressed, the nature of the required behavioral change, and the levels of the ecological model on which it is needed to work in order to produce an effective communication interventions.

1.2.4. Precede–Proceed Model

The PRECEDE–PROCEED model has been used to guide countless public health interventions. Developed by Green and Kreuter, and their associates, in the 1970s, the model works backward from a desired state of health and quality of life and asks what environment, behavior, individual motivation, or administrative policy is necessary to create that healthy state.

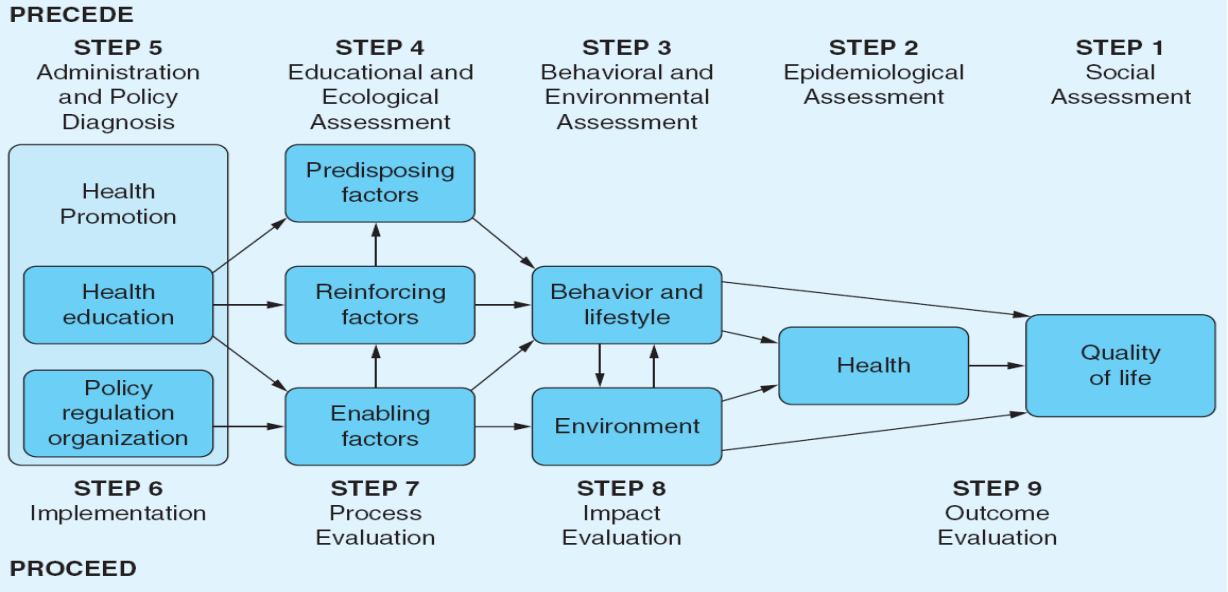


Figure 4 : Precede-Proceed Model

Modelsource: National Cancer Institute. Theory at a Glance, A Guide for Health Promotion Practice, 2nd Edition. NIH Publication No. 05-3896; 2005. Http://www.cancer.gov/PDF/481f5d53-63df-41bc-bfaf-5aa48ee1da4d/TAAG3.pdf

The needs assessment phase examines the predisposing, reinforcing, and enabling constructs in educational/environmental diagnosis and evaluation (PRECEDE). The implementation phase addresses policy, regulatory, and organizational constructs in educational and environmental development (PROCEED).

Predisposingfactors include existing beliefs, attitudes, and values (e.g., culturalor ethical norms) that influence whether a person willadopt a behavior. Enabling factors are largely structural, suchas the availability of resources, time, or skills to perform a behavior.

The model of communication has significantly contributing while developing the Advocacy, Social Mobilization and Behavioral Change Communications frameworks, which are could be pronounced as the three key interrelated pillars of this document.

1.2.5. National Health Communication and Promotion Frameworks

Based on the analysis of the national context and understanding of health communication gaps at the level of individual, community, social and environmental levels including enforcement of public health laws, a conceptual framework for the national health communication pathway towards the goal of improved health status is developed to identify domains of health communication interventions.

The purpose of the health communication pathway is developed to simplify understanding of the general context and the interplay of determinants impacting health. The context analysis helps to identify opportunities and challenges related to specific health issues and devise effective interventions for each of the domain of communication, namely; at individual/families, community, health facilities and at societal levels. The framework further illustrates how expected outcomes corresponding to each domain of communication and contributes to health status improvement, when the right mix of audiences, channels of communication and messages are applied.

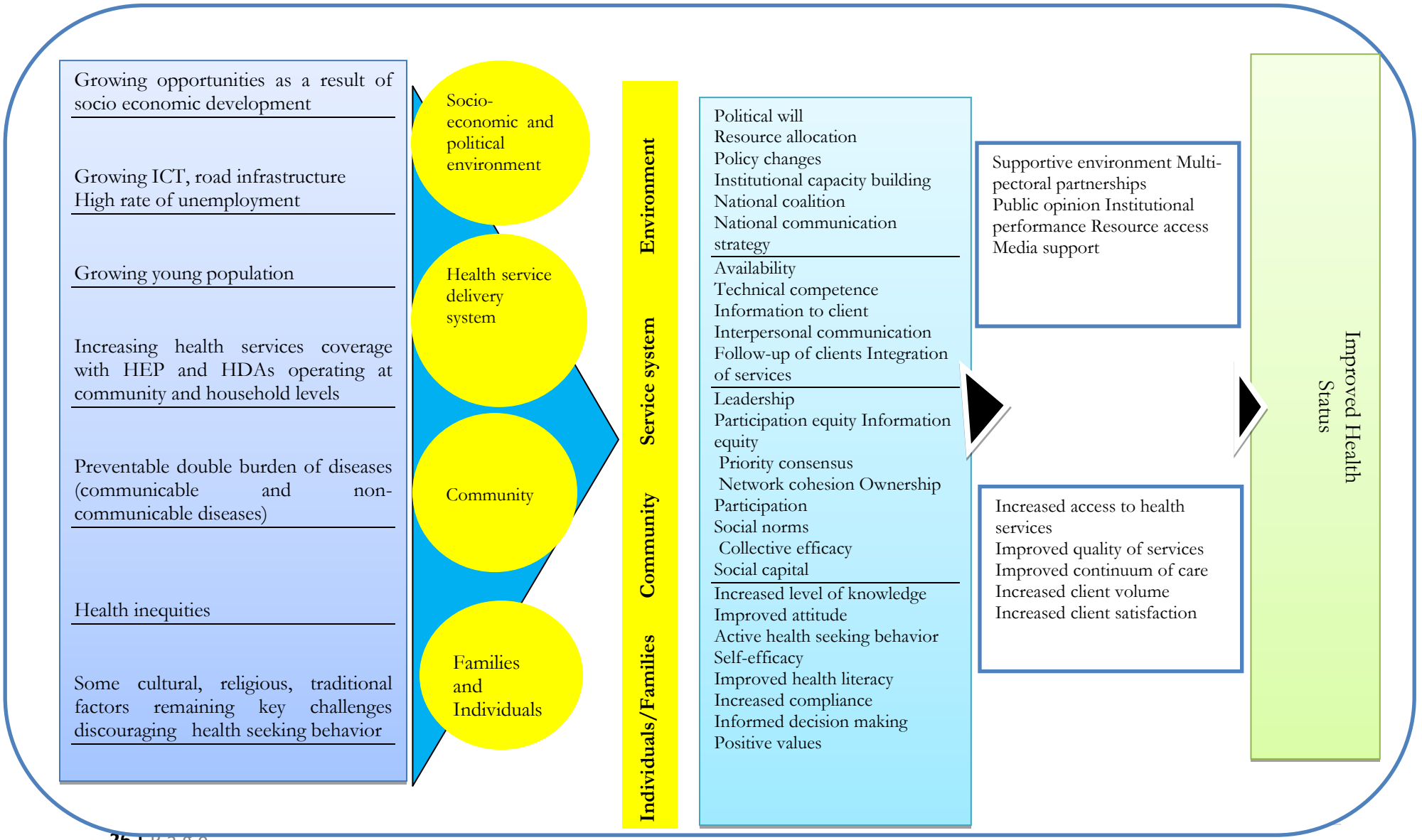
This communication guidelines harnessed the strategic pathway of the national health promotion and communication documents particularly in the section of defining and designing of integrated communication strategies for a set behaviors.

Thus, hygiene and environmental health communication guideline under the broader strategies and pathways wider national documents to ensure proper and integrated operationalization. Also designed to fit hygiene and environmental health sector documents such Hygiene and

Environmental Health Strategy (Final draft Sept 2016). In addition to these strategic document the guideline adaptation and development process on the basis finding from need assessmentfinding deliberated to inform conceptualization and operationalization process of this guidelines. This will be clearly presented and discussed on the next section guideline.

Advocacy .Social Mobilization .Behavior Change Communications

Figure 5 : National Health Communication and Promotion Frameworks



1.2.6. Scope of the Guidelines

1.2.6.1. Strategic Intervention Pillars

This document aims to support hygiene and environmental health professional working at federal, regional, woreda and Kebele levels for the government and development partners to plan and implement consistent, coordinated and effective hygiene and environmental health behavior change campaigns. It is also designed on the basis of practices,principles and theories of an integrated communication approaches.

The communication guideline is built on three key pillars. These are Advocacy, Social Mobilization and Behavioral Change Communications to address set of hygiene and environmental health behaviors.Strategically the document designed to focus on three most interrelated pillars of intervention. These are Advocacy Communication, Social Mobilization and Behavioral Change Communications.

A. ***Advocacy Communications***: Advocacy is an overarching pillar of this communication guidelines which is a single most important components of the guideline designed to inform and motivate leaders and public figures to ensure that enabling environment is created to support the overall communication campaigns achieve program objectives and development goals at national , regional , woreda and community levels.
B. ***Social MobilizationCommunication***: The social mobilization section the second most important component of this guidelines. It envisaged tooutline engagement and ensure harnessing institutions opportunities, community networks,and health development armies, social/civic and religious groups in enhancing demand for or sustain progress toward national and local development linked to positive hygiene and environmental health behaviors.
C. ***Behavior Change Communication***: The BCC section clearly sets out a mechanisms through which face-to-face dialogue with individuals or groups to inform, motivate, problem-solve or plan, with the objective to promote and sustain behavior change at individual, community and household levels.

Hygiene and Environmental Health a broader disciplines the guideline provisionally identified key thematic areas to focus at the outset of operationalization of the guideline using behavioral auditing and mapping to ensure the relevant priority areas (See section xx). The following table developed to serve practitioners in prioritizing key behaviors while designing Advocacy, Social Mobilization and Behavioral Changes Communication tools. It is presumed that those with higher priority will be addressed in the initial stage over medium and lower one.

Table 1: Summary of focus hygiene and environmental health behaviors with different level of priorities

S.N	Key thematic areas identified	Level of Priority			Remark
		High	Medium	Less	
1.	Proper & safe excreta disposal system - household	√			
2.	Proper & safe excreta disposal system – institutions	√			
3.	Proper & safe solid waste management	√			
4.	Proper & safe liquid waste management	√			
5.	Safe water handling	√			
6.	Personal hygiene	√			
7.	Emergency WASH[2]		√		
8.	Food & hygiene safety measures	√			
9.	Healthy home environment		√		
10.	Arthropod & rodent control		√		
11.	Pollution control & climate change adaptation & mitigation		√		
12.	Occupational Health and Safety Management		√		

[2] *The fact Emergency WASH has been provided a medium priority is on the basis of available strategy and communication tools in a separate policy documents. This guidelines expected to contribute immensely from prevention point of view.*

1.2.7. General Objective

To bring total positive behavioral changes towards a proper hygiene and environmental health practices through effective harnessing of different communications channels and messages throughproviding guidance in the process of designing, implementation and monitoring of communication programs.

1.2.8. Specific Objectives

- To increase the sector's understanding of the knowledge, attitude and practices of different target groups in relation to hygiene and environmental health behaviors issues;
- To avail evidences to support prioritization of key behaviors while designing communications messages in backing of local level practitioners in the process of developing and implementing effective communications campaigns;
- To articulate possible communications channels to be harnessed in the delivery of hygiene and environmental health related communications campaigns and
- To provide a framework for monitoring advocacy , social mobilization and Behavioral Change and Communication Campaigns in lieu of existing health and WASH monitoring systems.

1.2.9. Methodology

This strategy document was developed through processes outlined below. Initially, an extensive literature review to analyze hygiene and environmental health situation and to assess behavioral barriers and motivators to own and practice certain behaviors. The literature review included relevant project documents, international literature to give an overview of the global WASH situation, various studies done in the country, the Joint Monitoring Program (JMP) of WHO/UNICEF and provider-based water and sanitation.

The process of preparing this guideline began with an intensive review of existing knowledge products such as consumer research, KAP assessment, baseline surveys, published and unpublished articles, etc., pertaining to hygiene and environmental heath behaviors. Followed by a Situational Analysis of the hygiene and environmental health in Ethiopia. The situational analysis included a review of documents of national level studies such as the Ethiopia Demographic and Health Survey

(EDHS) reports, relevant policy, as well as studies, manuals and guidelines prepared by the Federal Ministry of Health , Ministry of Water Resources , Ministry of Environment Protections. Local and global strategies, guidelines, manuals focusing on BCC strategies for Water Hygiene and Sanitation, Malaria Prevention, HIV/AIDS and etc., has also been reviewed and feed the development of the underpinning principles , methods and approaches of the guidelines.

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Preceded by a series of stakeholder interviews and consultation were conducted with a range of policy makers, programstaffs, development partners and service providers. Then, consultative meeting was organized with regional health bureaus to get insight from regional health bureaus align national interest with regions, conducting preliminary KAP analysis, behavior audit and prioritize key interventions.

A communication technical working group with fair representation fromGovernment, Development Partners; International NGO, Faith BasedOrganizations (FBO), the Media and the Private Sector actors provided strategic inputs in the course developing the guidelines. The document also moderately benefited from Africa regional and Global insights towards finalizing the process of developing the guidelines.

The document was circulated for communication specialist from different sectors. The document also benefited from insights from regional and global professionals during the course of thedevelopment process.

In the end, a validation workshop were organized to solicit inputs received from key stakeholders , partners and implementers before officially launched and fully endorsed by the Federal Ministry of Health and wider hygiene and environmental health sector actors.

1.2.10. Outline of guidelines

The overall outline of the National Hygiene and Environmental Health Advocacy, Social Mobilization andBC communication guideline organized into six interrelated sections. The first sections present a general background and an introduction tobehavior change theories and models. The second section is where a background information is discussed and presented. In this section situational analysis and insights pertaining to key hygiene and environmental health behaviors research findings pertaining to hygiene and environmental health behaviors. This section also has shown the Knowledge, Attitude and Practices matrix supported with relevant statistics. This section also explained key behaviors and methods of prioritizing while communication tools.

Thethird section conceptualized communication guidelines into Advocacy, Social Mobilization and Behavioral Change Communications. This sections has also used finding from the situational analysis to prioritize key behaviors based on the resent status of broader hygiene and environmental health behaviors.

Section five presents the overall communication strategies approaches. This section set out to show how the audience segmented, develop customized messages for each segments and identifying communication channels and tools. Section six aim to show how the management of communication planned, monitored and evaluated during implementation of the guidelines. The last section this documents recommends operation frameworks, strategic milestones and implementation modalities to consider during implementation process.

2. SectionII:Background and situation analysis

2.1. Review of existing policies and strategies

The documents managed to harnessing policies, strategies, programs, manual and guideline aiming to promote positive health behavior developed at federal, regional and community levels in the course of development process. The situationanalysis largely build on the recently developed National Health Promotion and Communication Strategy.

2.1.1. Overview of national health promotion and communication strategies

The recently drafted National Health Promotion and Communication Strategy coined its overall goal to provide the necessary guidance to harmonize health communication interventions and drive improvements in implementation to increase knowledge, realize positive behavior change, healthy practices, increase demand of health services and facilitate a supportive enabling environment for sustained health outcomes, and ultimately improved health status of the population. The specific objectives clearly indicated as:

- Improve knowledge, attitudes and practices including addressing barriers for behavior change and community empowerment.
- Enhance community empowerment through capacity building of frontline workers /HEW, HAD/ and community leaders by promoting the use of standardized community guidelines and manuals.
- Promote and advocate for multi-sectoral involvement in addressing social determinants that affect health and mainstreaming health promotion in sectors including influencing policy & legal support and advocating for supportive enabling environments.
- Enhance effective engagement and wide use of public, institutional, social and community media and other new technologies for health communication programming in order to strengthen audience specific and need based social and behavior change communication programs.

- Ensure effective implementation of the strategy through continuous monitoring, evaluation and dissemination of best practices at different levels.

It is believed that the strategy is expected to provide a framework to guide the designing and planning of health communication and education interventions. To this end FMOH is expected to commit in implementing and realizing the vision of this strategy. The strategy is designed to build on national and regional capacity for sustaining health promotion and create an enabling environment for the people to have access to and adopt healthy behavior and to see a productive community that cultivate, harvest and consume its own health in the long run.

The NCH strategy also clearly defined the role of internal and external stakeholder in realizing the strategies goal. In this regard , the Health Extension and Primary Health Services (HEPHS) Directorate is bestowed crucial roles to coordinate the HEP including primary health services, Hygiene and Environmental Health and the Health Education and Promotion activities (Draft NHC Strategy , 2015).

2.1.2. Summary of relevant hygiene and environmental health and supporting policy

In an attempt for the hygiene and environmental health communication guideline to align, build and harnessing of relevant policies, strategies, manuals and guideline an intensive review were done on existing government strategic documents. An overview of the findings from this review is summarized as shown on the table below.

Table 2 : Overview of relevantstrategies,polices, guidelines and manuals

Strategies/Policies/Guidelines/Manuals	**Focus**
Health Sector Transformation Plan - IV	Building on the Health Extension Program's momentums HSTP-IV accelerating improvement of hygiene and environmental sanitation: excreta disposal, solid and liquid waste disposal, water quality control, food hygiene, proper housing, vector control (arthropods and rodent control), personal hygiene, health education and promotion.
National Health Promotion and Communication Strategy (Draft July , 2015)	Setting Strategic Frameworks and Guidance for developing health promotion and communication tools across the health sector.
Public health emergency management guideline (2012)	Health education and communication to the public to increase community participation
National measles surveillance and Outbreak management Guideline 2012, *Comprehensive multiyear plan (2016-2020) and EPI Implementation Guide*	Communicate outbreak findings for health professionals, communities and individuals
Health Extension program manual;	Health extension packages, community mobilization approaches and IEC/BCC
One WASG National Program	Aligning efforts of government agencies and development partners to improve uptake sanitation facilities.
CLTSH Training and Verification Guideline (2013/14)	Improve basic sanitation coverage through community mobilization tools
National Sanitation Marketing Guideline(2013)	Improve coverage of improved sanitation technologies through creating enabling environment to engage private sector in the sector.
National Sanitation and Hygiene Strategy (2005) – Under revision	Under revision
National Sanitation Technology Option Manuals (2010)	Popularize and promote exiting sanitation technology options.
Onsite Sanitation Protocol (2005)	Under revision
National Menstrual Hygiene Management Strategy (2015)	Under development
National Oral Hygiene Strategy(2015)	Under development

WASH and the Neglected Tropical Diseases Manual (2015)	Practical guide to WASH practitioners working to implement, support, and sustain WASH interventions at the country level.
National Health Facility WASH Manual	The provision of improved sanitation facilities will benefit mainly Health Centers and Health Posts.
Ethiopia Occupation Standard , Curriculum and TTLM (December , 2015)	Increase understanding basic principles of Hygiene Management for Entrepreneurs and Enterprises.

2.1.3. Stregth , Weakness , Opportunities and Threates (SWOT)analysis hygiene and environmental health sector

The recently SWOT analysis conducted to feed the National Health Promotion and Communication Strategy. Some of the relevant points were with a very few additions are presented as follows.

The strengths and weaknesses of health promotion and communication, and the opportunities and threats are summarized and presented as follows:

Strengths:

- The existence of the health development army structures;
- A well established, sustained health extension program with skilled workers;
- Continuous initiatives in disseminating health information to create awareness, publicize timely health issues, and keep the public at large informed;
- A functional Health Extension and Primary Health Services ;
- Existence of A Health Education and Communication at different levels,
- Policy environment for integration of health communication and opportunities to leverage resources;
- Strong emerging commitment for leadership and coordination role to continuously adopt innovative and effective interventions to encourage communities'
- Supportive policy such HEP , Sanitation Marketing Guidelines, Job creating and productive safety net programs , One WaSH National Program and
- Functional institutional structures capacity at federal, regional, zonal ,woreda and Community levels to develop , implement and monitor interventions.

Weaknesses:

- Limited understanding of the need and importance for specific planning of health promotion and communication;
- Inadequate strategic guidance and follow up for health promotion and communication interventions;
- Inadequate political commitment for health promotion interventions at every level;
- Inadequate monitoring and evaluation mechanisms in place to follow up and assess the effectiveness of health communications and their impacts.
- Insufficient national/regional guidelines on health communications ((Inter personal Communication Counseling (IPCC), advocacy, community empowerment).
- Insufficient experts in behavior change communication and proper placement at appropriate positions at all levels,
- Absence of structure and staffing at zonal and woreda level for managing health promotion and communication interventions,
- Inadequate resources allocation for health promotion and communication interventions,
- Insufficient harmonization and alignment of health communication and promotion interventions with law enforcement;
- Absence of emergency communication capacity and functional system to address public health emergencies during manmade and natural disasters,
- Loosen harmony and alignment within and inter sector which creates duplication of efforts and inappropriate utilization of resources,
- Limited efforts to harness existing enabling environment and institutional arrangements to design and intervene at scale BCC programs,
- Multiple communication strategies being implemented in the country which in most instances attributed among community as a sign of failure and communities growing tendencies in developing resistances for existing non-consistent and campaign oriented communication tools,

- Limited focus and deployment of resources to understand consumers behaviors as an entry point for designing evidence based approaches and
- Limited research and development effort to better understand behaviors to develop evidenced communication interventions.

Opportunities:

- Increasing number of community radio/TV outlets and print media;
- Increasing Inter-sectoral collaboration and availability of grassroots level structure and HEWs HDAs community participation;
- Steady increase partnership to make use of expertize and resource with partners
- Growing ICT infrastructures including the mobile and electronic media that have improved capacity to reach wider audiences.
- Increased level of expansion of schools and increasing in literacy rate
- Increasing opportunities for public-private partnerships to promote healthy lifestyles.
- Availability of supportive guideline and strategies such CLTSH , Sanitation Marketing Guidelines, Sanitary Works related Curriculums,
- Opportunity to hygiene and environmental health sector link with the national job creation strategies to improve access for hygiene and sanitation products,

Threats:

- Inadequate multi-sectoral collaboration in terms of pursuing fragmented and multiple approaches being undertaken within the community,
- Increased emergence of public health problems such as solid and liquid waste management in urban areas, water and sanitation, NCD, etc.
- Limited access to TV media constrained by unaffordable price for broadcasting fees;
- Low level of adult literacy rate;
- Emergency situations such as outbreaks and natural disasters;

- Climate changes and its effect on health;
- Increasing urbanization and industrialization;
- Audience diversity while using mass media
- Behavioral change needs long time,

Hygiene and Environmental health improvements of the country would not be possible without the improved awareness and behavior change among the people as a result of information, communication, social mobilization and advocacy work. Immense progress has been observed by the Ministry of Health, RHBs, civil societies, community-based organizations, partners and the media.

Yet, the capacity to lead, coordinate, harmonize, develop and guide implementation as well as monitoring and evaluation of health communication at all levels (FMOH, RHBs, Districts, Community) need to be enhanced through harnessing opportunities and strengths to address limitations and proactively manage emerging threats.

2.2. Research insights : Hygiene and Environmental Health Sector

This section aim to provide the context of hygiene and environmental health sector in Ethiopia based on research findings conducted to understand individual behaviors and the wider sector. The findings will be presented in two section. The first section is mainly focuses on individual level categorized as focal behaviors. The second category aimed providing back ground about the wider hygiene and environmental health sector practices focusing institutional and industry level practices.

2.2.1. Focal behaviors

A. Proper hand washing practices at critical times

A systematic review of trends of national hand washing practices showed that hand washing after possible contact with excreta is still far from universally practiced.The high income countries with data on hand washing frequency show rates varying between 48% and 72%, and low income countries, with whom Ethiopia has been categorized, show lower rates varying between 5% and 25%. With this very low hand washing with soap after using the toilet, much promotional and behavior change communication work is still needed to increase the frequency of this practice.

In Ethiopia knowledge of critical hand washing moments was reported in only 23 % of the total respondents (UNICE/WVE, June 2015). The same research found out that a little over half of the respondents know two of the five critical times of hand washing, which represents around 58% of all respondents.

Practicing hand washing at critical times for hygienic practice is important but also the properly way of hand washing is an essential aspect. There is an evidence from survey indicating that among those practicing hand washing practices majority of respondents barely wash their hands with water using appropriate materials like soap or ash.This is an indication that much has to be done on hygiene.

The hand washing situation seems the least satisfactory in schools where it was rare to find children who washed their hands after using the toilet and even more difficult to find the washing hands even before eating a snack while at school (UNICEF , 2010). The same research revealed that school aged children are aware of some hand washing junctures and know that toilets harbor germs; because of this, the importance of washing hands is emphasized. Washing hands before handling food is important but not as important as washing hands after eating. Similar to the findings of the community study, knowledge related to junctures among the children was high for some junctures (before eating and after using the toilet).

It was, therefore, concluded that while knowledge levels of some key junctures was fairly high, greater awareness needs to be raised concerning others junctures such as, after cleaning a child's bottom and before breastfeeding. School administrators cited budget constraints in providing soap. An issue noted in the behavioral trials in homes was that soap was regarded as a precious commodity and the fear that it could be eaten by rodents or stolen by others made them store in a plastic paper in the house. This could also be regarded as a barrier for practicing hand washing since most of the hand washing was shown to happen outside the house, except when cooking. Most of the schools rely on community water sources and do not even have reserves for drinking. In the few schools with water, it is most commonly reserved for use by the school administration. Hands were noted as washed to remove dirt and to avoid diseases. However, the method noted for washing hands was with water only in most of the instances.

Insights from the consultation meeting held with regional stakeholders also revealed not only knowledge gap, mainly proxy indicators like lack of water is the main problem. Regional

professionals also concur and share on some the research findings there is only partial or incomplete knowledge of proper hand washing practice. There is a lasting belief that the incompleteness of the knowledge inhibited from bringing positive changes in terms of develop good attitude and sustainably practice proper hand washing. It is also reflected that there is a notion of ignoring to wash hands whenever attending social events such as *Wedding, Graduation, Senbete, etc.* The proper way of washing hands before eating foods requires a due attention before this practice further develops. In terms of access for water and soap in public and business service providers such as cafeteria, restaurants, etc., there is no such facilities functioning properly to support the hand washing behaviors.

In sum, there is a growing evidence from research and KAP surveys revealing at school and community revealing that society has some level of knowledge proper hand washing. In most research findings it is cited either the society has incomplete information of critical timing of washing hands or do not provided the required attention for proper way of washing hands in those critical times. It is also learnt that there is encouraging development in terms of changing attitudes it still seems wider gap than increasing awareness of the society at large. Due to incompleteness of knowledge of hand washing behaviors, changing attitudes and most importantly lack of access for supporting enabling environment such as hand washing facilities and costliness of soap are the most pronounced factors inhibiting adoption of sustainable positive behaviors.Lack of consistent knowledge about each set of behaviors is given for hand washing after and before meals while little attention is given.

Based on presented evidences one can understand there is some level of knowledge in terms of proper hand washing practices but it still requires systematic way of addressing gaps the incomplete and inconsistencies of knowledge among the rural and urban segments.One way of addressing this is start working to bring the relevant attitudes so that people start proper practicing sustainably.

B. Constructing, utilizations and maintaining of improved latrines

In recent years Ethiopia has achieved remarkable result in terms of reducing open defecation practices. However, open defecation remain one of the challenges for appropriate hygiene and sanitation practices in Ethiopia. There is an evidence supporting that insignificant segments of the total population own and utilize toilets. The national figures (CSA, 2014) shows that 89% use un-improved toilet facilities (96% in rural areas and 53% in urban areas). The most common type of un-

improved toilet facility is an open pit latrine or pit latrine without slabs, used by 57% of HHsin rural areas and 43% of HHsin urban areas. The majority of the HHshas access to improved water sources but use unimproved latrines. This is likely caused by the fact that water and sanitation interventions are often combined i.e. Aproject that provides support for construction of new boreholes will often also have a sanitation component that promotes the use of improved latrines.

The structure of the latrines determines whether it will be used hygienically and also helps in defining the sanitation of the community. Most research finding broadly shares on the notion that majority of the latrine structures in use mostly lacks basic structure such as being an easily cleanable slabs. Though those latrines which have this structure are high in number, most of them are not constructed well enough to prevent flies and to avoid direct contact with feces. It is not surprising fact most of the latrines, especially, are only built from locally available materials. Most research finding revealed that cleanliness of the latrines from the point of how clean the latrines were at the time of the visit households, which revealed mostly latrines are not clean. Though some of the HHshave latrines the sanitation, cleanliness and regular maintenance of them is found to be low which minimizes the amount of protection it gives from contamination brought by flies.

There is also emerging research insights revealing that not only management of child feces rated as poor but also parents do not allow their children to use latrine at their early childhood stages. The most prevailing practices of managing child feces seems disposing child feces their homestead garden.

The regional consultation meeting outcomes shown that stool of young children are considered as harmless, or at least less harmful than those of adults, because they are smaller, their feces smell less, and contain less visual food residues.

Only one third of the mothers/caregivers practiced safe child feces disposal in Ethiopia. This mean that two-thirds of the population was at increased risk of pathogen exposure from contaminated environment with child feces besides other contaminants. Safe child feces disposal practice may be particularly important in prevention of fecal-oral transmission as children are more susceptible to these diseases and are often defecating in areas where other children could be exposed.

Knowledge about latrine use indicated that most of the HHssee the benefit of using latrines as being about maintaining privacy rather than the alleviating risks attached to open defecation such as such

as diarrhea. A perceived increase in status was also found to have significant role in the uptake of using latrines.

Open market places, bus stations and fence corners in town are ideal places for open defecation, something which has the potential to affect the health of the wider community. Moreover, the study areas did not have solid waste management mechanisms.

The leading barriers related to construction, maintenance and utilization of latrines among communities seems over high expectation of subsidy among the community members (SNV, Nov 2015). The same research revealed also unavailability of construction materials, frequent collapse of exiting unimproved latrines due to termites and loosened soil, failure to consider toilet as part of their home and social isolation and taboos for discussing personal hygiene among people with disabilities

According to research insights in the field there is no equal level of understanding of utilizing latrines among disabled and elderly with the rest of community segments when it comes to utilization of toilets. This is largely attributed that existing facilities do not accommodate or accessible for people within this segment. Existing community mobilization tools such CLTSH does not consider or accommodate these segments of community.

It is also understood that community failure to recognize latrine as part of the major infrastructure during construction of houses and other institutions were also surfaced as a barrier for owning and utilizing improved latrines both in rural and urban settings. Lack of functional supply chain for affordable sanitation facilities especially among the rural community is other factors inhibiting to construct and utilization of sustainable improved latrines.

C. Household safe water handling and treatment

The source and amount of water collected has a direct relationship with hygiene and sanitation practices of the households. This is because water collected from unimproved sources is prone to contamination .It is generally understood that collecting water from improved sources might not assure access to safe drinking water.

There is an evidence revealing that majority of HHsprefer to store water at the household level by using narrow mouthed containers. Materials utilized for water collection and storage vary in type and

size across the segments of the community. Most of the materials used for collecting water are narrow mouthed containers like Jerry-cans. In Ethiopia, the use of jerry cans to transport and store water was ubiquitous. Jerry cans are repurposed containers (e.g., that originally contained cooking oil) that are used by households. The jerry can also represent trade-offs between aesthetics and practicality. While clay pots were identified as a favorite style, the realities of transport, storage, and use make jerry can the container of choice. Research finding and field observation revealed that although narrow naked Jerry Cans are a better option amongst the types of storage households are recently using, they are also posing a challenges due to their inconveniences to wash inside corners, there is a fear among professional for possibility to turns them as sources of contamination. Wide mouthed water storage clay pots are mostly used in most hot climate areas for the purpose of cooling drinking water, but are liable to contamination at household level.

Lack of knowledge on different household water treatment options among the community is also one of the challenges of the households hampering them to practice proper treatment of their water. This lack of knowledge mainly attributed the limited efforts of the sector actors and private suppliers in education consumers on the benefits of consistently using house hold water treatment chemicals. In some areas although there is a growing demand to use these chemicals , insufficient supply of water treatment chemical distributing/selling outlets is becoming a barrier to practice water treatment.

HH level water storage using wide naked containers needs to be further worked upon. Despite water collection from improved sources, the level of water contamination with e-coli will be high. This requires integrated efforts of protecting water from contamination throughout the whole chain, from source to consumptions.

Several research finding in Ethiopia recognized and shared availability of knowledge gap in terms of safe water chain management among rural and urban community. This significantly affected the practices of water treatment at house hold level. Research findings also revealing that there is a long lasted misconceptions among the community for considering clear water as safe. There is also understanding among community, if the source of water is safe at the source such as pipe water and/or ground water, it does not require treating it before consuming. In addition, there is widely accepted beliefs that if water looks like clear with naked eyes; there is no need for treating it. There

are a number of misconceptions among the community such as "any water is as good as every mother" and "water is holly".

Awareness of drinking water quality and the need to treat drinking water varies in most instances. Some participants were familiar with consumable water treatment products (such as BishanGari); however, most had no experience with durable HWTS products. Participants were familiar with some water treatment products, in particular, two chlorine-based products, Wuha Agar and BishanGari. However, none of reviewed knowledge product reported for the regular treatment of their household drinking water.

Even if source of water is clean, the team observed a variety of opportunities for recontamination during collection, transport, and storage—using hands as a funnel during water collection; insufficient cleaning of transport and storage containers; uncovered drinking water storage containers in the home; and potential for contamination during dispensing drinking water at the point of use. There is a need for a greater awareness of water treatment products and a better understanding of reasons for use.

Insight from consultative workshop concur that people consider that water cannot kill instead give life in some cultures. Mostly the rural community argue that chemically treated water changes the natural test of the water. This is also reflected one way or another in practicing safe water treatment behaviors. Instead the rural community practice alternative way to treat their water some these are fumigating of water container is considered as disinfectant and simply rinsing water container is considered as sufficient for cleaning, which professional categorize these behavior as an inappropriate. Some of related barriers to proper safe water management at the household level includes inaccessibility and inadequacy of water, unavailability of water treatment, where there is access affordability of these chemical for the majority of the community members is also another challenges.

D. Proper menstrual hygiene management (MHM)

Menstrual Hygiene Management is one of the less documented obstacles that hinder girls' education in developing countries is absenteeism during menstruation. Studies by Mooijman et al (2005) and VarinaTjon-A-Ten (2007), have shown that marginalized girls can miss up to four consecutive days of school every four weeks due to their periods, meaning that they miss 10-20% of school time,

seriously impacting on their achievement at school. This is due to poor menstrual hygiene management caused by both lack of information, privacy and access for affordable sanitary pads (UNICEF, 2009) and (WEDC, 2012).

In Ethiopia, a need assessment conducted by Tiret Community Empowerment for Change Association (TCECA), a local NGO, indicates that school-aged girls face significant challenges with the onset of their menses, and receive little information or support from family or teachers since menstruation is often perceived as being polluting or shameful. Even health extension workers report that the issue is not covered in their trainings and that they do not talk freely about menstruation because of its taboo nature.

Recently conducted research shows that significant number of school girls who attained menarche voted for having knowledge of menstruation before they had attained this stages (UNICEF/WVE, June 2015).The most common sources of information school girls, sisters and friends. Most of the school girls have also indicated that here is no adequate facility at schools to properly manage. Similar studies also revealed that although they have some level of knowledge they have explained that there is no supporting facility to practice hygienically. It is also indicated that those with appropriate knowledge about menstrual hygiene are most likely to manage properly over those do not have knowledge. Absence of sanitary pads coupled with lack of WASH facilities has a negative impact on girls' education.

There is similarity on research findings that in most instances girls do not get adequate and affordable sanitary protection both commercially produced and homemade to enable them to continue attending school while having their menstrual cycles. In the current market in Ethiopia sanitary pads are sold for with unaffordable price points for most of women and girls. There are recently published research findings claiming that inadequate information and general lack of awareness about menstruation and its hygienic management by girl's, schools and community members in Ethiopia. Menstruation in many cultures is associated with silence, shame, impurity and other social taboos restricting mobility and freedom of women and girls. In Ethiopia there are both religious and cultural factors that restrict women and girls from any participation while observing their periods. Menstruation is particularly a strict taboo topic among certain ethnic groups and religious traditions. Amongst the Gumuz in Benishangul Regional State, a girl menstruating for the

first time will be isolated and sent away from home and made to stay in the menstruating hut. Her eating and drinking utilities will be isolated and thrown out later after that because the process is considered as impure and unclean (Bellene 2011). This perception is further aggravated by the lack of washing and bathing facilities, sanitary napkins and private space that can help women and girls manage the menstruation.

In terms of addressing poor practice of MHM experts suggested importance that the mother should have the correct and appropriate knowledge on menstrual hygiene to educate and support their daughters on they should be managing it.

Absence of girls' friendly toilets at school discourage girls from attending school (World Bank, 2009). Many of the toilets do not have cover, doors and comfortable seats. In such situations, girls will have no private place to change their napkins and WASH facilities to clean themselves up and change napkins. Most existing sanitation and hygiene facilities plans and designs completely ignore this very real need of women and girls to manage menstrual release.

Disabled students are a reality of every community and school. Existing WASH facilities do not address their special needs in planning design, implementation and hygiene promotion. In accessible schools are barriers to disabled students education. This is even more critical for girls at the onset of menstruation and may contribute to greater dropping out of school.

The research draw lessons, school girls who do not have knowledge and awareness about menstruation fell discomfort and become in tension which hinders them from attending the classrooms. They also feel shy for instance the boys consider them as they are harassed which later results in dropping out from classrooms and even till they totally dropout from school. They stigmatize (show sign of socially unacceptable) from schoolmates.

The consultative regional workshop reinforced that persistence of belief that menstruation is a sign of bad thing among community members. Due to this believes women are not allowed to attend temple and mosques. They are also forced stay around home while they are menstruating. In some segment of community such as Gumuz, other household member do not eat a meal which is prepared by a woman on menstruation. There is also unsafe disposal of used menstruation pads in urban setting.

In sum, analysis of exiting knowledge products such as KAP survey, lessons from intervention and National MHM strategy revealed that society has reached at different level of understanding about MHM. Also many of the research insight revealed that good level of understanding of the matter will most likely to lead to action – proper menstrual hygiene management. It is also evident that majority of the community reported that there is no supporting environment to properly practice bot at school and home.

It is based on this that the following consumer audit developed to indicate the level of audiences in terms of Knowledge, Attitude and Practice.

E. Proper face hygiene practice

Apart from the clinical barriers to accessing eye health services, the lack of eye health knowledge by the poor is another barrier. The majority of people in developing countries, especially those from poor households are illiterate and uneducated when it comes to eye health. Good quality information and advice concerning eye health have not been widely available to the public, especially in developing countries. According to Gilbert (2008), people from poor households lack eye health knowledge, are illiterate and they lack motivation for reasons to correct eye conditions. There are individuals who believe blindness is a natural part of ageing and therefore nothing should be done about it. Gilbert (2008) affirms that for older people in developing countries, going blind is considered inevitable and they see no reason why it should be prevented or treated. The lack of knowledge does not only prevent people from accessing services, but it also perpetuates the conditions which are detrimental to their well-being. As stated by Gooding (2006), households find themselves deeper into poverty after acquiring the disease than before the disease because they lack the knowledge needed to treat their condition. In addition, illiterate people (often those who are poor) are usually left in the dark as some believe that treatment will make their vision worse. In a recent, 2011, study conducted in kwazulu-Natal by the Brien Holden Vision Institute, respondents reported that the fear of poor outcomes from eye correcting techniques prevents them from correcting their vision. Individuals from poor households believed that eye treatment may make their vision worse. In accordance, Gooding (2006), points out that other studies have found that individuals in developing countries are exposed to conditions leading them to contracting eye conditions, and since they lacked knowledge on how to treat them, their lives have changed from good to worse. This situation does not help the poor elevate themselves from poverty, instead being

limited from knowledge causes them to remain in their poverty stricken situation. Knowledge and education in eye health and the treatment options available as well as the facts and clarification of common misbeliefs are therefore critically important. Gooding (2006) affirms from research conducted that people who have been educated on eye health and the services available are more likely to undertake surgery or any type of vision correction as compared to those who do not receive education and remain illiterate . However, the ability to read and write has been noted as a major challenge for most people in developing countries when being educated on eye health.

Overall, the prevalence of active trachoma among children and trachomatous trichiasis among 15 years and above population is very high in Ethiopia. Rural/urban differences in active trachoma and gender differences in trachomatous trichiasis are marked indicating the general inequality in the availability of clean water and sanitation facilities in the population; and the gender inequality in accessing prevention and treatment services. The prevalence of active trachoma is four-fold in the rural population compared to the urban (42.5% Vs 10.7%). This could be attributed to the poor sanitation and water supply conditions in rural areas. Several studies in Sub-Saharan Africa have reported high prevalence of active trachoma in areas where water supply and sanitary conditions are poor. In conclusion, it is clear that trachoma is a leading cause of eye problem in children as well as adult populations.

Children with less knowledgeable household heads about trachoma had about four times more likely to have infection than children from knowledgeable household heads. This finding was in line with investigations in Ethiopia which also reported overall reduction of trachoma ranges from 4% to 12% after provision of health education for community. The possible explanation for the differences could be less access to information, education and communication media on trachoma prevention, community based health education by trained health workers or volunteers and eye care units in the District. Unclean face, density of fly on face of a child and awareness of head of households about trachoma were also determinant factors for the occurrence of active trachoma. Access to sanitary water and frequently using latrines are essential factors of the 'E' component of the SAFE strategy. Moreover, there was higher prevalence of active trachoma in low land than medium land villages that needs special attention in preventive programs.

Trachomatous trichiasis is higher in females compared to males (4.1% Vs 1.6%). Over 9 million 1-9 year old children live with active trachoma, and 1.3 million people 15 years and older have trachomatous trichiasis.

Access to improved sanitation facilities was strongly associated with lower levels of trachoma. We found the strongest evidence of the association between hygiene factors and trachoma. The use of soap was associated with lower levels of trachoma, which is particularly relevant as current strategies for trachoma control advocate for face washing with water, but do not consistently emphasize the use of soap. Our analyses suggest that the presence of a clean face, the lack of ocular and nasal discharge, increased frequency of face washing, towel use, the use of soap, and daily bathing were all associated with lower odds of trachoma. A study conducted around an association between time to water source and decreased access to water (Mesfin et al). The relationship between a clean face and reduced odds of trachoma was one of the strongest associations. Considering the strong association between facial cleanliness and nasal discharge and trachoma infection, our results suggest that health behaviors that result in clean faces may reduce the prevalence of trachoma. Effective prevention programs should integrate education about proper latrine use and promote equal utilization of latrines among both genders and all age groups in order to preserve the protective nature of latrines.

F. Proper solid and liquid waste management

According to recently conducted survey on eight towns (UNICE and World Vision Ethiopia, June 2015) 44% of HHsvillages splash their waste throughout the compounds. Close to 32% of HHsin towns dispose of their waste in latrines. Most of the survey areas visited do not have proper liquid waste management systems in place. As a result, the compounds and outside yards are the most common places for disposing of liquid waste. The same study revealed that Solid waste disposal mechanisms study areas are found to be poor whereby only 24% of the town HH respondents reported an organized way of solid waste disposal by using designated places for waste disposal. Undesignated places for waste disposal is what most of those surveyed practice, representing 76% of the HHs.

In similar study findings in Ethiopia revealed that 88.2% reported that they clean their home and compound regularly. Regarding solid waste storage, only 6.9% of the households had temporary storage means (a container or a place where the solid waste is temporally stored before final disposal) in their compound. Of these 33.3% used dug pits and only 13.3% have been observed to

have cover for the stored waste. From those having temporary storage, 66.6% households responded that they have separate storage for different types of wastes and 76.6% dispose stored solid waste before three days. The study of the same participants were also asked about their hand washing practice after handling of solid wastes. The majority, 85.9% reported that they regularly wash their hands after they handle solid wastes. But among them only 50.9% used soap or ash to wash their hands, 36.4% used only water and the rest 12.7% used other materials instead of soap or ash to wash their hands.

Many researchers have underlined the relationship between public health and improper solid waste management (20). This study indicated that almost all the households dispose solid wastes in open dump, open pit or by open burning. This leads to a polluted environment. This study revealed that household management of waste in the community is poor. More than ninety percent of the households flush away waste water indiscriminately.

Only very small proportion of the households had temporary storage for solid waste. About two third of the households did not have latrines, and almost all of the available latrines were traditional pits in poor sanitary conditions.

There seems a broader consensus that the starting point among the community is improving their knowledge's to properly dispose solid and liquid wastes in urban and rural settings. This can be revealed from the fact that recommendations from various research coined around increasing awareness of the community which shows much has to be done to improve the practices across nations. However , the sector still lacks research undertakings to further understands focusing on higher level integrated waste management option such as reuse, recycling and composting which contributes to economic development efforts.

2.2.1.1. Analysis of Focal Behaviors

In order to better understand each behavior status in terms of Knowledge, Attitude and Practices of community in each of the thematic areas has been systematically analyzed through categorizing them into matrix. Following matrix. Each of focal behavior segmented into three using as Knowledgeable, Changes their attitude and sustainable practiced changed behaviors. Based on existing evidences these categories were labeled as RED, YELLOW and GREEN as indicated on the table below.

The rationale behind developing this scoring is to provide a basis to make a decision for practitioners through shedding light on the status of existing behaviors in terms of Knowledge, Attitude and Practices. It is presumed that the following labeling provides a basis for prioritizing a set of behaviors designing evidence based communication tools.

Table 3 : Scoring of KAP hygiene and environmental health behavior status

KAP	SCORING
Low/Poor	RED to categorize in terms of exposure to relevant information is very low level in terms of understanding key behaviors among majority of the segments. Incomplete and inconsistent knowledge level which is could possibly reasoned out as a major barrier to pursue poor attitudes leading to practicing behaviors properly.
Medium/Intermediate	YELLOW label signifies certain behavior is practiced inconsistently due to aincomplete knowledge gaps and lack of supportive enabling environment to maintain their practices in a sustainable manner.
High/Sustainable	GREEN is labeledfor availability of in-depth knowledge and positive attitude leading to properly and sustainably practice a certain behaviors.

However, the technique is constrained by unavailability of evidences in majority of the thematic areas. It is also limited most of the available information are qualitative in nature which makes the scoring subjective. As can be clearly observed in the matrix most of focal behaviors scaled poorly at knowledge and attitudes which obviously leading to acquiring and sustain desirable focal behavior.

In terms of measuring level of awareness and understanding for each of thematic areas is at an encouraging level but which still requires additional intervention to ensuring and maintaining completeness and consistency of knowledge.

		KAP METER

Table 4 : Hygiene and environmental health hygiene behaviors

		Knowledge			Attitude			Practices/ Sustain Behavior		
		Low	Moderate	High	Low	Moderate	High	Low	Moderate	High
1.	Proper Hand Washing									
2.	Proper Toilet Utilizations									
3.	Child feces disposal									
4.	Safe Water Handling									
5.	Solid and Liquid Waste Management									
6.	Menstrual Hygiene Management									
7.	Face Hygiene									

2.2.1.2. Prioritizing key behaviors

Thus, while designing the communication guideline it should be systematically designed to address filling the gaps in each of thematic areas across the segments – Knowledge, Attitude and Practice (KAP). In order to supplement additional tool has been used in prioritizingbehaviors based objectively and scientifically supported methods shown below.

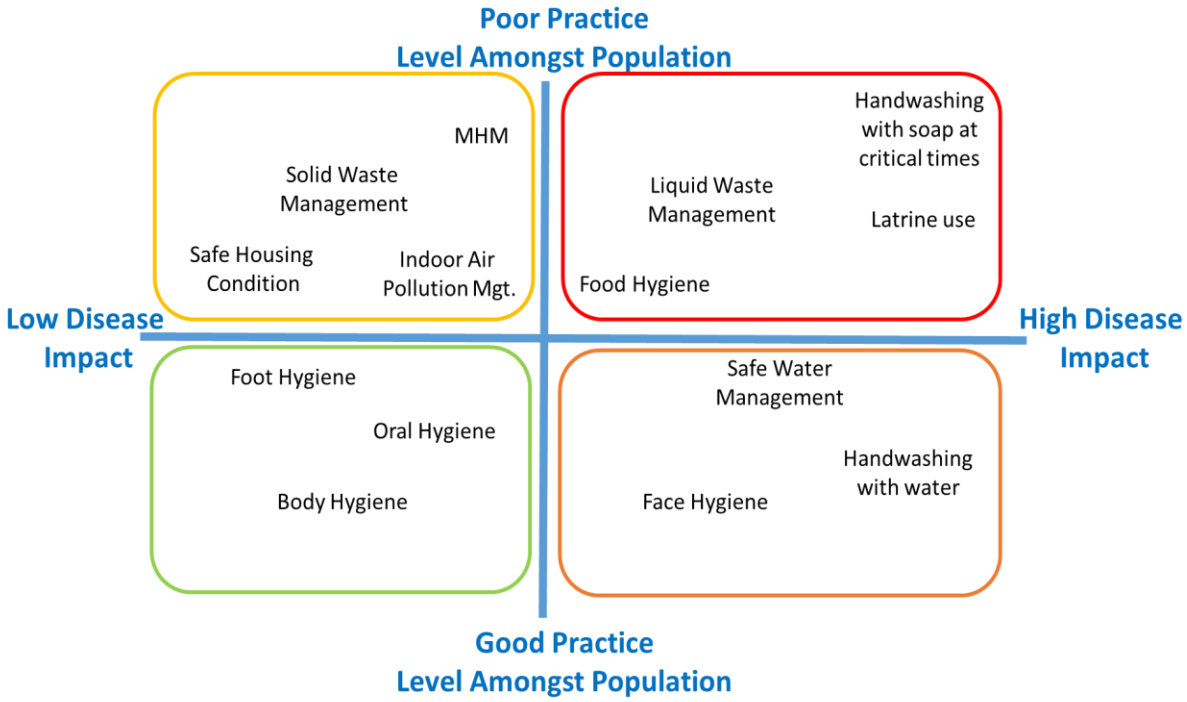


Figure 6 : Prioritizing key behaviors based on their level of practices and perceived disease burden

As clearly indicated on this matrix a set behaviors with high disease impact and poor practice of among society should be prioritized. Therefore, based on the level of knowledge among audiences. Latrine use and handwashing with soap at critical times requires more focus over the rest of behaviors. The safe water management, face hygiene, food hygiene as well as liquid water management are the next priority focal heavier to be addressed.

2.2.1. Overview of Hygiene and Environmental Health

A healthy society and productive workforce play an important role in long term economic growth and sustainable development. There is a clear link between the state of the environment and human health and well-being. World Health Organization (WHO) estimated that 23% of all deaths in Africa are the result of avoidable environmental hazards such as contaminated water, inadequate sanitation, poor hygiene, and poor water resource management, use of unsafe fuels, atmospheric pollution and poor infrastructure. Lack of access to sanitation, use of unsafe drinking water, and poor hygiene together are responsible for about 88% of all deaths from diarrheal diseases in developing countries (Prüss-Üstün et al, 2008).

The practice of environmental health is protection and prevention of health problems associated with chemical, biological or physical threats present in the different environmental compartments (water, air, soil, etc.). Most public health problems in Ethiopia are linked to hygiene and environmental health. Hygiene and environmental health problems accounts more than 90% of the cases due to ten top diseases in all regions of Ethiopia. Diarrheal diseases, respiratory tract infection and malaria were the leading causes of morbidity in 2007 EFY. Occupational health related diseases such as disease of musculoskeletal and connective tissue and trauma are also become in the list of ten top diseases. While malaria is the leading cause of morbidity in rural areas, air pollution health problems are become the leading cause of morbidity in urban areas of Ethiopia such as Addis Ababa and Dire Dawa. Therefore, contextualized hygiene and environmental health strategy is a necessity.

Large-scale anthropogenic changes to the natural environment, including land-use change, climate change, and the deterioration of ecosystem services, are all accelerating. According to Regional Health Bureau's report, air pollution related health problems are becoming leading causes of morbidity in Ethiopia. For example, acute upper respiratory infections with 242,968 (32%) and 38,415 (25.7%) cases was the leading cause of morbidity in Addis Ababa and Dire Dawa respectively in 2007 EFY.

Summary of Wider Hgiene and Environmental Health Practices[3]

S.N	Hygiene and Environmental Theme	Enabling Enviromnet	Availability of Legal Frameworks	Enforcement of legal frameworks	Physical access for functional physical facilities	Availability of resources to support the legal enforcement
1.	*Institutional WASH Facilities*					
	1.1. School					
	1.2. Health Facilities					
	1.3. Prisons					
	1.4. Market place					
	1.5. Service provide institutions					
	1.6. Hotels, restaurant , café , etc.					
2.	*Outdoor air pollution*				NA	
3.	*Institutional/Industrial Solid Waste Management*					
4.	*Institutional/Industrial Liquid Waste Management*					
5.	*Occupation Hazard Safety*					
6.	*Environmental Noise Pollution*				NA	
7.	*Water body pollution*					
8.	*Land contaminations*				NA	
9.	*Disposal of hazardous wastes*					

	Low		*Medium*		*High*	*NA*	*Not Applicable*

[3]*The above table developed based on the Federal Ministry of Health's Hygiene and Environmental Health Related Facts and Figures Sheet Report (January 2016)*

The above table developed after critical analysis of the recently developed *Hygiene and Environmental Health Related Facts and Figures Sheet Report.*

The summary table aimed to summarises the overall picture of the hygiene and envirimnetal health prctices. The anlysis intended to providinisghts to infom decision of the practitioners for further analysis while developing advocacy and social mobilization campains. Respective thematic areas were anaysied on the basis of broadly defined five varianles. These are Enabling Enviorment ,Existances of Legal Frameworks , Enforment of Legal Frameworks , Physical and technological access and Resounces in each of the pactices.

Under each variables assessement has been done to inform practicition identify key intervention areas. Thus , those varibales labelled with RED will have a priority areas of interventions. While YELLOW describes either respective practices requires has reach some level or requires strengthening efforts from practioners. The GREEN depicts the practices has been properly managed but requires an on goind support for sustaining the practice levels.

Section III: Communication models: social mobilization, advocacy and behavioral change communications

3.1. Overview of Advocacy Communications

The advocacy communication mainly aimed at and falls into the domain of persuasion, which is bout narrowing options and motivating decision makers to choose one among many. Advocacy requires that communication be persuasive enough to sway decisions to be made for or against an issue. Advocacy communication in this guideline aimed to hinge on the creation of a broad network or coalition of support. Such networks bring greater pressure to bear on decision makers.

The over goal of the advocacy is to attain a positive behaviour change among people with respect to acquiring and sustaining positive hygiene and environmental health behaviors. This will include enhancing knowledge, attitudes and practices on key thematic areas of hygiene and environmental health behavior.

In summary, the overall objective of the advocacy communications in this guidelines intended to enhance *awareness, attitudes and practices of target audiences of advocacy to influence behaviors of at community and individual levels.* This broader objective could be realized through attaining specific objectives shown below*:*

i. Increase mass awareness levels and make the identified audiences more conscious about issues related to the importance of hygiene and environmental health;
ii. To influence decision makers and opinion leaders to advocate for positive hygiene and environmental health standards, thus creating an overall positive environment; and
iii. Ensure that households have knowledge of the linkages between sanitation, hygiene and health leading to increased public demand for quality services and adoption of sustainable hygiene and environmental health practices

3.1.1. Core strategic focus of advocacy campaign

The role of advocacy in this guideline is determined to influence the choices and actions of those who make laws and regulations and those who distribute resources and make other decisions with regards to hygiene and environmental health behaviors,which affect the well-being of community. It provides a guidance on delivering messages in each thematic areas that are intended to influence

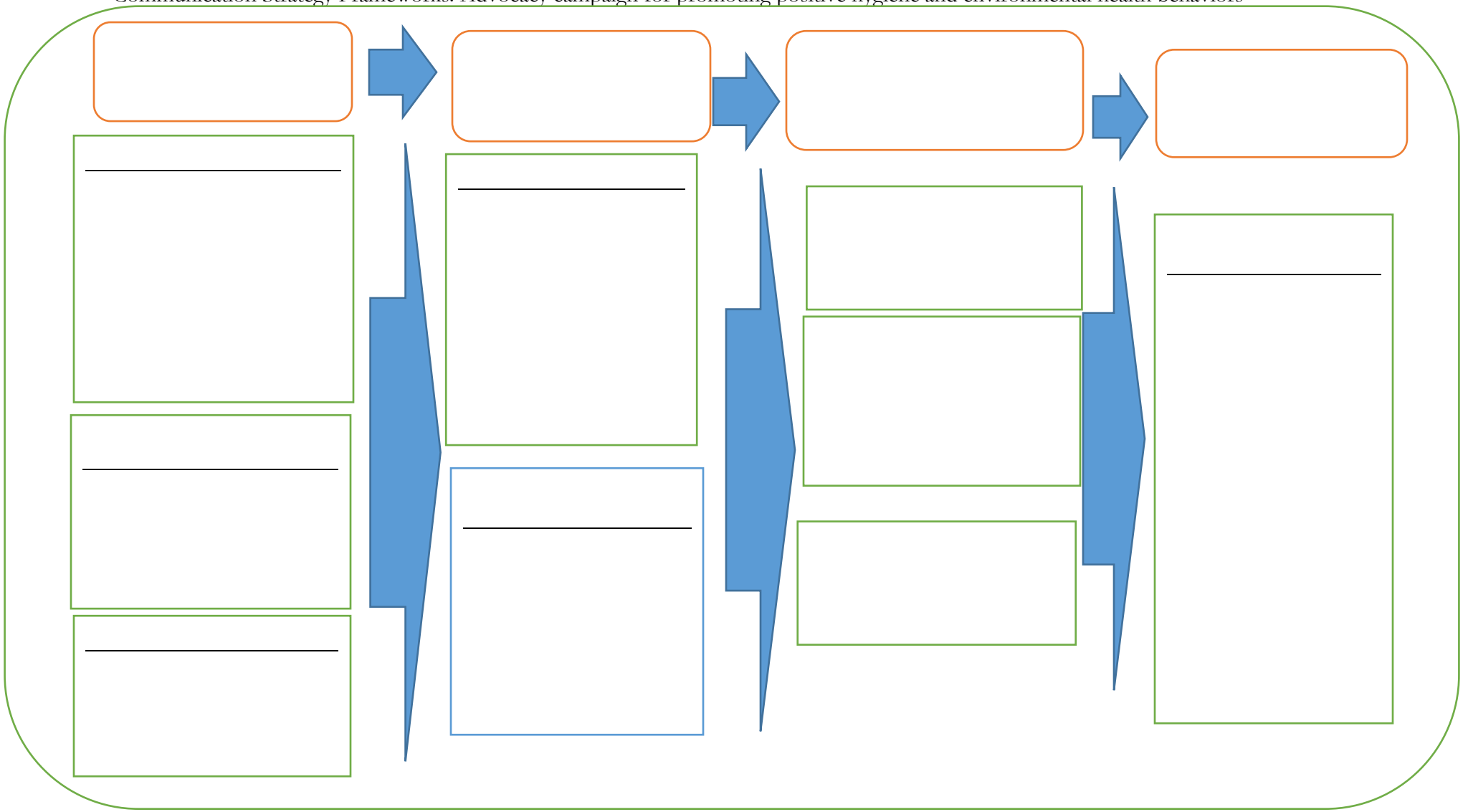
thoughts, perspectives and actions of leaders, politicians, policy makers, planners and others in authority. Basically the advocacy essentially focuses on three key policy change in hygiene and environmental health thematic areas: These include:

A. Creating policies where non exist;
B. Refining harmful or ineffective policies and
C. Ensuring good policies and followed, implemented and enforced.

It is evident that there are no standard strategies for advocacy work, especially when the advocacy objectives is broadly defined with multiple thematic areas such as hygiene and environmental health behaviors. Rather mostly influenced by the socio-political context, target institutions, objects, policy problems, actors, etc. But, whatever the context, this guideline should recognize the need to weigh existing hygiene and environmental health practices, associated risks, possibilities and opportunities that each approach offers and cultivate powerful allies both inside and outside. The ultimate goal should be to open up political space for negotiations. The main strategies of doing advocacy work include but not limited to campaigns. The following tables summarizes some of the most prominent campaigning techniques and tools which could illustrate advocacy communication campaigning tools and techniques which could be applied.

Figure 7 : National Hygiene and Environmental Health Communication Advocacy Frameworks

Communication Strategy Frameworks: Advocacy campaign for promoting positive hygiene and environmental health behaviors



3.1.2. Advocacy approaches

The purpose of the advocacy phase of the strategy is to mobilize government, media, civil society, implementing agencies and other stakeholders to strengthen sanitation programming and policies. Advocacy will create a platform to bring about effective implementation of the programs of the government. The focus of the communication will be to inform through evidence-based advocacy to increase knowledge and influence key decision makers. The objective is to galvanize support to translate commitments into concrete actions. The advocacy strategy is broadly classified into interrelated phases as shown on the diagram below:

In general these approaches could be realized using advocacy planning systems. The advocacy planning includes understanding and mapping existing hygiene and environmental health practices, assessing your level of leverage, realistically set a feasible advocacy objective, design and implement advocacy campaigns.

Understanding the obstacles to the change you are proposing or trying to prevent will inform all aspects of the campaign from feasible objective to developing your messages, activities and communication tools. Obstacles in the process can be varied and include strong opponents, value conflicts, lack of support, or the lack of access to the policymaking process. Overall, try to identify what combination of these various elements is blocking the process and see if there is a core tipping point that would change this. While mapping and detailed planning make sure the following guiding questions such as what's stopping the policymaking process from moving in the direction you wish? What obstacles or challenges exist to having your proposals accepted and acted upon?.

The key is to identify what you have got to catalyze the change you want. This could be one piece or a combination of new evidence, analysis, or research data; a new problem definition or solutions/policy options; support from opinion leaders, stakeholders, or experts; credibility; money; votes; and/or an open policy window or opportunity in the decision-making process. Similarly, make sure to answered pertinent questions such as what can you bring to the policymaking process to address identified obstacles and create the momentum to push the process in the direction you want? What combination of new striking insights or evidence, supporters, and opportunities can you use to move the process?

Setting feasible objectives will give you a realistic chance of making or preventing change. Some guiding examples of setting feasible set objectives to:

- Stop or start a particular policy initiatives by the government,
- Have your recommendations accepted by the government,
- Change the nature of a public debate around a certain issue,
- Get an issue on the agenda of the government.

Try to avoid just writing down a wish list; being realistic will show you that influence is possible. Also remember that the objective is not the policy outcome you want but the process change you are targeting.

For instances , the focus could be on enhancing knowledge of audiences on understanding open defecation as a problem and provide correct knowledge on sanitation and hygiene practices. As the objective of this phase is to raise awareness and increase knowledge the emphasis will be on increasing the visibility of the issues and keeping it firmly in the national spotlight.

On this initial phase of advocacy the information will be provided to equip the advocates' appropriate information to enhance their awareness. The messages mainly defined as:

- Address the nation on the dangers of open defecation and need for correct hygiene practices,
- Understand and acknowledge the need for building, using, and maintaining a toilet,
- Understanding why safe disposal of child feaces is important/ risks related to not disposing child faeces safely and ways to dispose child excreta safely
- Know the critical times of handwashing with soap-after defecation, before food and after
- Handling child faeces
- Describe the benefits of handwashing with soap/risks of not washing hands with soap at critical times
- Know how to safely store and handle drinking water/risks related to drinking contaminated water and other emerging hygiene and environmental health behaviors,

3.1.3. Advocacy campaigning tools

At this stage various the communication tools will be used to address key environmental health behaviors progressively. In choosing communication tools, one might consider two main types of audiences:

Experts: those who have a deep technical knowledge and background in the target policy area. These are commonly advisors, bureaucrats, and people from international organizations, research

institutes, think tanks, and universities. In order to convince audiences, they need to see the full argument, including literature, evidence, proposals, predictions, and research (methodology and analysis). Having said that, it is also important to note that such groups are small much more heterogeneous in background and experience than those from a single academic discipline and this needs to be considered in making your communication accessible.

Informed Non-Expert:practitioners who work in the target policy area and are users rather than producers of policy research. They are often decision makers, journalists, NGO employees, or civil servants. These people can normally be convinced by seeing the significant outcomes of research and do not need all the in-depth academic and research detail. If possible, these people will consult experts to confirm if their reading of a policy proposal is correct. This is usually a much more heterogeneous group than the expert group in terms of educational background and experience.

In sum, some of the recommended methods of communication activities will include but not limited to:

- **Mass Media:** This is an important medium to communicate effectively with a large number of people by leaving them with a powerful image. It can overcome barriers of literacy and language and it is ideal for delivering a simple, clear and focused message. Although there are several 'media dark' areas in the country, there has been rapid progress towards increased TV and radio coverage and penetration. In this Strategy mass media is expected to provide the type of support that has been extensively documented in public health. It can support community mobilizations and interpersonal communication efforts; promote specific behaviour through multiple activities and products such as radio and TV public service announcements, radio and TV magazines, and radio and TV shows; enhance the credibility of non-professionals such as community volunteers as reliable sources of information and services; convey important logistical information easily, for example, about where applications for toilet construction can be submitted.

- **Outdoor media:** For areas that are still media-dark outdoor media such as, wall paintings, hoardings and traditional mediums like folk theatre will be used. In this strategy, mass media will be closely linked with and reinforce other communication efforts.

- **Public Service Announcements (PSA):** Appeals will be developed including some with national celebrities on hygiene and sanitation for broad dissemination through radio and television. They will be developed in different regional languages to have an all India reach.
- **Mobile media campaign:** The aim of the campaign would be to build awareness and create a national movement demanding adequate sanitation and hygiene standards for India to stop open defecation. Activities will include recording a mobile voice message with a celebrity with pan-India appeal, emphasizing cleanliness and hygiene, which can be sent out to citizens via partnership with an Indian mobile telephone company. The message will be interactive by giving options to the mobile phone user.
- **Print and audio-visual communication:** Press releases and video packages to be used as communication tools to generate interest of journalists. Partnerships with key media (in print, radio, television and internet) will be leveraged to promote hygiene and sanitation issues over the duration of the campaign.
- **Celebrity spokesperson:** A celebrity spokesperson of national stature to be identified to promote the campaign. The spokesperson will talk about the issue at appropriate forums and will be available for the duration of the campaign.
- **The general public:**unless they have a stake in the issue or it is a matter of broad public concern, the general public are not normally interested in policy research. Of course, if a policy proposal will divide them into winners or losers or feeds into their hopes and fears, they can easily be made interested. Such an advocacy eff ort would have to target the specific c relevant sector of the general public to get them to buy into the ideas. What is needed in this case is the simplest and clearest presentation of the evidence in such an argument.

Advocacy efforts need to be adapted for each state using the basic advocacy framework as above. Each state will identify relevant state level partners and stakeholders to implement the advocacy strategy to achieve the desired outcomes.

- **Evidence-based advocacy package:** An evidence-based advocacy package to be developed, including fact sheets, human interest stories and power point presentations on relevant sanitation and hygiene issues. The package will be used for one to one meetings with policy makers and also for the orientation of elected representatives (i.e. Pris and

legislators) in order to garner their support in the implementation and lobbying with the government on hygiene and sanitation issues.

- **Media kit for journalists:** Partnership with both national and regional media to be encouraged. Development of media kits including human interest stories, fact sheets, photo essays and stand-alone pictures on sanitation. The package creates awareness among all stakeholders on sanitation and its health implications. A CD containing photo images and graphics on sanitation for easy replication can be included.
- **State fact sheets:** Snapshots from states to be developed using census and other data. Once the baseline data is available from the districts, it can be complied into a summary and a presentation made to the state and central government counterparts, particularly for district collectors.
- **Field visits:** Exposure visits to field for media, celebrity advocates and elected officials to be conducted to increase awareness on sanitation issues and increase civil society participation.
- **Process documentation:** Distinct process documentation products to be developed: 'Good Practices', 'Lessons Learned', 'Innovations', and 'From the Field.' The focus will be to choose one or two particularly valuable examples on hygiene and sanitation.
- **Seminars and conferences:** National conference/s for scaling up nationally and regionally best practices on hygiene and sanitation to be organized. District collectors from the states to meet and share initiatives at both state and district level. Lessons learned will help inform and improve implementation.
- **Strengthening institutional capacity:** One of the key focus areas of the advocacy strategy would be to strengthen the existing institutions in the state working on sanitation and hygiene. This would include strengthening the capacity of key opinion builders and policy makers, including NGO workers and nodal institutes at the state level.
- **Private sector partnerships:** Corporate and other partnerships to be cultivated to assist in campaign development, messaging and dissemination and support in programme implementation.

3.2. Social Mobilizations

In this guideline *social mobilization* is defined as the process of bringing together all feasible and practical inter-sectoral allies to raise awareness of and demand for hygiene and environmental health program, to assist in the delivery of resources and services and to strengthen community participation for sustainability and self-reliance in terms of acquiring and sustaining appropriate behaviors.

The focus of this guideline includes but not delimit a decision and policy makers, opinion leaders, nongovernmental organizations (NGOs), professional and religious groups, mass media, private sector operators, communities and individuals at national , regional and woreda levels. In assumption this guideline recognizes that sustainable social and behavioral change requires many levels of involvement and interventions of every allies from individual to community to policy and legislative action.

Advocacy to mobilize resources and effect policy change, media and special events to raise public awareness, partnership building and networking, and community participation are all key strategies of social mobilization.

The social mobilization is framed to undertake at different levels which includes national, regional, woreda, community levels and individual levels. Specific activities and tactics includes group and community meetings, partnership sessions, school activities, traditional media, music, song and dance, road shows, community drama, leaflets posters, pamphlets, videos, and home visits. The following session will provide broad guidance in terms of determining different approaches to define each set of activities federal, regional, woreda and community levels.

At the national level, our strategy will mobilize major influential groups to become strong proponents of the benefits of positive hygiene and environmental health behaviors the population in general and to remove myths and misconceptions. This contributes towards ensuring both enhanced and sustained political commitment. Federal and regional elected parliaments representatives and influencers could be used a platform to mobilize the society wield a key role both at the national level by influencing the development of policies and programmers as well as in their local constituencies to change people's perceptions and behavior in adopting birth spacing. Media, both electronic and print, is known to be most effective method for sharing information and shaping

people's perceptions and attitudes.In addition, media will be encouraged to raise the issue of the need for health providers and other important influential groups to proactively promote positive hygiene and environmental health behaviors. Elected representatives and influencers can also wield a key role both at the national level by influencing the development of policies and programmers as well as in their local constituencies to change people's perceptions and behavior in adopting positive behaviors.

The mobilization ensure relevant work will involve engaging in social mobilization process with:

- Prominent religious leaders/ scholars
- Community influencers
- Media representatives
- Parliamentarians
- Elected representatives
- Policy makers at the district, provincial and national level
- Professional health associations and academic institutions, etc.

These key players can be instrumental in creating an enabling and supportive environment, either directly or through the influencers at the community level, to bring about behavior changes in favor of total positive behaviors:

- Community Resource Persons (CRPs)
- Private provider
- Consumer associations
- Professional associations
- Chamber of Commerce
- Public health university and colleges
- Civil society organizations and NGOs
- Community Based Organizations -
- Social Networks
- School clubs,

The community mobilization strategy is designed to create an enabling environment that will promote acquiring and sustainably practicing hygiene and environmental health behavior through direct interaction at woreda, Kebele, community and individual levels. Active mobilization of

support from key influencers practicing in the community using various interpersonal communications and community based interventions and approaches.

Social mobilization at the community level will consist of a number of community-based activities involving influencers who are community leaders and gatekeepers including district officials, elected representatives and informal leaders identified by the community as important sources of advice.

3.2.1. A framework for Social Mobilization: Path way

The overall purpose of the Social Mobilization is to ensure that both primary and secondary audiences are equipped with the necessary knowledge and attitude so that they can provide appropriate and integrated support for the BCC campaigns, through reinforcing key messages to change an attitude of people and community to make collective decision making in terms of adopting positive a set of hygiene and environmental health behaviors. This pathways, indicated below is developed to provide a guidance the social mobilization has to peruse in creating a climate on which the intended change to occur. The frameworks also destined to out to garner support from local people so that the programs and interventions are accepted and well suited to the felt need through engaging and empowering key community members to take the guiding roles of their own situations, including accepting or rejecting sets of behaviors.

Strategic Frameworks: National Hygiene and Environmental Health Social Mobilizations for Behavioral Changes

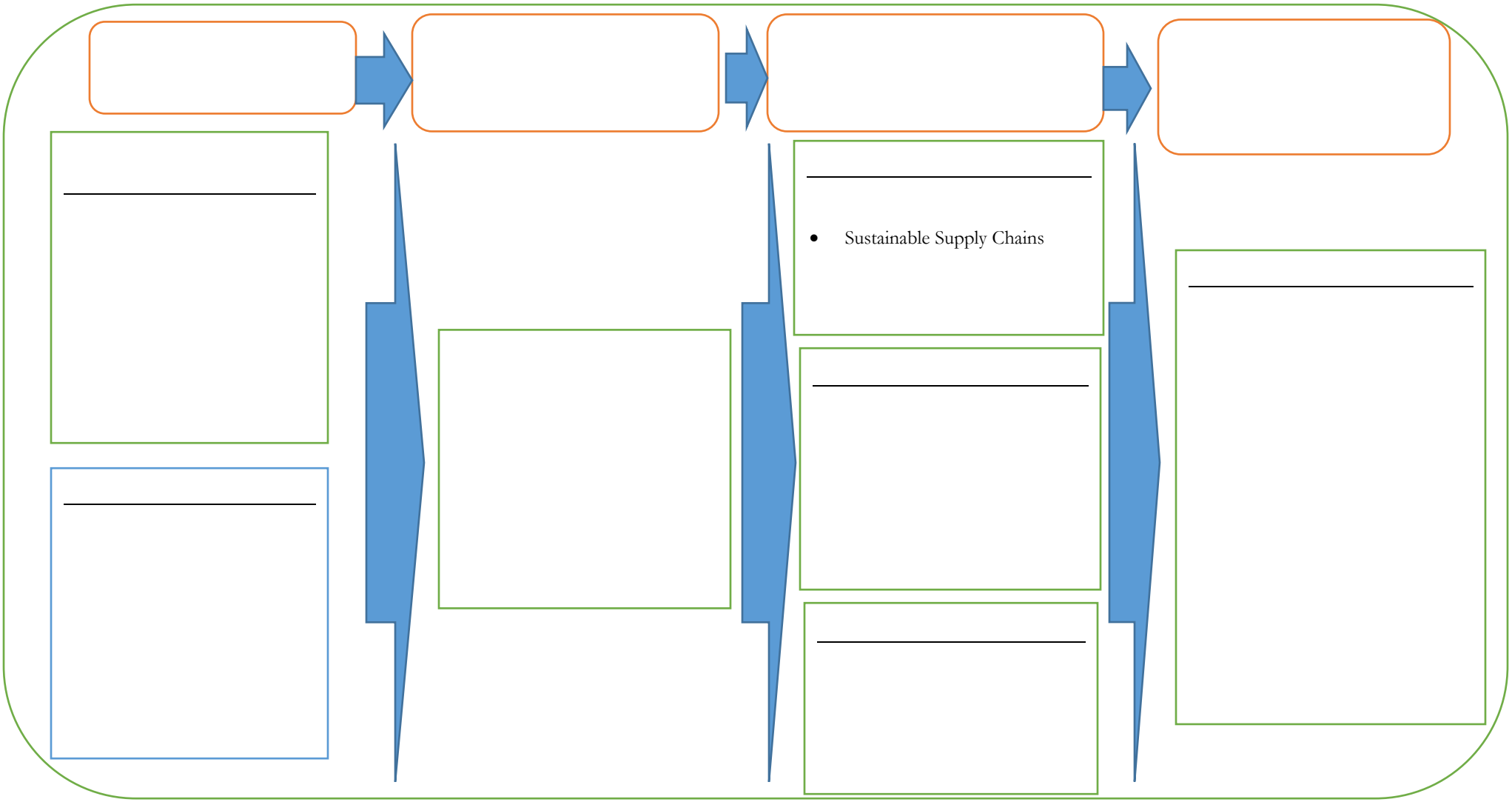


Figure 8: Strategic frameworks for National Hygiene and Environmental Health Behaviors for Social Mobilizations

3.2.2. Social mobilization thematic areas:

Insight from the situational assessment revealed that there are a number of areas that requires social mobilization to carry on to ensure the ultimate BCC campaign effectiveness. This guidelines has clearly identified those areas requiring attention from perspectives of social mobilization campaign to cultivate enabling environment to sustainably practice of hygiene and environmental health behaviors. These thematic areas clustered into three major areas. These are:

Creating and Sustaining Access

A. Equity
B. Sustainable Supply Chains
C. Resources Mobilizations
D. Public and Institutional facilities

Creating and utilizing opportunities

A. Inclusiveness
B. Research and Development
C. PPPs
D. Voice of Citizens (VoC)
E. Partnership and alliances

Motivations

A. Incentives
B. Output based rewards
C. Empowerment
D. Legal enforcement

3.2.3. Audiences of social mobilization communications

In terms of the audiences the frameworkidentified both primary and secondary audiences. Primary audiences are those whose behaviour is to be modified before engaging in in actual BCC campaigns

In the framework shown below indicative examples are given, these could be community, institutions such as cooperatives, CBOs, social networks and structures such as Idir and religious leaders. The tertiary target audiences is comprised of people and institutions who will be used as an alternative platform playing an intermediary role to get the social mobilization message across these include private provider , consumer associations, professional associations, Chamber of Commerce , Universities and colleges ,CSOs, NGOs, etc.

In terms of the communication tools for effective social mobilizations few tactics and techniques of are provisionally prescribed on the frameworks among them community meetings; training or sensitization sessions with traditional authorities, community or religious leaders; street theatre and other cultural activities and marches and demonstrations. Mass media campaigns through using radio, television, billboards or other media to reach a wide segment of a community. It also offers individuals, especially young people, access to valuable information and resources without having to go through others they may not trust. Entertainment-education or 'edutainment', is a particularly useful strategy that entails the "process of purposely designing and implementing a media message to both entertain and educate, in order to increase audience members' knowledge about an educational issue, create favorable attitudes, shift social norms, and change overt behavior". Edutainment may have a particular appeal to young people and thus may present a special opportunity to affect norms before they are fully set. Other innovative approaches that can be effective in reaching diverse audiences include: children games, electronic technologies (mobile phones and computers), street theatre, art, music and cultural activities. Together, communication and social marketing campaigns are some of the most popular means for engaging in mobilizing the society to peruse total hygiene and environmental health behaviors.

3.3. Behavioral Change Changes (BCC) Campaign

BCC is an evidence- and research-based process of using communication to promote behaviors that lead to improvements in health outcomes. BCC intends to foster necessary actions in the home, community, health facility or society that improve health outcomes by promoting healthy lifestyles or preventing and limiting the impact of health problems using an appropriate mix of interpersonal, group and mass-media channels. Maintaining social marketing focus, effective communication strategies rely on formative research on consumers to understand the context, the issue from their perspective, and factors that influence improved hygiene and environmental health practices.

3.3.1. Identifying and prioritizing behaviors

Effective communication tools are mainly built on solid research aimed at proving insights on each set of behaviors to inform the designing of BCC campaigns. The research gaps indicated in the situation analysis should be prioritized as this strategy moves forward. In particular, updating Knowledge, Attitude and Practice research is essential to create a baseline prior to the launch of any national, regional and local communication campaign and to informing the design of specific messages.

The explicit emphasis on behavior change as an outcome helped to highlight the need for a thorough understanding of the full range of determinants, both internal and external factors, to understand why people do what they do and how to facilitate healthy options, decisions and support. These determinants could include knowledge and attitudes as well as many other factors elucidated in theories such as access to services, emotions, real and perceived consequences, social support.

While developing this national guideline is based on existing research from different sources, the selection of channels and design of messages for the national campaign and any resulting regional/ community campaigns must be pretested and tested. Pretesting should involve exposing target audience members to variations of materials and messages and discussing their appropriateness and audience reactions. Pre-testing is necessary to ensure that materials and messages are not based on assumptions of what will work to affect change. Beyond pre-testing, behavioural surveillance on an ongoing basis can help inform alterations to the communication campaign at the national and provincial or regional level to continue to optimize materials.

The purpose of identifying priority behaviour should assist in developing a focused BCC guideline that can contribute to sustainable change. Specific behaviour related to hygiene and environmental health will be addressed at the individual, household and community levels using tools that enable specific BCC, rather than the —prescriptive one-way messages. Need based BCC focuses on establishing dialogue and motivating change that can be easily assimilated within the socio-cultural milieu of communities.

In order to identify, select and address feasible behaviour from a broader of hygiene and environmental health behaviors there should be a set of criteria. Based on situation analysis and reviewing global experiences provisional lists of behaviors indicated in the Box as a set of criteria is recommended to inform decision pertaining to prioritizing behaviors to be addressed.

Provisional lists of criteria

1. Expected outcomes – believes that the benefits of performing the behaviour exceed the disadvantages;
2. Intention – has committed to perform the behaviour;
3. Skills – possesses the skills to perform the behaviour;
4. Self-efficacy – has the conviction that they can effectively perform the behaviour;
5. Emotion – believes that the behaviour is most likely to produce an overall positive effect;
6. Self-standards – believes that performing this behaviour is consistent with her/his self-image.
7. Perceived social norms – recognizes greater social pressure/acceptance to perform behaviour than not to perform it;
8. Availability of prior consumer behavioral analysis, and
9. Barriers – experiences fewer environmental obstacles to performing this behaviour

These factors are core tenets of the social cognitive theory which is founded on the concept of self-efficacy. A person must believe in his or her capability to perform the behaviour (i.e., the person must possess self-efficacy) and must perceive an incentive to do so (i.e., the person's positive expectations from performing the behaviour must outweigh the negative expectations).

Furthermore, from the perspective of the audience, it is key to select behaviour that have a significant health impact, easy to perform, have positive effects on the lives of the audience, accessible and affordable, non-time-consuming, are compatible with and similar to current behaviour, and observable.

This guideline provides to step by step process for implementing BCC campaigns at national level in coordination with regional, woreda and community level counterparts. The campaign will focus on selecting and prioritizing behaviour and messages and select channels accessible to a large portion of the population. Additionally, create a framework to support the creation of more targeted regional manuals and strategies that are coordinated to the national guidelines, but target more specific audience contexts.

Messages of specific behaviour should be targeted to specific audiences. While some generic messaging about the branded campaign is essential to raise the profile of the issue in general, specific behavioural messages, even while carrying brand elements, must speak directly to target audiences in order to be most effective.

The design process of BCC campaigns mainly surround primary audiences with messaging from several sources, and use secondary audiences as trusted source communication channels to create intersections of messages that perpetuate the understanding of the message and adoption of the behaviour. Many secondary audiences are also a primary audience for a message delivered through a different or similar channel which is designed to reinforce the behaviour change of the primary audience and help create a sense of efficacy for the behaviour – that the behaviour is "do-able" and sustainable.

Thus, the focus of the guidelines at the initial stages designed to focus on key behaviors carefully prioritized based on pre-established criteria developed based on principles and practices. These behavior includes:

i. Improving and utilizing latrines
ii. Proper hand washing at critical times
iii. Face hygiene
iv. Proper household solid waste management
v. Proper household liquid waste management
vi. Safe water handling along the chain

3.3.2. The process of behavior change

BCC has its roots in behavior change theories that have evolved over the past several decades. These theories are valuable foundations for developing comprehensive communication strategies and

programs. BCC practitioners draw upon various models and theories to design effective programs and activities. These include the Diffusion of Innovations model (Everett Rogers), the Stages of Change model (Prochaska, Di Clemente and Norcross), the Self-Efficacy model (Bandura) and the Behavior Change Continuum (World Bank). The PBC framework recognizes that behavior change—and thus communication intended to influence behavior change—is a process. People usually move through several intermediate steps in the behavior change process (Piotrow et al., 1997). In addition, there is typically a correlation between increases in behaviors, such as partner-to-partner dialogue. Furthermore, this framework suggests that people at different stages constitute distinct audiences. Thus, they usually need different messages and sometimes different approaches, whether through interpersonal channels, community channels, or mass media.As clearly described on the diagram below an audience can generally be described as:

Stage 1: Pre contemplation: People with pre knowledgeable or unaware of the problem or risk.

Stage 2: Contemplation: Knowledgeable and aware of the problem and desirable behaviors.

Stage 3: Preparation: People with approval state of the desired behaviors.

Stage 4: Action: People with intention to personally take the desired actions.

Stage 5: Maintenance: Practicing: Started practicing Practices the desired behaviors.

Stage 6: Termination /Adoptions: Advocating the desired behaviors and advocates them to others.

It is important to understand where the audience is in relation to these elements before embarking on a strategy. Progress from one element to the next increases the probability of behavior change and continuation.

TABLE 2.1 Applicable Processes of Change During Each Stage of Change

Precontemplation	Contemplation	Preparation	Action	Maintenance	Termination/Adoption
Consciousness-raising	Consciousness-raising	Consciousness-raising			
Social liberation	Social liberation	Social liberation	Social liberation		
	Self-analysis	Self-analysis			
	Emotional arousal	Emotional arousal			
	Positive outlook	Positive outlook	Positive outlook		
		Commitment	Commitment	Commitment	Commitment
		Behavior analysis	Behavior analysis		
		Goal setting	Goal setting	Goal setting	
		Self-reevaluation	Self-reevaluation	Self-reevaluation	
			Countering	Countering	
			Monitoring	Monitoring	Monitoring
			Environment control	Environment control	Environment control
			Helping relationships	Helping relationships	Helping relationships
			Rewards	Rewards	Rewards

Source: Adapted from J. O. Prochaska, J. C. Norcross, and C. C. DiClemente, *Changing for Good*, (New York: William Morrow, 1994); and W. W. K. Hoeger and S. A. Hoeger, *Fitness & Wellness* (Belmont, CA: Wadsworth/Thomson Learning, 2002).

Public policy and communication strategies influence both individual and collective change, establishing new community norms and, over time, providing support for stronger and more effective policies and programs. The process can play an important role in creating an enabling environment to support new behaviors. Advocacy is a key element in this process and can help make the desired behavior sustainable.

When changing behavior, the individual, community, or institution goes through a series of steps—sometimes moving forward, sometimes moving backward and sometimes skipping steps. Even when individuals, communities, or institutions adopt new behaviors, they may at times revert to old behaviors, at least under certain circumstances. Understanding where the majority of a group is in the change process is crucial when designing a BCC campaigns.

Different channels have been shown to be more effective at different stages of the continuum and for achieving different goals. Communication through mass media can ensure that correct information reaches a specific population and can model positive attitudes, but when an individual

or community is motivated to attempt new behaviors, policies and the larger social environment become more important. When audiences become ready to change, the activities, services, or products being promoted must be available to them.

3.3.3. Formulation of behavioral change objectives

Behavior change objectives are short, clear statements of the intended effect of a communication effort. Clear, concise behavior change objectives keep a communication program focused and on track. Objectives that are "on strategy" drive the program forward and move it closer to the long-term vision of improved health. This section provides guidance on developing behavior change objectives for each audience segment. It discusses how to develop objectives that are congruent with the needs and characteristics of the intended audience, as determined by your analysis of the situation and audience segmentation. You will link the objectives to the outcome or evaluation measures developed for the communication program. To facilitate measuring the impact of the communication interventions, you will identify indicators that will help measure progress toward objectives. The use of clear objectives and indicators that track progress will benefit the strategic communication effort, while simultaneously demonstrating the program's contribution to the overall health situation in a given community, region, or country.

Use this description to ensure consistency throughout the development of the communication strategy. Each audience segment may require a different behavioral change objective. You and your team should be consistent in defining the objectives for each group or audience segment.

Name the behavior that will change as a result of the audience hearing, seeing, or participating in the strategic communication messages. Is the behavior change ultimately going to impact the audience's health needs? For example, washing hands properly can reduce deaths due to diarrheal disease. Review the summary of the analysis of the situation, and note any behavior identified as needing attention. At this point, you may need to clarify further the intended audience's behavior. If so, consider conducting some qualitative research to make sure that the program is on the right track.

3.3.4. Determining potential target audiences

The primary audience for a communication strategy will usually be the people who are at risk of or who are suffering from hygiene and environmental health behaviors problem. One exception to this is children, in which case their caregivers are usually addressed as the key influencing audience. To help identify potential audiences, review the available research about the extent of the condition or

disease. Sources of this information include the MOH, local health centers, and national health surveys. Environmental health personnel can explain how the problem spreads and can identify those at risk or affected by it. There may well be gaps in available information that will require formative research or baseline studies before you can understand enough about potential audiences to clearly articulate and describe who they are.

A. Identify common audience characteristics

As you identify potential audiences, group them according to common characteristics, such as age range, gender, occupation, residence, or number of children, as well as by lifestyle and access to print, radio, and television media. Look for characteristics that differentiate the potential audience from persons who are not at risk or do not have the health problem. Make sure that your analysis is gender-sensitive by considering the different gender roles and relationships among potential audience members. Understand how e the potential audiences currently behaving in relation to the concepts of gender equity and gender equality. Also look at whether members of potential audience groups have a high degree of perceived social support, which can play an important role in an individual's ability to change.

Communication Conceptual Frameworks: For Designing and Implementing Hygiene and Environmental Health BCC Campaign

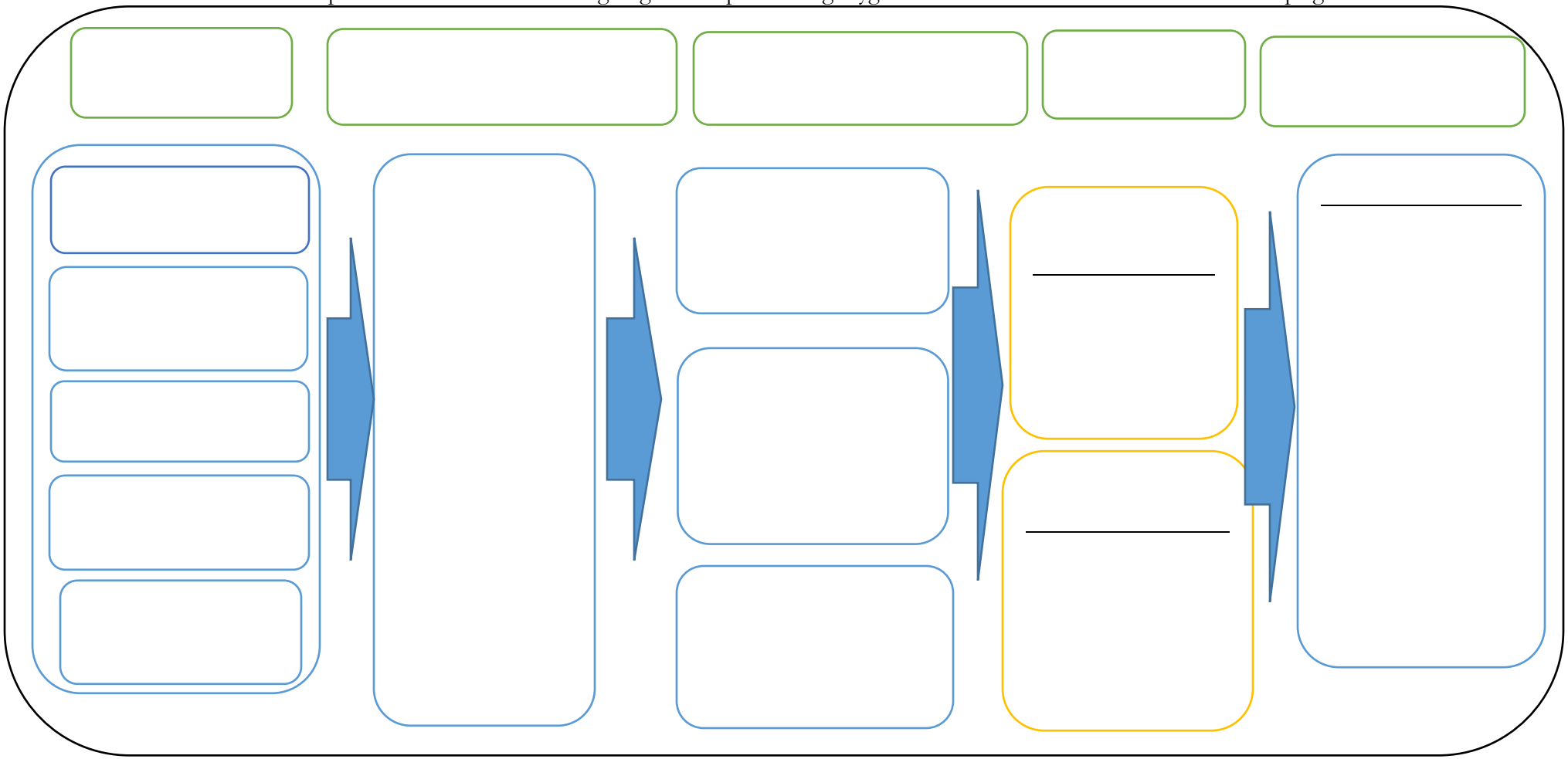


Figure 9 : National Hygiene and Environmental health BCC Campaign frameworks

B. Identify behavior change stage

For each audience, look for information that identifies current health behaviors compared with desired or recommended health behaviors. One useful approach is to categorize your potential audience according to framework presented in the previous section of the guidelines. To develop estimates of the stage of behavior change of the potential audiences, review existing quantitative data, such as Ethiopian Demographic and Health Surveys (EDHS) and census data. Both sources may provide relevant information about the stage of behavior change of various groups of people within a country's population. EDHS generally ask about knowledge, attitudes, and practices. In addition to reviewing formal studies, interview local experts to get their opinions on the stage of behavior of the group in question. Also, to gain additional insight, talk with program personnel who work with the potential audience on a daily basis.

C. Identify known barriers to behavior change

As you interview program workers, health experts, community representatives, and members of the potential audience, ask why they think the audiences are not adopting the desired health behaviors.

Often one of the main barriers to adopting behaviors is the fact that the audience is pre-knowledgeable. However, you and your team must also consider barriers that go beyond awareness and knowledge. Understanding the barriers to change—even those that may be beyond the ability of communication to change—is important for making strategic communication decisions. This knowledge will help you estimate the degree of change that can be achieved within a given timeframe.

D. Identify key influencers

After you have identified your potential audiences, find out who influences their health behaviors. Talk with program managers who work in the community as well as community workers who visit the audience regularly. Review relevant research findings. Make informal visits to communities and homes. Consult members of the potential audience and community leaders about the health problem.

3.3.5. Identifying communication tools mix

The focus here is on identifying and assessing potential resources that can help you carry out a communication program. Health communicators define communication channels broadly as a delivery system for messages to reach intended audiences. They have categorized them as

"interpersonal," "community-oriented, "and "mass media." The latter two channels are particularly effective when the goal is to change community or cultural norms.

A. Interpersonal channels

Focus on either one-to-one or one-to-group communication. One-to-one channels include peer to peer, spouse to spouse, and health clinic worker to client. An example of one-to-group communication may be a community- based outreach worker meeting with a women's development armies. Interpersonal channels use verbal and nonverbal communication.

B. Community-oriented channels

Focus on spreading information through existing social networks, such as a family or a community group. This channel is effective when dealing with community norms and offers the opportunity for audience members to reinforce one another's behavior.

C. Mass-media channels

Reach large audiences. They are particularly effective at agenda setting and contributing to the establishment of new social norms. Formats range from educational to entertainment and advertising, and include television, radio, and print media, such as magazines, newspapers, outdoor and transit boards, the Internet, and direct mail.

Section IV: Communication Strategy

4.1. Audience segmentation process

The term "audience segmentation" means dividing and organizing an audience into smaller groups of people who have similar communication-related needs, preferences, and characteristics. Health communicators segment audiences to achieve the most appropriate and effective ways to communicate with these groups. Health communicators identify several potential audiences for the communication strategy. Each audience consists of people who will directly benefit from the desired behavior changes. Your task is to determine the audiences on which to focus communication efforts.

This section of the guideline is designed to provide a step by step guide for carrying out the segmentation process to determine the primary, secondary, and influencing audiences. Following these steps will lead to the decisions and descriptions that will form the core of the audience portion of your communication strategy.The focus of this section to provide a guidance on the step by step audience segmentation process for Social Mobilization, Advocacy and BCC Campaigns.

Step 1: Determining Audience Segments

Step 2: Prioritizing Audience Segments within the Strategy

Step 3: Identifying Influencing Audiences

Step 4: Painting a Portrait of the Primary Audience

4.1.1. Determining Audience Segments

The first question for you to resolve is whether there is need to segmentaudience at all. If the potential audience as a whole can be effectively reached through the same set of channels and receive the same set of messages, you do not need to segment. In most cases, however, the audience will benefit from being segmented, and your communication activities will be more effective. Indeed, health communicators have found that to most effectively promote behavior change, they need to segment the audience and design several different customized messages, appeals, or calls to action.

The question of available resources also influences your audience segmentation decisions. The costs involved in developing and executing separate communication efforts for several groups may outweigh the benefits. If resources are limited but segmenting the audience is warranted, it may be appropriate to focus on either fewer segments or to look for ways to leverage funds with other programs.

TIPS FOR PRACTITIONERS

It may be useful to segment audiences in the following cases:

- *When it is useful to separate users of a product from nonusers or people who practice a behavior from people who do not practice the behavior, segment accordingly.*
- *When separate groups within an audience require different types of information or motivation to promote behavior change, segment by information needs and motivation.*
- *When separate groups are likely to identify with different spokespersons, segment by effective sources of information.*

4.1.2. Prioritizing Audience Segments within the Strategy

The need to prioritize is based on the answer to this question: Are enough resources available to reach all the people identified as being affected by or at risk of the health problem? If not, it is needed to decide which audience segments should receive attention first. A phased approach to audiences helps to build momentum for a communication effort and to create in one segment of the audience the capacity to help others who are at different stages of behavior change. The communication strategy may start by addressing the audience that is easiest to reach, most receptive to hearing the message, or at a stage where it is most likely to move to the next behavior change stage. An audience segment that already practices a behavior can be encouraged to advocate the behavior to others. These "practitioners" become credible motivators of the "intenders," who will follow them through the stages of behavior change.

4.1.3. Identifies influential people in the primary audience's social networks.

The goal is to mobilize these groups to influence the primary audience in favor of the healthy behaviors.

TIPS FOR PRACTITIONERS

To help you determine who influences the audience's knowledge and attitudes about the health problem, ask these questions:

- *Who suggests ways that they can prevent or treat the health problem?*
- *Who influences their decision to seek assistance in preventing or treating the health problem?*
- *Who influences their decision to try certain products or practice hygiene and environmental behaviors?*
- *Who influences their decision to continue or not to continue their new health behaviors?*

Describe these outside influences both in terms of such characteristics as age and gender and in terms of their relationship to the primary audience. For example, are they friends or relatives? Are they offering services or products to the audience?

Identify all providers of services and supplies to the primary audience. Identify your own provider network and alternative providers. For example, does the primary audience seek treatment from traditional healers? If so, these healers are likely to have a strong influence on the audience. Does the audience seek services from government clinics, nongovernmental outlets, or private clinics? When identifying the audience's health care providers, be as specific as possible.

To identify opinion leaders, ask program managers and community workers who influences community opinions about health problems and who directs policy decisions about health care matters. Interview these people about their views on the health problem, and ask them for the names of other opinion leaders and policymakers in the area.

As you list the influencers, estimate their degree of influence. For example, the relationship between a client and a provider is a powerful one in influencing health behaviors. Certain relatives, spouses and parents, are also strongly influential.

4.1.4. Painting a portrait of the primary audience

In order to prepare a creative approach for effectively communicating with the primary, secondary, and influencing audiences, developing a description of each segmented audience to "paint a portrait." In other words, this step provides a way to "bring each audience to life." The purpose of painting the portrait is to fully understand the desires, wants, and hopes of the intended audience, so that while developing messages, the focus should be portrait rather than on a mass of people. Start

reviewing quantitative research as a foundation, and then layer qualitative information on top of it. As you describe each segment, consider psychographic variables as well as physical and socioeconomic data. Data collection sometimes includes the psychological traits of audience members and can help in understanding such issues as self-esteem, risk-taking tendencies, and fatalism. Analyze these characteristics together with socioeconomic data. Then, compose a profile of the audience that is realistic and vivid.

This exercise will help to get inside the mind of the audience by painting a portrait of one person in that audience. Think of the characteristics of the key audience, and begin to paint a mental picture of a person that best represents that audience. What is his or her name? Get a photo or picture that represents that person. Describe him or her. If a woman, how old is she? What does she look like? Where does she live? If she's married, what is her husband like? How many children does she have? Does she live with her mother-in-law? Does she live in a village? Does she work? If so, what does she do? What are her media habits? Is she more likely to watch television or listen to the radio? Develop a story about the character. In the story, describe her behavior and some key attitudes about hygiene and environmental health behavior that the program intended to communicate. This "portrait" won't be solely based on facts, although the audience research you have gathered will provide many factual details.

4.2. The messages briefs

A message brief is a document that the communication team develops and shares with experts at an advertising agency, PR agency, creative writers and designers, or any other organization or person involved in message development. The creative experts use the message brief as a springboard for developing creative concepts.

Remember, it is the job of these experts to develop creative materials. The strategic hygiene and environmental health communication team such as outlines "what" the messages need to say. The creative experts determine the execution—"how" the messages will be designed. The more precise the message brief is, the more likely it is that the communication will be effective. A "tight" message brief leaves nothing to interpretation and is incapable of being misunderstood. A well-crafted message brief allows the creative experts to explore a variety of approaches, as opposed to a loosely worded brief that confuses the creative professionals and leaves them wondering what the client really wants and needs.

To communicate effectively with the intended audiences, one need to design messages that are relevant, attention getting, memorable, and motivational.

Finally, the communication team describes perception intended audience associates with the user of the product, service, or behavior. The desired output from this section is a simple, brief document that completely describes what the message needs to accomplish.

TIPS FOR PRACTITIONERS

Creative Briefs Can Work for Activities as Much as for Materials Development Creative briefs can also be used for activities, not just for materials. If a social or community mobilization or advocacy activity is planned, key audiences, objectives, barriers to change and message briefs should be developed in a similar manner. For example, media advocacy for journalists need a certain tone and content in order to raise their interest. Journalists need clear concise statements which can be understood by their public. Journalists are also often not aware and/or interested in the public health aspect of the story they write, but they are always eager to use a new and interesting angle. Media advocates therefore, need to think how their public health angle fits to the news of the day. To put your issue into a news context, advocates should advise journalists with the following statement.

4.2.1. Message design

Message design cuts across all communication channels, such as IPC, community based activities, and mass media. The more the messages reinforce each other across channels, the higher is the

probability of effective impact. Strategic health communicators craft key message points that are consistent and relevant for all channels and tools. This consistency and relevance contribute to the overall effectiveness of the communication strategy by ensuring that, for example, the service provider, the community mobilizer, and the actor featured in a radio announcement all reinforce the same key message points. This approach does not mean that planners create only one message for all these venues. Rather, it does mean that they identify key points that are to be made in every message that is communicated to the audience, no matter which channel or tool is used.

BOX SAMPLE CREATIVE BRIEF

AGENCY OBJECTIVE: *[Restate succinctly what is in Terms of Reference. What you want agency to do: develop an Integrated campaign, buy media, etc.]* ***TARGET AUDIENCE:*** *[Specify what target audience is the focus of this brief]* ***BEHAVIORAL OBJECTIVE:*** *This campaign is expected to contribute to the following key program behavioral objective among the target audience: [Specify what behavior is the focus of this brief]*
SUMMARY OF RESEARCH FINDINGS: *[Insert relevant baseline data and research findings and insights such as: coverage, behavioral determinants, willingness to pay, buying behavior, benefits sought from sanitation, etc.]*

COMMUNICATION OBJECTIVES: *[There are several ways to present the communication objectives are shown below.* *State the communication objectives based determinants. For example, if research points to an association between beliefs and the targeted sanitation behavior, then the communication objective would be stated in terms of beliefs and so on. Option 2 uses a commonly found model used in commercial marketing – Do, Feel, Think Today and Tomorrow].* *Illustrative]: The campaign should achieve the following specific communication objectives based on the insights gained from formative research. The behavioral determinants targeted – based on the project's behavior change framework. After the campaign, the target audience will:* 1. *Understand that true purpose of a toilet is to separate feces from contact with people (knowledge)* 2. *Know that adding a simple inexpensive slab to your toilet can improve your community's and family's health and (knowledge)* 3. *Believe that having a good toilet is possible (belief)* 4. *Know that all feces, even children's, are harmful to others and to the environment (knowledge and social support)* 5. *Know that it is no longer acceptable to defecate in the open (social norms)* 6. *Speak to a mason for more information (intention)* 7. *Re-examine their priorities for expenditures (competing priorities)*
MEASUREMENTS FOR SUCCESS: *[This is how the ad agency's outputs will be evaluated – list below is illustrative]* • *Thorough pretesting including: comprehension, attraction, persuasion, identification and acceptability.* • *Number of audience members reached.* • *Level of exposure and retention measured through longitudinal survey.*
MANDATORIES: *[Include what you consider as essential for agency to keep in mind – this serves as a check-list throughout]* • *Approach: [Here you want be clear that you want to avoid a traditional IEC/health belief/emphasis on disease approach – specify what you are looking for such as aspirational, entertainment-education, etc.]* • *Integration across all channels* • *Tone: [Specify tone you want: captivating? Humorous? Dramatic? Etc.].* • *Characters/visuals: [Specify any guidance on characters for example rural or low- literary, etc.]* • *Durability: [What happens after? Will campaign serve as platform or foundation for future campaigns?].* • *Close collaboration and approval/sign-off by the Project at multiple points: [Specify where you want to get more involved and sign-off such as casting, draft and final scripts, etc.*

4.2.2. Message brief outline

There are many variations of the message brief tool. They all designed to generate creative concepts and messages. In the field of commercial advertising, the "creative brief" is used for this purpose. In this context, the message brief is suggested as a useful means of gaining insight into the audience, which is one of the keys to designing messages that will resonate with audiences.

4.3. Choosing communication channels and tools

You will spend the bulk of your communication budget on creating materials and placing them in the most suitable channels and on using the most appropriate tools for communicating to audiences. This section will help you select the communication channels and tools that are most likely to move the strategic approach forward in the most cost-efficient manner.

In previous section, you listed the available communication channels and the audiences best reached by these channels. In subsequent section of this guidelines, you identified the primary and secondary audiences, set behavior change objectives, determined the

Overarching strategic approach, and developed key message points. Now it's time to put these pieces together by matching audience profiles with the channels of communication.

4.3.1. Choosing effective channels

Before deciding what materials to produce, you must first determine what communication channels will best reach the intended audience. Health communicators have defined communication channels as modes of transmission that enable messages to be exchanged between "senders" and "receivers."

The various types of communication channels are:

Interpersonal Channels: Which include one-to-one communication, such as provider to client, spouse to spouse, or peer to peer.

Community-Based Channels:Which reach a community (a group of people within a distinct geographic area, such as a village or neighborhood, or a group based on common interests or characteristics, such as ethnicity or occupational status).

Forms of community communication are:

- Community-based media, such as local newspapers, local radio stations, bulletin boards, and posters.
- Community-based activities, such as health fairs, folk dramas, concerts, rallies, and parades.
- Community mobilization, a participatory process of communities identifying and taking action on shared concerns.

*Mass Media Channels:*Which reach a large audience in a short period of time and include:

- Television
- Radio
- Newspapers
- Magazines

- Outdoor/Transit Advertising

Stage and type of information	*Possible Communication Channels*

- Direct Mail
- The Internet

4.3.2. Select the best channel mix

Evaluate the Best Strategic Approach for the Channel Mix. The next decision is to decide the focus of the channel mix. What is the best way to reach the intended audience, based on the objectives? Should you focus on building reach, building frequency, or maximizing both?

To reach as many different people in the audience segment as quickly as possible, the channel mix will be based on reach. This approach means lead channels selected are ones that can reach a large number of people in a short period of time. In some countries, television is considered such a medium. In other countries, it is radio. Community events can reach a large number of people within a community, but the frequency of message exposure is limited to the timeframe of the event and to the number of events planned for a community.The channel mix required that steadily conveys a message to build recall over a long period of time, frequency, and use a medium that may not reach as many people quickly but is affordable enough to repeat messages regularly over an extended period of time. Radio in many countries is a good model of a channel that helps to build frequency. Radio advertising is relatively inexpensive, and radio spots can be repeated over and over during a campaign.

To build reach, but not at the expense of minimizing frequency, consider using an equal combination of these approaches. Plan to reach a large number of people on an ongoing basis. In some cases, a combination of television, radio, community events, and IPC is a way to build both reach and frequency at the same time.With a rationale determining which channel should be the lead channel and which ones will serve as supporting channels. Just as a locomotive pulls the other cars on a train, the lead channel will be the "engine" that pulls the other channels with it. Think about your worksheets as you answer the following questions:

- Which channel will reach the largest proportion of the intended audience?
- Which channel will fit the message brief most appropriately?
- Which channel will achieve the greatest impact?

Unaware: *Need to provide information on ways to personalize risks and provide personal testimonies—usually to many members of the primary target audience.*	***Print media*** : Posters, pamphlets , buttons, stickers , bulletin boards ***Community-based channels*** : Local health fairs – folk drama, concerts , rallies and parades ***Mass media*** : Television, radio, newspapers magazines, public transit advertising, internet and text blasts
Contemplation: *Helps members of the target audience move from an intention to change to a decision to take action.*	Print materials , community-based channels, mass media IPC : Couple or youth , health extension workers , model household members, HDAs , etc.
Decision/determination : *Needs concrete step-by-step action plan —for an individual who is ready to take action*	Mass media , community-based channels , IPC, print materials with "how to" information to reinforce IPC and IPC and to leave with audience as reinforcement
Action – *Needs positive feedback for having acted (changed behavior) and social support to sustain action—mostly individual members of the target audiences*	IPC, social support through peer support groups, social groups, etc.
Maintenance	Intermittent IPC , social clubs and successful community members

Although a mass medium may reach more people, it may not always make sense to choose it as a lead channel. Use the following worksheet to determine the lead channel and supporting channels. Suppose you want to visit your relatives in another town. You have many ways of getting to the town. You can go by river and take a ferry or hire a small boat. You can go by rail and take the express train or the local train. You can go by road and take a taxi, take a bus, or drive your own car. The river, rail, and road serve as the route to get you from one place to the other—they serve as the channel. It is the same with communication channels and tools. For example, television and radio are mass media channels, while advertising and publicity are tools. Channels enable you to reach the audience, while tools are what you use on those channels.

Tools are the tactics used to send messages through the channels and include advertising, publicity, entertainment education, advocacy, community participation, provider training, events management, and private partnership development.

A communication strategy team has a bag of tools or a toolkit to choose from. The challenge is to choose the best combination of tools to follow the strategic approach and achieve the objectives.

Your team needs to understand how the tools work, what tools will work best to achieve objectives, and when to use them. Advocacy, for example, can help to establish an environment that supports a behavior before an audience is exposed to messages. A mass media advertising and PR campaign can help dispose policymakers to support a policy change.

The advantage of strategic communication is that the planning process allows you to see a whole picture of how to use messages, channels, and tools to maximize communication efforts.

5. Strategic Operational frameworks

Behavior change at the individual, community or institutional level requires a commitment to a coordinated, comprehensive strategy designed to engage multiple audiences with targeted messages through strategically selected channels. A process of research and extensive stakeholder consultation has brought about the following key points recommended to consider while operationalization of the guideline.

Strategic Activity 1: Ensuring Commitment

Structured process must be initiated to coordinate the implementation of this guidelines at federal, regional, woreda and community levels. A national-level media campaign, or a few provincial school-based approaches working independently of one another, will not achieve the desired at scale behavior change. Therefore, all stakeholders should commit to applying the principles, harmonizing to the themes and messages, and if possible, integrating the materials of the strategy. This requires strengthening the national technical working group and establishing functional technical working groups at regional and woreda levels. The technical working groups at different levels device a mechanism to coordinate and complement each other's role.

Strategic Activity 2: Identifying champion agency and partners

To distinguish the lead organization from collaborating partners, start by identifying the key functional areas and skills that need to be in place to carry out the strategy. Typically, these roles include management coordination, policy, research, advertising, media planning and placement, PR, community-based activities, training, monitoring, and evaluation. Some of these may not apply to the particular communication strategy at hand, and often functions not listed above may be relevant. Plan only for those roles that are appropriate to the situation.The lead organization should take the responsible for obtaining all necessary approvals for activities. It often serves as a focal point for issuing status reports and for alerting other groups to problems and issues that require attention. This organization should always have a clear, "big picture" notion about why various activities are taking place and how these activities interrelate. Also, this group should work collaboratively with other partners in establishing clear timelines that include decision making approval points. The lead organization often helps build the capacity of the collaborating partners through the day-to-day work of implementing the communication strategy.

Strategic Activity 3: Defining roles and responsibilities of each partners;

Once the lead organization and collaborating partners have been identified, the next step is to delineate respective roles and functions to ensure successful implementation of the program. As these roles are determined, try to establish ways of working that will benefit the partner organizations as well as support the communication strategy. For example, a group of health professionals may be willing to advocate for government support of the strategy because that will help them forge closer ties. Partner organizations must derive a benefit from participating in the strategy; otherwise, they are unlikely to collaborate.

Strategic Activity 4: Outlining how partners function to deliver intended objectives;

Write a brief memorandum of understanding (MOU) for all parties to sign outlining how day-to-day management will be handled. Summarize who the players are, what their functional roles will be, and how they will coordinate their activities. To get started, answer the following questions:

- *Will there be an advisory body consisting of the collaborating partners?*
- *Will the advisory body meet on a regular basis?*
- *What decision making authority will the advisory body have?*
- *Will the lead organization handle day-to-day coordination and provide the collaborating partners with regular written updates of activities?*

Many different ways of managing and coordinating exist, and it is important to select a set of tools that makes sense for all of the partners involved.

Strategic Activity 5 : Develop resource requirement and possible sources

Developing a budget ensures that you have available the financial resources that you need to carry out your communication strategy in all its parts. Although the strategy team may use several different approaches for developing a budget, one of two situations usually prevails and will drive the process:

The amount of funding is fixed, and the strategy team must allocate these funds across all activities for a finite time period and must justify these allocations. The team conducts an analysis of the situation, identifies the intended audiences, sets objectives, and then obtains funding commitments from one or more sources to continue designing the communication strategy and to implement it. In this instance, opportunities for leveraging funds from other organizations or programs are usually also explored. To estimate the actual amount of funding needed for each category in the budget, you

should research comparable costs in your country and obtain quotations from contractors for services, such as research and advertising.

Strategic Activity 6: Focus on a select number of behavior

Communication strategies too often fail for trying to achieve too much. The complexities of the behaviors and issues related to hygiene and environmental health the individual, community and institutional level require careful understanding, prioritizing and focusing only on a selected ranges of behaviors. Focusing on a few specific behavior that audiences can understand clearly and achieve consistently creates self-efficacy the sense that a promoted behavior is do-able and sustainable among target audiences. A more focused approach is also easier to coordinate among many stakeholders and activities. Selecting a core of specific behaviors that are agreed to have the potential for the greatest impact is the greatest starting point for consensus in coordinated programming. Finally, achieving and communicating to the public about measurable change in select behaviors helps continue the success of the guideline.

Strategic Activity 7: Identify and utilize multiple, reinforcing channels

To bring positive hygiene and environmental health sanitation behavior – which are practiced (or not) several times in a day, audiences must be surrounded by messages from multiple sources. Audiences must be reached directly with messages that are designed specifically for them, and indirectly through trusted sources that have also been targeted. This requires that the message carry both the information to create change, as well as a call to action to communicate with others about the issue, or even spread the specific message. This approach must be scaled up to include many influencers like teachers, religious leaders, family elders, peers and others – surrounding an individual with the message at any given point during the day and creating message intersections where audiences are primed to respond to calls to action.

Strategic Activity 8 : Integrate messages with access to products, services and supplies

Nearly all of the messages to be promoted through the national Advocacy, Social Mobilization and BCC guideline should involve the access or use of a product or service, whether it is safe water from a filtration plant, water treatment supplies, soap, or supplies for constructing a hygienic latrine. Coordinating with private sector partners to leverage their investments in marketing water treatment, sanitation equipment and hygiene supplies will extend the reach of this guideline through the highly visible channel of commercial marketing. Private sector actors such micro and small enterprises

must be a significant partner of the national Advocacy , Social Mobilization and BCC strategy in order to make behavior change sustainable in the targeted audiences. Linkages should also be established with the different government agencies that are extending services across the nations at all levels. The private sector is an essential partner in the success of the national BCC strategy. The reach of commercial supply chains for many products, including soap and basic materials for constructing latrines, goes deep into rural areas and the communication behind the promotion of those products should be leveraged by the national BCC strategy in coordination with the strategy's messages. The reach of other products, like water treatment supplies, are not as extensive and need to be encouraged through partnership with the national BCC strategy. People must have access to the products essential for sustaining the behaviors promoted through the national BCC strategy. If, for example, people don't have access to soap after being heavily targeted with messages to wash hands with soap, they may disregard the message as irrelevant and not wash their hands at all, even without soap. In addition to leveraging commercial channels and linking with product access, messaging must be targeted properly to ensure that only appropriate behaviors are promoted in areas where services are available. For example, if safe water is made available, management of drinking water and hand washing with soap must be promoted. But if safe water is not available from a distribution system or through the distribution of household filters, treatment of water must be promoted instead. Promoting an inappropriate message to a community will lead to the audience ignoring messages they view as irrelevant and perhaps ignoring that communication channel – teacher, radio station, community volunteer – altogether. As a result, any later, more appropriate messages will prove ineffective as well. The additional danger is that audiences reached with inappropriately targeted messages will feel that the promoted behavior is not possible for them, making the entire behavior seem incorrect and reinforcing barriers to change.

Strategy Activity 9: Unite messages as part of a coordinated approach.

Creating a brand for the overall national level communication campaign has strategic advantages. A branded approach unites the different target behaviors and messages under a single identity that reinforces and amplifies their presence in the different communication channels. This approach also provides a mechanism to harness effectively existing enabling environment through setting up coordination mechanisms. The placement of a logo or identity on all materials and media created by different partners working on these issues provides the opportunity for the partner to check if their

message is consistent with the messages and channels of the national strategy. If all partners use the brand, it further unifies different strategies and activities into an even larger presence for audiences to experience. The brand should be independent of a particular government ministry, simple and easy to recognize, and easily transferable to different media and environments.

Strategic Activity 10: Establish planning, monitoring and evaluation system

The communication strategy should establish a common set of indicators and objectives and work to collect data from across all stakeholders to feed into national level reporting. The many different projects active in which monitor and evaluate their interventions have different objectives and indicators that often measure nearly the same things. However, because they are worded or collected differently, it prevents data from being easily combined. A common set of basic indicators that can be drawn out of different implementers' M&E data and reported up to the federal level for analysis and reporting would inform the ongoing coordination of the national communication strategy among all partners.

Ensuring messaging is properly targeted can be greatly aided by using the locations and channels for expansion of services as communication channels. Water filtration plants should be a site for reaching people, through posters, outreach by volunteers and NGO agents, community events and other activities. Filtration plants can serve multiple purposes, promoting related sanitation and hygiene behavior and providing a hand washing station with soap. NGOs that are implementing programs to build latrines or sewage systems in villages must also be sure to target messages properly so that latrines are actually used. This is especially true in areas that are being rebuilt after the 2005 earthquake, and in camps that have housed internally displaced people where sanitation practices different from previous practices may have been adopted by affected people. For example, some IDPs may have begun using a latrine in a temporary camp but do not have access to a latrine when they return home. NGOs should shift their focus to promote the construction of latrines and coordinate their messaging with organizations and agencies working to return IDPs home to continue with the desired behavior change.

6. Monitoring and evaluation

6.1. Monitoring

Monitoring is an important, but often overlooked, function in strategy execution. A good management plan contains a clear process for tracking the implementation of campaign activities. For example, how will you know if clinic materials, such as handouts, are in all of the appropriate places and are being distributed to the intended audience? How will you determine whether community events have occurred according to the strategy? Who will track the advertising to make sure that it is aired or published on schedule? Who will be responsible for ensuring a continuous supply of campaign materials? Who will collect client service statistics?

To avoid situations such as the one in which a large number of posters were printed and then were stored indefinitely in a warehouse because no instructions had been given to the health clinics about why the materials were important and how the clinics should use them.

To monitor such activities. Decide what organization will be responsible for each activity. For example, your advertising agency will likely conduct media tracking; the lead organization or one or more collaborating partners may perform other monitoring tasks.

Plan includes a clear description of the roles and responsibilities of the partners involved, a realistic timeline, a feasible budget, and a description of monitoring tasks. It takes strong leadership, organizational skills, and collaboration to work in a team environment that builds local capacity and generates effective communication strategies.

Each of these types of evaluation requires different action and skills. Monitoring requires attention to process, performance, and, to a lesser extent, outcomes:

6.1.1. Process monitoring

Here evaluators must measure whether activities occurred with the planned frequency, with the planned intensity, with the appropriate timing, and as directed to reach the intended audience. Ideally, monitoring begins at the start of the program activities and continues throughout the length of a program or campaign. Retrospective monitoring is less reliable than ongoing monitoring.

6.1.2. Performance monitoring

The quality, quantity, and distribution of communication outputs must be closely followed. For example, were the expected number of posters printed and distributed to the designated locations? Were the expected number of health care providers or others trained in the proper use of communication materials? Did all members of the management and communication team carry out their functions as planned? Were the quality and volume of the outputs, whether posters, serial dramas, or community events, at the expected and desired levels? In what ways did the performance of the management team meet expectations and work plan requirements?

These measures of both process and performance monitoring should be as specific and as quantitative as possible, since it would be impossible to determine the success of the strategy if, in fact, it was not carried out as planned.

6.1.3. Outcome monitoring

Here the evaluation focus shifts from activities and actions back toward original objectives. If the objectives were increased attendance at certain specific clinics, increased purchase of certain products, or increases/decreases in a specified behavior, such as partner reduction or condom use, to what extent did these changes take place? During the monitoring process, extensive surveys may not be possible, but onsite observation and interviews are important to ensure that expected outcomes are beginning to take place. Unintended outcomes, different from those identified as original program objectives, would immediately call for close attention, feedback to program directors, and, if necessary, changes in either implementation or strategy.

In sum, monitoring is essential to be sure that the program is being carried out as planned and that no unintended, unforeseen, or unexpected events or shifts are taking place. Whether the planned activities are in fact responsible for producing whatever changes may be observed (for example, the question of causality) usually cannot be determined at this stage during the progress of a campaign.

6.2. EVALUATION

Evaluation plays a key role in a communication strategy because without it no one can judge whether the strategy was either applied or effective. Planning for evaluation occurs from the very beginning of the strategy design process. Ideally, an evaluation plan is generated in participatory fashion with input from various stakeholders, such as program staff, community groups, research experts, and donor organizations. The communication specialist does not need to be an expert in

research methodology but does need to play an active role in developing the evaluation plan to ensure that it focuses on the appropriate communication issues

Evaluation must be introduced, under stood, and planned from the start of a program and must be based on the program objectives. It cannot be a last minute addition. To measure change, it is essential to have baseline data before an intervention takes place as well as post intervention data. Communication program evaluators need to assist program personnel in articulating objectives in measurable terms consistent with behavior change theory and in using research methodologies that are practical and appropriate to the situation. Evaluations should avoid overly sweeping claims of impact from pre- and post-data alone. Cross-sectional data can document correlation between variables but not causality. The use of different types of data and more extensive analysis can strengthen the probability that a specific communication intervention caused a measurable change in behavior or contributed an identifiable amount to the change.

There are six steps of evaluating any communication interventions. The following set of activities a general overview how the evaluations should be planned and undertakes. Determining the appropriate scope and type of evaluation that is both needed and possible is a key element in strategic design. At the basic level, evaluation serves the purposes of:

- Finding out whether the implementation activities spelled out in the work plan were actually carried out (process evaluation or monitoring)
- Determining whether the objectives set forth in the strategy, were achieved (impact assessment).

Evaluation, like research, must be addressed at the beginning of any strategic communication project. The initial definition of strategic communication objectives guides every stage of evaluation. Thus, an objective of changing individual behavior requires an evaluation that will measure individual behavior over time; a policy objective of passing specific legislation will require a means to determine whether or what part of that legislation became law; and an objective of stimulating community activism will require from the start measures or indicators of community activism.

The evaluation design must focus on the intended unit of analysis as well as expected changes. Therefore, those who carry out the evaluation should ideally participate in helping to set SMART

objectives in such a way that those objectives and the process of achieving them can be accurately and precisely measured throughout the project.

6.3. Indicators

The first step in impact evaluation is to determine the indicators you will use to determine whether your objectives have been achieved.

Examples of *individual-level indicators* for the behavior change communication strategies include (Bertrand &Escudero, 2002):

- Percent of audience with a specific attitude (toward a product, practice, or service)
- Percent of audience who believe that their spouses, friends, relatives, and community approve (or disapprove) of a product, practice, or service
- Percent of non-users who intend to adopt a certain practice in the future
- Percent of audience who are confident that they can adopt a particular behavior

At a broader social level, the indicators listed below can be used to measure social change. Some of these indicators are measured qualitatively and others are more appropriately measured through quantitative techniques:

Annex :Illustrative process indicators

 # target population reached
 # IEC events conducted
 # IEC campaigns
 # IEC materials developed
 # IEC materials products disseminated
 # formative studies/assessments conducted
 # BCC or targeted interventions training sessions conducted (by focus of training)
 # people trained
 # BCC workshops conducted
 # workshop participants (by focus of workshop)
 # organizations receiving BCC technical assistance
 # BCC materials and guidelines developed and produced
 # advocacy activities (by focus) implemented
 # people reached
 # active field workers (by targeted group) and by sex and age
 # peer educator services provided per targeted group
 # peer educator services provided
 # group education activities (by focus)
 # participants
 # new contacts by peer educators
 # peer educator referrals for STI care
 # persons referred by peer educator accessing services
 # targeted population reached with educational programs
 # condoms distributed to the target population
 # condom sales outlets open in the area during this timeframe
 # condom free outlets open in the area during this timeframe
 # condom demonstrations provided to targeted population
#, type, and frequency of activity/channel (print, radio, TV, theater/song/video, hotline/call-in radio show, newspapers, or lectures/presentations)
 # Print coverage and estimated readership
 # Amount of time on radio and TV and estimated audience
 # New organizations, businesses, and media outlets participating in program

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