



IPC TOOLKIT

A compilation of examples, lessons learned and best practices in IPC programs based on the IPC Deep Dive conducted in 2011.

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INTRODUCTION

Interpersonal Communication (IPC) is any face-to-face interaction that takes place with a target audience with the objective of changing their behavior. IPC generally refers to face-to-face interactions with the community but IPC techniques can also be used with health care providers. When IPC is conducted with providers it is often referred to as medical detailing or supportive supervision.

This guide is meant to consolidate PSI's learnings and resources on IPC into a tool for PSI countries using or planning to use IPC. As this tool was created with WHP support, it focuses primarily on family planning and reproductive health. However, most of the principals and techniques outlined in this guide can be applied to other health intervention areas.

IPC DEEP DIVE

The IPC Deep Dive was a pilot project conducted in 2011 to improve IPC programs and PSI support to country platforms under Women's Health Project (WHP). The objectives of the Deep Dive were: to develop best practices and build capacity in IPC and examine different models of technical assistance that PSI could provide. Twelve months of technical assistance were provided to four countries; El Salvador, India, Madagascar and Tanzania. The IPC Deep Dive team was led by Risha Hess, and implemented by Mario Flores (El Salvador), Shannon McAfee (Madagascar), Kiran Thejawsji and Sanjay Chaganti (India) and Meg Kays and Nirali Shah (Monitoring and Evaluation). Donna Sherard and Beth Skorochod from the HIV Department also sat on the team to ensure the work they were doing on DELTA+ Promo modules, which include IPC was harmonized with Deep Dive findings.

The first step for each of the four countries was a qualitative needs assessment. Using the IPC framework, presented below, to facilitate a discussion with the IPC team, each country summarized their approach to each component of the framework. In general, the assessment allowed the teams to identify areas of excellence and areas that needed more work. Technical Assistance was then provided for each priority improvement area. The evaluation took place in Q4 2012 (details to be provided).

FRAMEWORK

In January 2011, the Deep Dive roll-out team developed an **IPC Framework** to help assess platforms' performance and give the PSI world a common language with which to discuss IPC.

The framework builds upon the DELTA process with selected Behavior/s, Marketing Objective/s and Target Audience/s. Completing the DELTA process is crucial to the success of any behavior change program. IPC is a promotional or communications tactic that is only one part of your larger DELTA strategy.

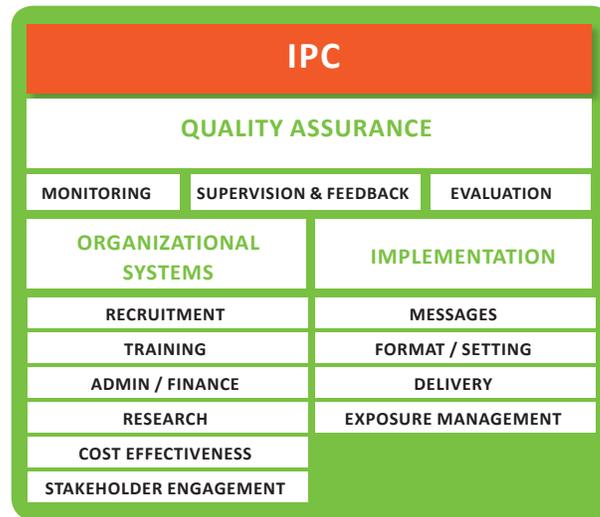
Figure 1: IPC Framework



This framework (and the detail on the next page) is meant as a way to ensure projects are considering all aspects that are necessary for a successful IPC program.

USING THIS TOOLKIT

The remainder of the framework is divided into three ‘pillars of excellence’; Quality Assurance (QA), Organizational Systems, and Implementation. QA is a crosscutting component of the framework, and should also be applied to Organizational Systems and Implementation.



One of the key lessons learned from the Deep Dive was that while most programs are doing an acceptable job in aspects of program delivery, they are not focusing enough on issues linked to Quality Assurance. When our programs show poor results or fall apart, it’s usually because of a weakness in QA. This finding is crucial particularly in light of the fact that many programs report that their greatest technical assistance needs are in the area of Organizational Systems and Implementation. **It is highly recommended that all countries implementing or planning to implement an IPC program begin program strengthening with the Quality Assurance aspects before focusing on any other areas.**

The reason we are emphasizing Quality Assurance is that the IPC Deep Dive pilot started with an in-country analysis (needs assessment) to identify areas that needed support, and then provided TA to support implementation. An implementation model was delivered (priority target segments, tools, communications skills and frequency plan, all discussed in detail in this toolkit), and was well received. In retrospect, the Deep Dive team realized that improvements introduced as a result of TA won’t really take hold, and we won’t know how programs are doing because we didn’t *first* address the structural issues, namely MIS and supervision.

Even if countries have lined up solid strategies, stellar IPC agents and effective tools, without proper monitoring and a reliable MIS, we won’t know how well the program is working and importantly, when it ceases to be effective.

Without enough capable supervisors dedicated to overseeing and managing the IPC team, trainings or other program improvements may be lost. Supervisors are

key to keeping the program on track, reinforcing skills and guidelines and making the IPC team accountable for their activities.

GAP ANALYSIS

Existing IPC programs can benefit from improving all three areas – Quality Assurance, Organizational Systems and Implementation. Based on the above lessons learned, the first step is to assess the Quality Assurance aspects. The QA ***Gap Analysis Questionnaire for IPC Quality Assurance*** includes key questions about MIS and Supervision to help you determine where you need to improve. A similar assessment for Organizational Systems and Implementation will be available shortly. See [El Salvador's IPC Assessment Case Study](#).



TESTIMONIAL

El Salvador: “The gap analysis really helped us focus our program. By first collecting the perceptions of the CR and the program manager and then confirming it with field visit by someone with a fresh perspective, the process helped us identify gaps and some misaligned parts of the strategy. That allowed us to align our strategy (archetypes, targets, research, etc.) and plan trainings and TA to fill the gaps.”

TOOLKIT SECTIONS

Each element of the framework (i.e., Recruitment, Messages, etc.) is available as its own section in this toolkit. Each section is divided up into four sub-sections; Best Practices, Advice For New IPC Programs, Frequently Asked Questions and Resources. The toolkit is meant to serve as a guide and as a clearinghouse of resources. If you have additional resources or questions you'd like to see addressed, please email **Risha Hess** at rhess@psi.org.

PRE-REQUISITES TO LAUNCHING AN IPC STRATEGY

A DELTA is a pre-requisite to starting any IPC program, below are specifics in several DELTA categories that apply to IPC programs.



BEHAVIOR

No matter what health area you are looking to address using IPC, the behavior you want people to adopt should be **specific** and **measurable**. This is equally important in programs focusing on end users as those focusing on providers. Clear behavioral are just as essential. This focuses our messaging, and allows us to define (and consequently measure) success. The following are examples of provider behaviors:

- Inserting at least 15 IUDs in the last month.
- Talking to 5 female clients who came in for other services about their family planning needs.
- Scoring at least 80% on 3 consecutive implant insertion checklists.

PRIME PROSPECTS/ AUDIENCE PROFILE

Family Planning: Generally, our default methodology for segmenting targets uses age and geography (i.e., urban youth, aged 18-24). However, in family planning, this methodology isn't sufficient to craft messages. In more ways than not, the family planning needs of a 19-year-old new mother living in urban slums is similar to a 30-year-old new mother living in the village. The defining aspect of a woman's need is often **lifecycle** versus traditional demographics.

In the IPC Deep Dive countries we stepped back and identified priority segments or prime prospects - people that we especially wanted to work with and follow-up with. In all four pilot countries (El Salvador, India, Madagascar and Tanzania), we used a combination of health needs (the "Four Toos" below) and non-health characteristics.

- Too many: > 5 children delivered by one woman
- Too close: < 24 months between last birth and next pregnancy
- Too old: > 35 years old at the time of a pregnancy
- Too young: < 18 years old at the time of pregnancy

(from [Healthy Timing and Spacing of Pregnancy.pdf](#))

When we factored in non-health related consequences of unwanted pregnancy—including the loss of education and earning potential for a woman in school— El Salvador adjusted the age of "too young" to 17 or older, while Madagascar specified between 15-18 years of age.

We also considered women who were most likely to stop using contraception (other than wanting to get pregnant), women who were most likely to adopt a new method quickly and those who could influence others. While the lists differed slightly from country to country, they often included the following segments <handouts on prime prospects in pdf form [English \(Tanzania\).pdf](#), [Spanish \(El Salvador\).pdf](#), [French \(Madagascar\).pdf](#)>:

- **New Mamas** – related to the “too close” health need of spacing;
- **Young Non-Users** – related to the “too young” health need to delay the first pregnancy (found to be a bigger health issue in some countries than others);
- **New Users** – based on the idea (re-affirmed by the [Willows Project](#)) that because of the side effects experienced in the first few weeks after starting a new method, this is the time when most women stop using;
- **Satisfied IUD Users** – as IUD use is disproportionately low in most of our settings, we specifically want to find satisfied users who can talk about IUDs within their social networks;
- **Dissatisfied Users** – similar to new users, this group will likely stop using FP unless we address their concerns and/or side effects. This group often also communicates their dissatisfaction and share negative events with their peers. As in the commercial sector, dissatisfied customers are more likely to tell people about their bad experience than satisfied customers are to talk about their positive experience. This links to bias in risk assessment by those peers and therefore could negatively impact adoption.
- **Interested Non-Users** – This is the largest group in most places, and one that we think we can move quickly to trial as they are expressing interest and just need their final barriers addressed.

For more information see the [Case Study on Segmenting for Family Planning.pdf](#).

IDUs: One unique program type that relates to how you select your prime prospects is the Break-the-Cycle concept for injecting drug use. In this case your target audience is non-injecting drug users and your behavior is to not start injecting. The prime prospect then is current injectors and the desired behavior for them is to not initiate new users (specifically: Don't inject in the presence of non-injectors; Don't talk only about the positive effects of narcotics, in front of non-users or non-injectors; Don't assist someone with their first injection;



Develop skills to refuse unwelcome requests to help someone learn to inject). For more on this approach see [Break the Cycle.pdf](#).

MARKETING OBJECTIVES

If a program has completed the DELTA process, it is assumed that they have identified the major factors of use of family planning methods. For IUDs as well as other modern methods, common themes include beliefs that the methods are “safe”, “effective” and “easy”. Accessibility (including price) is also a common issue, as is partner and family/friends support. See [RH Marketing Plans here](#), also see examples of research questionnaires [from TRaC](#) and [from FoQus](#).

PROMO P

After looking at which of the 4Ps can address each determinant, the team will likely identify issues they would like to address through promotional activities. The next question is, what form(s) of promo?

What is IPC?

For the purposes of this toolkit, Interpersonal Communication (IPC) is any face-to-face interaction with a target audience with the objective of changing their behavior. IPC generally refers to face-to-face interactions with a given community or end users but IPC techniques can also be used to change the behavior of health care providers. IPC formats can include small group interactions, one-on-one and larger forums. These are referred to as group sizes and are discussed in the [Format/Setting](#) section.

When to use IPC?

Many of us use IPC because we have a vague sense that it is good or because it is part of a donor’s requirements.

Before embarking on an IPC program, it is crucial to know that IPC is a resource-intensive medium that often has limited reach and coverage. Doing it at scale is expensive and demands complex supervision and administration. For those reasons, it should only be used strategically. Good reasons to use IPC include :

- To reach populations that are not exposed to other media,
- To move people from interest to trial (like sampling efforts in the private sector),
- To reach specific, highly stigmatized (i.e. sex workers) and/or homogenous populations,
- When the remaining barriers to behavior adoption are inherently personal and require personalization,
- To conduct demonstrations – this could include skill building such as improving negotiation skills through role plays and practice e.g., when asking for the money to go to the health center, or convincing a partner that they should use FP, or putting on a condom, and/or
- To create networks of immediate social support (e.g. women’s group

members start talking about FP, and building a sense that using it is acceptable).

<Implementation Brief - When to use IPC.pdf, [English](#), [French](#)>

Integration with other Mediums

We know that IPC is more effective when reinforced in “surround sound” with messages in other media ([Kim et al 2001](#), [Gupta et al 2003](#), [Pinfold 1999](#)). Yet, we see too many programs saying, “we’ll address beliefs through radio and television, and self-efficacy through IPC.” (actual quote) So effectively, you’re addressing two different factors with two different promo tactics. While it understandable to want to address as much as possible at once, and notwithstanding that some messages are better suited for particular channels, it is more effective when people hear the same messages at or around the same time from several different channels. One hand, this is due to the different levels of trust people have in different sources of information, and on the other hand, to the greater effect multiple exposures to the same message will have on the audience.



IPC

QUALITY ASSURANCE

ORGANIZATIONAL
SYSTEMS

IMPLEMENTATION

- 1 MONITORING
- 2 SUPERVISION & FEEDBACK
- 3 EVALUATION

Quality Assurance is the key to a successful long-term IPC program. Why? Because without strong supervision and feedback, we won't know how well the IPC agents are doing, won't be able to help them get better and build or reinforce skills and won't be able to ensure they adhere to our strategies. Without monitoring (mostly MIS) and evaluation we won't know *if* it's working or which strategies or team or agents are most effective and where the gaps are.

For a summary of why see the Best Practice Brief: Best Practices_IPC Quality Assurance.pdf.

See also the Self Assessment (Gap Analysis) for Quality Assurance of IPC.docx

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MONITORING

Monitoring is ongoing data collection, analysis and reporting for decision-making. Just as a sales rep collects monthly sales figures to determine how well sales are going, your IPC team should be providing regular updates tracking their progress, and letting them know if there are areas that need improving. This can take many forms but will likely include ACTIVITY reports (tracking quantity), QUALITY OF COMMUNICATION reports (tracking delivery quality) and SUCCESS reports (tracking impact).

Monitoring is a key element of quality assurance. Without proper MIS and understanding of what's happening on the ground, we cannot track successes and will not know when a strategy ceases to work.

BEST PRACTICES

- Your MIS is data-entry friendly and automatically generates reports.
- Your MIS tells you how many contacts and sessions have been conducted, by target audience segment, during which period of time, by group size, activity type and setting (when applicable), as well as how many referral cards have been distributed (when applicable) by each IPC agent, team and overall program.
- Your MIS reports on the quality of IPC delivered by individual IPC agent, team and overall program (per pre-defined quality parameters such as using open-ended questions).
- Your MIS can link/correlate the activities of the IPC agents to behavioral outcomes achieved, such as use of clinics, insertions and/or progress in stages of change. (Please note: these may in fact report output indicators and do not necessarily prove success, but will give you an indication that your program is on the right track).
- Your MIS tracks the efficiency of IPC (how many people reached versus how many go to a clinic, for instance).
- Your IPC Supervisors and Program Managers use reports from MIS at least quarterly to revise program strategies, identify capacity building needs, compare strategies and approaches between IPC agents/teams, and reward successes.
- You have built in data checks or quality checks into your MIS, such as calling a random sample of people who IPC agents said they've met and comparing the input sheets to the data actually entered on a random sample every month.

Software

If you have field teams that don't make it to headquarters at least monthly, you will want to consider a system that allows IPC agents and supervisors to input data from the field, either through software that can be loaded onto laptops or regional office computers, or through a web-based (or SMS-based) interface. You will want to ensure it is linked to the system through which you collect clinic data as well. Avoid using MS Excel-based reports. It is tempting to set these up as a temporary "fix". Don't. They end up being more resource consuming and producing less reliable and manageable data sets. Often, if the programs begin before the MIS system was in place and figures were copied and pasted into excel sheets, data isn't available in a way that can be easily used. A Microsoft Access or other database system is recommended.

Designing System

The first thing to consider in building your system is what types of reports you want to generate (see [sample](#)), and what kinds of programmatic decisions you want the data to help you make. Your goal should be to only collect information that will actually facilitate decision-making. There is great temptation to try to capture 'everything', because it could be interesting or potentially useful in the distant future. We recommend you resist that temptation! Similar to PSI's "backwards research" approach where we start with defining what we want as outputs to determine inputs; our approach to MIS should be "Backwards MIS". If your team is keen to collect additional data for the IPC agent's use, it can be included on the collection form, which should clearly state which data is for entry into the MIS, and which is not.

Efficiency Measures

Family planning programs collecting information from clinics should use two categories may be used to measure IPC efficiency – a key measurement of SUCCESS:

- **Clinic efficiency:** Number of women reached (as reported by IPCs) by number of clients (as reported by clinics). Example: 4:1, for every 4 women contacted by IPC, there is 1 insertion at affiliated clinic.
- **Referral card efficiency:** Women reached (as reported by IPCs) by number of referral cards redeemed. Examples: 20:1, for every 20 women contacted by IPC, 1 woman walks into the clinic with a referral card (note that this number is *not* how many referrals cards are distributed).

We want to look at efficiency and be able to compare it across regions within a country and between countries, and judge whether we are "up to par". We found that programs were generally measuring clinic efficiency or the referral efficiency and therefore weren't comparable. While Kenya reported a 1:8 clinic efficiency ratio (for each 8 women reached at the start of the project, 1 person

had an IUD inserted), Tanzania reported closer to 1:50. We realized after review that this was because Tanzania was reporting *referral efficiency* (for every 50 women IPC agents talked to, one brought a referral card to a clinic and had an IUD inserted), a much stricter measure than clinic efficiency. Referral Efficiency is a more rigorous indicator of performance because it only counts visits that can be definitively attributed to the IPC work, while Clinic Efficiency counts all visits, regardless of how they were motivated. Comparing the same metric across countries can help reveal program gaps and inefficiencies.

Other Measures of Effectiveness

- **Clients per IPC agent:** How many FP clients (or IUD insertions) each IPC agent brings in. For instance Cambodia sees approximately 1.5 IUDs per IPC agent (as measured through referral cards redeemed) in a month (calculated by referrals redeemed divided by number of IPC agents). This is similar to referral efficiency but is less about how many people are reached versus how effective they are in a month. The idea here is that we might not care how much work an IPC agent has to do (Agent A may talk to 100 and Agent B may talk to 2) but if we pay them the same and they both bring in 2 clients per month this measure sees them as equal.



SPOTLIGHT ON
REAL WORLD

Monitoring as a Management Tool

El Salvador was using clinic efficiency to judge the efficiency of their IPC. After the Deep Dive they started monitoring referral efficiency as well. In the first month they realized that one whole team brought in zero referrals and were getting credit for the demand that the clinic itself created. The majority of the team and the supervisor was laid off. See [video on this](#).



Referral Cards

Referral cards are an excellent way to track effectiveness of your IPC program. In setting up a referral program, several key factors should be taken into consideration:

- ? What is the added value for a woman of using the referral card?** The most common reason is to receive a discount. If your program cannot provide the client with a discount, will the providers offer their own discount to get the referrals? Will they prioritize seeing the women who come in with a card? If women don't have a good reason (monetary or otherwise) to present the card, they often will not – even if they use the service. Make sure you create an incentive scheme around referral cards that benefits both clients and providers.
- ? What is the added value for the provider?** Again, the most common reason is monetary, e.g. they will receive payment or reimbursement for services rendered, or for returning the cards. Several programs have found that if providers are only required to drop the cards in a box, or if membership to the PSI network or franchise of clinics is valued enough, they are willing to collect referral cards without incentives.
- ? What information should be on the cards?** On the side filled out by IPC agents (or a logbook they keep on referral cards), the date, agent name, group size (one-on-one, group), activity type (theme or games, kiosks, etc.), setting (whether household, university, clinic etc.) should be noted, along with other elements you'd like to compare. The redeemed side on the reverse should have the name/code of clinic it was redeemed at, and optionally, the service rendered. The India example below is a nice example of linking IPC to other parts of your promotional strategy (in this case mass media). [Sample referral card.pdf](#), [India referral card.jpg](#)
- ? What should be included in MIS reports?** All the information collected should be reported on (otherwise, stop collecting it!). Examples of data tracked include referral figures per each IPC, per team/region, per group size, activity type, setting, and length of time between referral and redemption.

New technologies should also be considered, such as electronic or SMS referrals.



SPOTLIGHT ON
REAL WORLD

Referral Cards

Willows-Like Strategies: e.g., India: PSI/India has done a thorough mapping of all women of reproductive age who are married and then gives the IPC agents lists of all the new users. Each agent is supposed to visit each non-user 4 times a year. In this program women are given a referral card only if they are interested in visiting the clinic within the next week. The conversion ratio from cards given to cards redeemed is 34%.

More Typical Strategies: e.g., Tanzania: Tanzania is more typical of PSI's IPC programs. In these programs there is a combination of small group, large group and one-on-one interactions. In several countries the one-on-one interactions are used for women that we identify as "Prime Prospects" and want to follow-up with.

However, most of our contacts in these programs (and most of our referrals) are from the small and large group interactions. In these sessions we achieve the necessary reach and use them as opportunities to find Prime Prospects for follow-up. For members of the groups who are not Prime Prospects we have no set policy on whether or not they should receive a referral card. Some agents will give several cards to everyone, with the idea that they should give them to their friends, daughters, etc. Others will act more like the India team and only give cards to those who seem really, really interested. Most IPC agents fall somewhere in the middle. For instance, in Tanzania in September 2010 the percent of reached women who received a card ranged from 1% to 65% with an average of 17% of women reached receiving cards. In these programs our referral strategy is more like nudging, as a way to remind women to go and let them know about the service.

The redemption rate of cards in that same month ranged from 0-233% (meaning that cards given in previous months were redeemed); with an average of 40%. And no matter what strategy used (giving cards to everyone, giving selectively or something in-between), the referral efficiency – that is the number of referral cards redeemed for an insertion as a percentage of total women reached – was at 3%.



Data Checks

It is important to ensure that the data in our system is accurate. As the old saying goes, “junk in, junk out”. There are two common causes of inaccurate data:

1. Data entry mistakes, and
2. Fraud in filling out the forms.

To *prevent* data entry mistakes, the first step is to minimize how many times figures need to be copied. If an IPC agent has to fill out the number of people reached on one form and then add it up on another form and then the IPC supervisor fills out a summary form and then someone data enters it; there are four chances for data entry mistakes. If the IPC agent fills out one form and then it gets data entered, that’s two. If the IPC agent directly enters the data into a phone or computer, that’s one. The fewer chances for data entry mistakes, the better. To *audit* for data entry mistakes, someone should randomly compare a sample of the data in the system to the to the forms.

The most common fraud is an IPC agent or supervisor saying they’ve conducted activities or reached people they haven’t. To *prevent* fraud, random supervision is suggested (have a work plan for your IPC agents and supervisors, call them a little while before they are due to be somewhere and ask if you can join). When IPC agents know that this happens, they are more likely to list true activities. Further you want to make sure they aren’t incentivized too much on activities conducted but rather successes. To *audit* for agents can also record the contact info of one person per session and supervisors can randomly back-check a sample of those reached by calling or visiting them and asking if they were actually seen (and how many other people were there, etc.).

Several programs have good examples of data checks ([India’s backcheck.xls](#), and many others). For one methodology see the attached [LQAS method write-up](#).

FREQUENTLY ASKED QUESTIONS

How can I ensure my team USES the data?

In setting up an MIS system, time and money should be set aside to train project managers and supervisors to *use* the outputs. They should review sample output sheets and discuss what decisions and conclusions they would make based on them. This should be done each reporting cycle (monthly, for instance) to help ensure data is actually being used.

Do we have too many forms?

We ended up in many cases combining several forms (e.g. combining all IPC activity types under one form – i.e., clinic activity versus group meeting) to make the process more manageable. We also tried to minimize the need to transcribe information from one form or sheet to (or adding sums), as this increases the chance of errors. Having one sheet (sample [Daily Activity Report.xls](#)) that captures all activity level information (that also includes different types of activities and follow-up) is ideal. Then we suggest two forms for the supervisors; one of their observations ([english.docx](#), [spanish.doc](#), [french.docx](#)) and one collected from the target audience ([english.docx](#), [spanish](#), [french.docx](#)). A separate form may be used for follow up visits, to help the IPC agent remember details of the previous visit, but not be included in the MIS system.

How can we improve our software/systems for analysis?

We found many countries using MS Excel forms, which are emailed to HQ and then someone (often someone at a Director level) cuts and pastes and cleans the data into one report. This is incredibly time intensive, and means a lot of data is lost (if it's conflicting or unclear).

As mentioned above, we highly recommend using a dedicated software to track data. The software package should be made available on all regional office computers and laptops, or be installed as a web-based program that allows people to enter data and send it through the web from the field (i.e. regional offices, internet cafes, etc.). This allows for data to be easily combined, errors to be tracked and lessened, and reports made available to all managers, supervisors and IPC agents.

We are only collecting activity-level information, is that enough?

A recent review of MIS systems revealed that the only information collected by IPC programs is linked to process indicators, i.e. reports on *what* people are doing. MIS should also be collecting information about the quality of interactions and program successes *Quality information* includes quantitative supervisor feedback on their assessment of the quality of the session they observed using standard quality metrics <sample Supervisor Observations Form ([english.docx](#), [spanish.doc](#), [french.docx](#))> and quantitative feedback collected from the target audience <sample Audience Feedback Form ([english](#).

[docx](#), [spanish](#), [french.docx](#)>. It is recommended that this quality information is collected monthly for each IPC agent. *Success information* includes the efficiency ratios mentioned above, as well as standard information on insertions, referrals, clinic visits for the clinics the IPC attends to. If your program is using a key segments approach (prioritizing some target audiences - see [Prime Prospects section](#)), success data can include how many of women per segment the IPC was able to 'convert' (into a new user or advocate or other applicable measure of success).



SPOTLIGHT ON
REAL WORLD

Using Target Audience Feedback

In year 4 of the PSI/India Avahan program, one team started collecting feedback from the target audience (in a form similar to the Supervision Form - Target Audience Feedback). Behavior change had plateaued and they wanted to know why. By doing Lot Quality Assurance Sampling in each hotspot they worked in they realized that their scores for "Unique" and "New News" were lower than the rest. It was determined that people were not really paying attention because they thought they had "seen" it already. Activities were changed to look drastically different and three months later behavior spiked again (from 70-79% consistent condom use with CSWs correlated with exposure).



How do I deal with staff not able to enter data (either because not trained or lack of internet/computer)

This is a challenge for most programs, to which there are a number of solutions. At the most basic, the IPC agent will send paper forms to a head office where the data can be entered. This is the least desirable option as it delays the process and increases the risk of data entry errors because the person who filled out the form may not be available for clarifications. If training is the problem, it often makes sense to hire a full- or part-time data entry person at the field office level. Appropriate software can also help address internet unreliability issues by ensuring forms can be filled in offline, and uploaded when a connection is available. Entry may also be web-based and completed from an internet café if IPC agents and supervisors don't have access to computers or internet connection.

Forms collect information on reach but not frequency, should they do both?

Having multiple exposures to the target audience is preferred to one-time contacts in many situations (see Exposure Management). Depending on the strategy, this may or may not be possible to track through MIS. A way around this is by targeting specific people for follow-up, and getting their name. If your IPC activities are mostly in groups, and you don't collect contact information, MIS is likely not the best way to measure frequency of contact (periodic questioning of the target audience on how many times they've seen you). Evaluation is likely to be more effective.

If you can collect contact information then the IPC input forms should indicate whether a contact was follow-up or initial <sample activity report> and corresponding reports should show those results.

What do I need to know about Unique Identifier Codes?

A unique identifier code (UIC) is a confidential, yet reliable tracking system that is useful in monitoring coverage and reach. This simple system of anonymous client registration and tracking service usage can also be manually generated and assigned by an IPC agent. For example, a program in Central Asia asked its IPC agents to develop a 7-digit UIC for each person reached. This consisted of:

- First two letters of mother's first name
- First two letters of father's first name
- Gender (single letter M/F or number 1/2)
- Year of birth (last two digits)

This information provided key data about the client, including age and gender, without including any information that could be easily used to identify that person.

When clients were approached by an IPC agent, they were prompted for their UIC with the question, "Without saying your mother's name, please provide me the first two letters of her first name." By introducing the UIC to individuals in the target group in this way, trust is developed in a system that will ensure anonymity. As a consequence, clients are more willing to provide this information. This allows the agent to easily measure repeat reach.

If your IPC program is structured in such a way that one agent responsible for a geographical coverage (e.g. in one project in Uganda one IPC agent is responsible for 30 households) and the IPC agent documents each visit to a particular client using a client information form, a unique identifier is necessary. This can be generated by your MIS and coded on the client information form. Unique identifiers are perhaps most relevant for IPC projects that focus on one-to-one communications.

How can we come up with a way of counting and verifying the numbers of people reached with messaging, especially in mass media events, community events and bus-rank promotions, where there is no entry point into the event and the event is not hosted by PSI?

We've seen two approaches to counting reach; especially through in-person events or IPC.

1. Try really hard to be accurate. This is probably only possible when you're talking about small group (2-10 people) or one-on-one interactions or in fixed group meetings of any size. We've seen three ways to verify this.
 - » Take the name and contact info of a few people at every group and contact a random sample of them later and have them estimate the size of the group to compare to the staff's estimate. Not helpful for large groups where estimates will be way off.
 - » Make this part of the supervisor's responsibility. When they attend events, they also note how many people they think are in attendance and discuss after with the staff if there are differences in their estimates.
 - » Give clear instructions that staff should take a count at least twice a session and take the average to account for people coming and going.

2. Admit there will be flaws in counting, ask for consistency in methods and triangulate. This is what India did when using the type of events you describe. This is a good method for programming and planning but not necessarily for donor reporting. Each state's teams developed different ways of counting and it became clear that they were flawed but would remain so. Therefore we asked the teams to keep counting as they had been - i.e., just be consistent. They then had surveys in the areas they worked and randomly asked a sample of the target audience if they had seen the activities. Then compare that (called recall) to the staff counts (called reach). So - if we knew the target population was 100,000 and in our staff's reach counts they said they'd reached 3000 of the target audience in the past 6 months and our recall surveys indicate a 30% recall we can say we're about accurate. If not we can see our errors and assume similar errors throughout the length of project. It's not perfect but counting large groups of people is not realistic.

Also remember that you may need count different types of people differently - i.e., if your target audience is women 18-45, count them separately from older and younger women and men.



RESOURCES

- [Self Assessment for Monitoring of IPC.docx](#)
- [El Salvador's video case study of importance of Monitoring and Supervision \(youtube link\)](#)
- [Data Dictionary for IPC.docx](#)
- [Sample Terms of Reference for building a new IPC MIS.docx](#)

Sample MIS Forms

- [Sample IPC Daily Activity Report.xlsx](#)
- [Sample Supervisor Observations Form \(english.docx, spanish.doc, french.docx\)](#)
- [Sample Audience Feedback Form \(english.docx, spanish, french.docx\)](#)
- [Sample Output report.xlsx](#)
- [Sample web inputs/outputs.zip \(from Madagascar\)](#)
- [India's backcheck.xls](#)
- [Sample referral card.pdf, India referral card.jpg](#)

PSI Write-ups

- [Unique Identifiers Central Asia.pdf](#)
- [Unique Identifiers in Vietnam.doc](#)
- [PASMO Unique Identifier Pilot.docx](#)
- [LQAS method write-up.pdf](#)

External Readings

- [Manoff Group: Social Marketing of Vitamin A in 3 Asian Countries.pdf \(discusses how they were monitored\)](#)
- [WSP: Developing a Decentralized Performance Monitoring System in Senegal.pdf](#)
- [Drug Demand Reduction Unique Identifier Codes.pdf](#)

2

SUPERVISION & FEEDBACK

Quality of IPC delivery is contingent upon **quality feedback**. Moreover, motivation (which effects the retention of IPC agents) is contingent upon **quality supervision**. Quality feedback and supervision is about both **content and quantity**. IPC agents value frequent supervision, and substantive feedback. Too often, we leave our IPC agents hanging in the field, then show up once every 6 months with a perfunctory “good job.”

The IPC program organizational structure should be developed with adequate IPC agent management in mind. Agents should be supervised WELL and OFTEN. Supervisors need to give feedback on both the **quality of the IPC agent’s delivery** and to **check that they are in the right place, at the right time**.

Two-way feedback, letting IPC agents know how they are doing relative to others, and as a group, is also an important tool to maximize program efficiency. Likewise, the program needs to hear about and analyze what IPC agents are experiencing in the field. IPC agents are effectively running focus groups every day! If we aren’t listening, we are missing a major learning opportunity that can help us shape future messaging.

Supervision and feedback is a key element of quality assurance. Without it, new skills and strategies will not be effectively implemented in the field. Too many trainings are taking place without adequate follow-up supervision – this results in wasted time and resources.

BEST PRACTICES

- Each IPC agent receives some time at least once a month where their supervisor accompanies their activities in the field (observes at least one session) and gives them feedback on their technical accuracy, communication skills, communication effectiveness and adherence to strategy.
- IPC Supervisors have no responsibilities other than supervising IPCs and related activities such as paperwork, strategy sessions and trainings for themselves.
- Supervisors regularly access MIS reports (which means they have this access) and closely follow how their teams and individual IPCs are performing.
- Supervisors have demonstrated technical competence on the clinical aspects of FP and communication skills; understand what makes communication effective and how to give feedback.
- IPC Supervisors receive feedback at least quarterly on how to improve on their own supervisory skills.
- IPC teams and supervisors meet regularly to improve activities and learn from one another.
- After new skills or strategies are introduced, IPC agents receive increased feedback (each IPC agent benefits from at least 3 feedback sessions on the new skills in the 2 months following the training).

You want to ensure that IPC agents get frequent feedback on:

1. Quality of communication (see section on Delivery)
2. Adherence to methodology (staying on script, following lesson plan, adapting the conversation to each person, etc.)
3. Targeting (talking to the right people at the right time)
4. Clinical/Technical accuracy (what they are saying about family planning methods is correct), and referring participants to a health care provider when they do not know the answer to a health or method related question.

This means training the supervisors on all these points, giving them the tools to aide their supervision and ensuring that they have enough time to supervise the agents (at least monthly). In addition, some programs have found it helpful to train supervisors in giving effective feedback.

Minimum Standards for Supervision

When devising the supervisory structure and the number of IPC agents for which each supervisor will be responsible, it is important to assure that each IPC agent is able to receive a minimum of one observed supervisory visit with feedback from their supervisor per month. There is no set “ideal” ratio of number of IPC agents to supervisors as this will vary based on geographic and other considerations, but generally the number should be between 15-20 IPCs to 1 supervisor. The more supervision the better. The most successful (effective and surprisingly cost effective) programs have IPC agents receiving in-the-field supervision more than three times a month.

Supervisor Scope of Work

Supervision will entail not only providing technical guidance and feedback, but also dealing with day-to-day tasks such as logistics, checking up to make sure agents are where they are supposed to be, assuring proper authorizations for IPC agent activities, certain administrative and finance issues, and liaising with affiliated clinics if the need arises. Some programs have one supervisor responsible for all of these issues, other programs set up one line of supervisors that deals with technical issues and another line that manages the operational side. It may be efficient for large IPC programs to divide the responsibilities between technical and operational. However, in these cases both supervisors will still need to do a minimum of one monthly supervisory field visit. IPC agents should have one designated supervisor whom they principally report to.

Often programs underestimate the time required to perform supervisory tasks and fail to consider supervision as a full-time job. It is tempting to add many other non-supervisory tasks to the supervisor’s scope of work. This should be

avoided at least until it is clear that the supervisor has time on his or her hands. The priority role of the supervisor should be to provide support and feedback to the IPC agents in order to continuously ensure high program quality delivery and impact.

[Sample Supervisor Job Description.doc](#)

Supervisor Profile

The profile of the supervisor can vary widely. In many of the WHP countries IPC Supervisors are medical professionals, while in others the supervisors come from management or communication backgrounds. There is no ideal profile as the person requirement is often context-specific. The crucial characteristics of a great supervisor are **leadership** and **mentoring** skills, as well as solid **organizational** and **coordination** skills. The supervisor should be willing (and enjoy!) spending time in the field, providing feedback and coaching IPC agents. Building on that willingness, the platform should adequately train new supervisors on all aspects related to their jobs, including but not limited to operations, management skills, communication skills and effective approaches (e.g. ETL techniques), providing feedback, clinical and technical issues around the health areas they work in, and MIS.

Supervisor Competency and Training

Supervisors must be trained on all the areas pointed out in the beginning of the section and provided with appropriate tools to aide their supervision. Supervisory tools should include objective checklists that are directly linked to the IPC agent activities, quality of delivery and targets. IPC agents should be familiar with these checklists and understand clearly what is expected of them. Sometimes it is also beneficial to give Supervisors training in being a Supervisor; how to find joy in mentoring, developing and selecting IPC agents. See [example of training slides on being a manager \(ppt\)](#).

Communication Skills: Supervisors should understand and be able to give feedback on good interactive communication techniques. We are currently using Education-through-Listening techniques as our standards. At a basic level ETL is about establishing rapport, listening more than talking/drawing out information and the OARS approach. Are IPCs using:

- **Open ended** questions to initiate and guide the discussion
- **Affirmations** to encourage participation
- **Reflective listening** to clarify what was said and what was meant
- **Summary** of the key discussion points and a key question to come up with plan of action

See Delivery Section for more information and training guides.

How to Give Feedback: Too often Supervisors give feedback that is either critical or just to praise. We want feedback that helps IPC agents to improve. A Situation, Behavior, Impact (SBI) approach is recommended. This approach gives feedback by first describing the Situation that was witnessed, followed by describing the Behavior that was observed and finally describing the Impact of that behavior. Situation – Behavior – Impact. This keeps the conversation focused on the behavior versus judging the person. It also lets the IPC agent see the impact of their behavior – and a behavior is easier to change than a general impression (such as having “good energy” or “not being committed”).

eg.
NON SBI FEEDBACK

“You have great energy!”

“You just don’t seem committed”

“You were condescending”

eg.
SBI FEEDBACK

Table 1: SBI Examples

SITUATION	BEHAVIOR	IMPACT
This afternoon when the women’s group leader asked you if the pill causes infertility...	You laughed and said: “I can’t believe that you still believe these village myths. Do you want to be a modern woman or not?”	I noticed that the entire group got very quiet after that. I think you shamed her in front of the group, and made the group afraid to ask any more questions.
When the woman expressed concerns about an IUD moving around the body....	You used the example of how a baby doesn’t leave the uterus.	The woman seemed convinced and I think that was a great use of an example that she could relate to so helped her understand.

The [SBI Training guide and materials-English \(zip file\)](#), [SBI French.zip](#) is built around this approach to feedback. Also see this [external site](#) with videos and guides on giving feedback.

Logistics: From the experience in El Salvador, at the beginning of the program logistics required intensive efforts and resources. Having someone with logistics experience was key to launching the program. If you can afford to have a logistics person assigned to the job instead of delegating responsibilities to the Supervisor, it would allow the supervisor to focus on coaching IPC agents in the crucial first few weeks and months of the project.

FREQUENTLY ASKED QUESTIONS

How many IPC agents should supervisors have on their team?

This answer will depend on the geographic spread of the IPC agents. The supervisor to IPC agent ratio varies from program to program. The ratio should be guided by the need for supervisors to conduct one monthly field visit per IPC agent. Generally this means between 10-20 IPC agents per supervisor.

Ensuring that each IPC agent receives at least one supervisory visit a month is key to maintaining motivation and ensuring quality IPC delivery. This was found to be a particularly weak point in the Deep Dive pilot country programs. Many supervisors were occupied with other tasks, and field visits were not prioritized. To remedy this, the Deep Dive countries have begun to shed tasks from their supervisors' scope of work so that the minimum standards of field visits can be fulfilled.

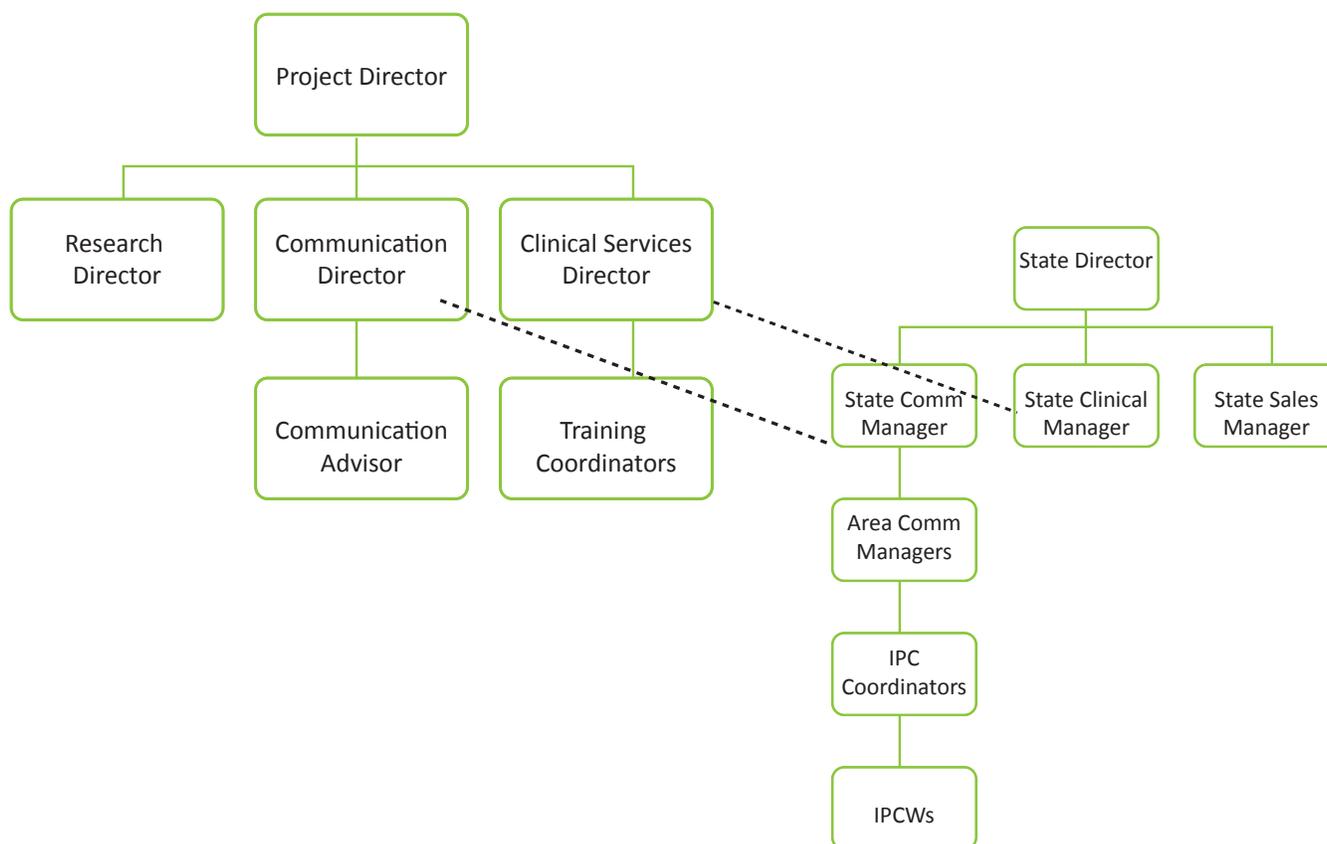
Can we have different people giving feedback on the medical/topical and communications aspects?

In cases where there are more than one IPC supervisor, such as one supervisor for medical issues and another for communications issues, challenges are sometimes seen in coordinating the two. Issues arise and ineffectiveness may result when roles are not clearly defined, and mechanisms for sharing information are not in place. This may have a negative impact on IPC agents who become de-motivated and less effective.

If there is more than one supervisor, it is important to clearly designate the roles and responsibilities of each supervisor in relation to the IPC agent and to each other. This includes designating the primary reporting supervisor, how evaluations will be coordinated, and how communications to the agents will be handled. Even if there is one primary supervisor, both supervisors should be responsible for conducting field visits once a month for each agent. Communication channels should be in place to ensure an open and constructive dialogue between supervisors and their agents. Figure 1 below shows an example of how India structured their communication technical inputs separately from their line managers in the field.

In practice, it is often challenging to manage a matrix reporting structure. Even after clarifying roles and responsibilities between clinical and communications supervisors, Uganda found that IPC agents were often confused and underutilized due to the lack of coordination. Their time would be taken up by supervisor visits. Finding the right balance between too little and too much supervising, and the most efficient structure, is key. Uganda decided to merge both supervisor roles into one. The medical supervisor was trained in communications and the second supervisor role was eliminated. The restructuring had the added benefit of cutting program costs.

Figure 1: India's Avahan Structure



How can I increase my supervisor's competence/effectiveness?

Beyond the points already mentioned, several other issues can lead to low performance and competency of supervisors. These include improper training, lack of tools, and insufficient management. The importance of recruiting the right candidates and training them at the onset of the project cannot be overstated. Supervisors must feel competent and confident in their role in order to carry out their responsibilities. Time should be dedicated to ensuring that the training they receive is comprehensive, relevant and complete. In addition to adequate training, supervisors need to be equipped with appropriate tools. The minimum tools needed include: an objective supervisory checklist linked to actual IPC delivery activities (see *Supervision Form - Target Audience Feedback* (English.docx, Spanish, French.docx), *Supervision Form - Supervisor Feedback* (English.docx, Spanish.doc, French.docx)), reporting forms, MIS reports, in addition to a detailed individual work plan and targets, based on the overall IPC program work plan.

Just as supervision of field agents is important to ensure quality activities in the field, supervision of supervisors should not be neglected. Supervisors will also need support and coaching in their role. They also need to have clarity as to whom they report to. Therefore, when devising an IPC program, it is important to consider the entire management chain, not just the IPC supervisors and IPC agents. This means that managers of IPC supervisors should also be trained and equipped to conduct occasional field visits to observe supervisors in the field and provide feedback.

How do I support supervisors to make sure they provide the right kind of feedback?

Many programs assume that supervisors will always know what to give feedback. This is simply not true. The best way to address this is to train supervisors and provide them with supervision forms to guide them on the areas you want them to focus on. The form should include the key four areas mentioned earlier, i.e. (1) Quality of communication (2) Adherence to methodology, (3) Targeting, and (4) Medical/Technical accuracy.

Many supervisors within WHP IPC programs seem to focus their feedback on the technical accuracy of interactions, largely because they are often from medical backgrounds, playing to their pre-existing strength. Some supervisors are also reluctant to provide any feedback that might be construed as negative or damaging to the relationship between the supervisor and the agent. However, IPC agents need feedback on a variety of issues and in a constructive manner.

To provide a foundation from which to give solid feedback, most of the IPC Deep Dive countries instituted the Situation, Behavior, Impact (SBI) approach, and trained their supervisors in this technique. SBI allows supervisors to provide feedback in a non-threatening and non-personalized manner. See SBI description above and [SBI facilitation guides](#).

Building on this foundation, supervisors need to have a solid understanding of the other skills and issues relative to the IPC agent job, so that they can provide pertinent and relevant feedback. An important area that supervisors should be trained on is communication skills. They should be trained on the same skills and techniques that the IPC agents are charged with using (such as ETL). This will allow supervisors to be more skilled and confident on giving feedback in these areas. This type of training may be conducted exclusively with supervisors or together with IPC agents. Supervisors may also either “shadow” or actually perform the same activities as the IPC agent during a set period of time, as part of their training. This will help them get a better understanding of field realities, and be more aware of the nuances of the tasks and challenges IPC agents may face.

When in-person supervision is not ideal because of the need for confidentiality and privacy during an activity, teams may use tape recorders so supervisors and IPC agents may listen to the conversation together, and supervisors may have the opportunity to provide feedback. This technique was used in El Salvador in order to provide feedback on individual sessions with clients. Permission to record an activity should always be requested in advance from clients (sample supervision forms: (see [Supervision Form - Target Audience Feedback \(English.docx, Spanish, French.docx\)](#), [Supervision Form - Supervisor Feedback \(English.docx, Spanish.doc, French.docx\)](#)).

How often and when should supervisors give feedback to their IPC agents?

Providing feedback right after new agents start fieldwork, and/or new techniques or new strategies are introduced, is KEY to ensuring success. We recommend conducting **extra (at least 3) supervision/feedback sessions for the first two months** after any new change. The more the better, if you can manage it.

For on-going feedback we recommend that **each IPC agent benefit from a supervisor ride-along at least one day a month** (spend a few hours doing regular work with the IPC agent). Agents should receive immediate feedback from their supervisor that day.

What to do if supervisors aren't giving feedback in a way that's helping the IPC agent to improve?

Giving feedback on the appropriate areas is half the challenge. The other half is how that feedback is given. Many people get very tense when giving or receiving feedback and feel that it is going to expose their weaknesses and leave them feeling ashamed. Depending on the culture, we find that people over-emphasize either the negative or the positive aspects. We recommend that this be balanced. We want feedback to help IPC agents to continue doing what they are doing well as well as to reinforce areas they can improve on.

An SBI feedback approach (described above) is recommended.

We don't have a feedback loop: how can we learn from what the IPC agents are learning?

An important aspect of successful feedback is ensuring that IPC agents aren't just learning from their supervisors, but that supervisors are also learning from IPC agents. Many countries use monthly or quarterly regional meetings to do this.

Passing up on the feedback loop is an incredible missed opportunity! We have tons of people out in the field talking to our target audience every day. If we are adequately learning from them, it can save us from costly mistakes or extra research.

Many countries put "difficulties encountered" or "FAQ" sections in IPC agent reports managers as well as IPC supervisors should take the time to review and *use* this information. In far too many cases, this information doesn't go anywhere, which can cause frustration and de-motivate IPC agents. If you find you haven't had time to use this information in the past 3 months, get rid of that section and find a new way to open the lines of communication (see below Spotlight for one example).



SPOTLIGHT ON
REAL WORLD

Getting Feedback from your IPC Agents

In year 4 of a 5 year Avahan project PSI/India realized that the barriers had changed but their research wasn't capturing it. They hypothesized that their IPC agents, most who had been working directly with the target audience for 3 years, probably knew what the new challenges were but hadn't been able to feed that information back up through the HR structure. They therefore focus grouped their own IPC agents, asking them what the issues were that they were hearing in the field. Why were some people adopting the desired behavior and others not? This exercise resulted in hundreds of statements that the HQ grouped into determinants and research was able to test. This also resulted in IPC agents realizing their job was to ask questions and learn (as well as "educate").



What do you suggest we do when working through local partners, should we have a PSI supervisor for each organization or set up the system within the partner??

Outsourcing your IPC is very common - and while it's not directly addressed in the supervising section above, the basic ideas on supervision should remain the same. We address the idea of working through outsourced IPC a bit in the recruitment section. Cambodia does this through contracts with CBOs and have found that paying per referral redeemed was key to increasing productivity (they are referring to FP services in clinics). In this model the CBOs do the supervision as well as the actual IPC. Kenya is looking at scaling up by working through a variety of partners. They are currently working on determining which parts of the supervision to do in-house and which to outsource.

What we currently recommend is to keep the MIS and concept of supervision within PSI. This means training and supervising the supervisors or actually hiring the supervisors on our staff. We want them to know what to supervise (technical accuracy, communication skills, communication effectiveness and adherence to strategy) and how to give feedback (SBI is one technique). We should give them the forms and guidelines about how often to supervise (ideally once per month in the field with each IPC agent).

How do you validate work done with MARPs by implementing partners?

In some cases, collecting phone numbers, unique identifier codes, or participation cards is not possible or reliable, so how do we verify even the numbers of participants in partners' reports (never mind quality)? In the Dominican Republic, PSI is attempting to supervise 30% of partner activities. Options include:

- 1) Work out a population size estimate for each catchment area, per type of MARPs. This will give you a sense of how many MSM/FSWs/etc. the partner organization will likely reach each month.
- 2) Sample and interview a sub-sample of MARPs in one or two catchment areas (just select a few locations) and ask whether they have been reached by XXX (partner name) during YYY (time period). You will get the percentage of MARPs reached by the partner organization. Then multiply this percentage with the estimated population size. Significant discrepancies should be discussed with partner organizations.

If you have any questions regarding population size estimate, please email Lung Vu: lvu@psi.org.



RESOURCES

- [Self Assessment for IPC Supervision.docx](#)
- [SBI Training guide and materials-English \(zip file\)](#)
- [SBI Training guide and materials-French \(zip file\)](#)
- [Supervision Form: Target Audience Feedback \(English.docx, Spanish, French.docx\)](#)
- [Supervision Form: Supervisor Observation \(English.docx, Spanish.doc, French.docx\)](#)
- [Sample Zambia IPC Field Monitoring Form.pdf](#)
- [Sample Supervisor Job Description.doc](#)
- [Madagascar IPC Supervisory Case Study.pdf](#)
- [Foundations of management course on PSI/U](#)
- [Example of training slides on being a manager \(ppt\)](#)

SBI websites:

- http://beta.ctcdata.org/wiki/index.php/SBI_Feedback_Model
- <http://mappio.com/mindmap/cbrown/the-sbi-model-giving-effective-feedback>
- [Dropbox site with videos and guides on giving feedback, similar to SBI](#)

Articles on Feedback

- [HBR: There's no such thing as constructive criticism](#)

3

EVALUATION

This chapter is meant to help IPC program managers evaluate their IPC programs. In all cases you should talk to your researchers in country as well as your regional researchers, and it is advisable to start this conversation as soon as possible.

Additionally, most of the discussion in this chapter is meant for cases where IPC is the main thing you want to evaluate. When IPC is a small component of a much bigger promotional campaign, you may need to take a different approach and should talk to your in-country and regional researchers.

Evaluating your IPC program can serve several purposes: internal learning, external learning or external accountability. It's important that you are clear on what you want to evaluate and why. Generally, there are three levels of evaluation:

1. **Process evaluation:** this can help you answer 'what is happening with the program?'
2. **Outcome evaluation:** this can help you understand what the results were for the target audience (i.e., changes in knowledge or behavior); and
3. **Impact evaluation:** this will answer what the effect is on the target audience's behavior and health status compared to if they had not received the IPC.

BEST PRACTICES

- Be able to clearly articulate what you expect IPC to achieve; behaviors and/ or OAM factors and what levels of exposure (frequency and combination of formats/group sizes) you expect to be necessary to change them.
- Link your evaluation design to the program logframe. Decide in advance on reporting time periods for assessing indicators as promised in the logframe, and specifically which indicators contribute to programmatic monitoring and which contribute to evaluation. For example, assessment of population level estimates of contraceptive use may be needed to help evaluate the program, but the program needs to know numbers of IPC sessions conducted for monitoring purposes.
- Build evaluation design into program design from the beginning for greatest flexibility and best results.
- Your MIS has a wealth of information about how your program operates. Make the most of it when planning and conducting your evaluation. Separate data collection may not be necessary or may only need to be done in a limited manner. (see [Monitoring Section](#)).
- Sampling (or how many people and which people you will interview): if you do population-based sampling, you need to make sure that you get enough IPC exposure in the population being sampled. Programmers don't need

to know how to sample, just be aware of how this limits your choices for IPC evaluation.

- Get necessary approvals. Several studies have encountered problems because they don't anticipate the ethical board's requirements in data collection. The PSI/REB can advise on the research/non-research determination and on the structure of informed consent forms.
- Measurement:
 - » Recall: Consider spontaneous (e.g., "where have you heard about FP in the past 3 months?") and prompted (e.g., "have you talked to a PSI agent in a yellow shirt in the past 3 months?") recall. Include visual aids to assist with prompted recall. Make sure to pre-test messaging before fielding and check on recall ability then.
 - » Indirect exposure: Consider also whether indirect exposure (such as word of mouth) to IPC might be relevant for programmatic effectiveness, based on your program theory.
 - » Make exposure definitions in advance – what does it mean to "see" an IPC agent – do they need to talk to them for some amount of time? How will someone recognize your IPC agents?
 - » Consider dosage: Do you want to measure different types and formats of IPC separately? Do you want to know if seeing the IPC agent twice was more effective than once?
- Dissemination: develop a plan from the beginning of how you want to share the results of your evaluation and identify your audiences.

How to Talk to Researchers

So you've decided you want to evaluate your IPC program and have called the research team for a discussion. Here are the following things you'll want to prepare in advance (because they'll ask you) and things you'll want to ask them. See [Talking to your Researcher about Evaluating your IPC Program](#) for examples of these questions/answers.

Evaluation Design Options

Your IPC evaluation can focus on Process, Outcomes and/or Impact. The following describes the differences between these methods and tools available.

In all of these you should FIRST consider whether you can answer the questions through routine data collection (MIS) rather than needing an additional study. Most Process questions can be answered through MIS (How many people are reached on a monthly basis?

- What resources (people, budget) are needed to reach those people?
- Are some groups systematically not being reached?

Many Outcome questions (e.g., How many people are behaving before and after your intervention if you can track referred clients?) can be answered through MIS if your IPC refers to clinics or services using referral cards. Impact will always need other forms of data collection since you will need to include people who did not receive IPC. For more on collecting MIS information see the [Monitoring Section](#).

Quantitative research asks a specific, narrow question and collects numerical data from participants to answer the question. The researcher analyzes the data with the help of statistics. The researcher is hoping the numbers will yield an unbiased result that can be generalized to some larger population. Quantitative research aims to answer what happened, to who and when.

Qualitative research asks broad questions and collects word data from participants. The researcher looks for themes and describes the information in themes and patterns exclusive to that set of participants. Qualitative research aims to answer the why and how something happened.

1. IPC Process Evaluation

Other names: Process Monitoring, Implementation Research

Goal: to document how the IPC strategy operates and to diagnose how to make operations more effective

Process evaluation is achieved by talking to either your own staff/partners or by talking to people who have been exposed to your program.

Establish your main questions first: what you want to understand about how the program operates and how IPC operates within the program. Did the program accomplish all of its activities? How well were the activities implemented? Questions of satisfaction, acceptability and feasibility can all be addressed within a process evaluation. Hint: it may be helpful to imagine that you have to replicate your program in a new setting and think about what information you need about how the program operates to be able to replicate it exactly. Second, decide where you can get the information. Much of the information you need may be contained in project forms, donor reports and your MIS. For more information see <http://www.cdc.gov/healthyyouth/evaluation/pdf/brief4.pdf>

PROCESS EVALUATION - QUANTITATIVE

Options	Small-scale studies to understand the reach of the IPC strategy, how well messages are being understood and accepted by program beneficiaries.
Sample Questions	<ul style="list-style-type: none"> • How many people did the program reach, and what are their population characteristics? • How much did IPC agents' knowledge of contraception improve after being trained for the program? • How satisfied were targeted women with their IPC interactions?
Methods, Existing Tools	<ul style="list-style-type: none"> • MIS • Exit interviews (interviewing people after they've received the IPC session or asking women just attending a clinic if they ever experienced IPC) • Mystery client studies (where we send trained people to pretend they are target audience members and sit in on the IPC)

PROCESS EVALUATION - QUALITATIVE

Options	Specific studies can be designed to sample from program beneficiaries or stakeholders to investigate their perceptions on how well the IPC strategy is operating.
Sample Questions	<ul style="list-style-type: none"> • What did project partners learn from each other by implementing the project? • How closely did IPC agents follow their scripts for interacting with targeted women?
Methods, Existing Tools	<ul style="list-style-type: none"> • Flash FoQus • See the FoQus suite of tools, which provide a basic framework, but discuss adaptation of these tools with your platform and regional researchers.

2. IPC Outcome Evaluation

Other names: Outcome monitoring

Goal/s: to determine

- Whether program targets have been achieved?
- Whether there were any unintended consequences of the program?
- Whether any intermediate outcomes contributed to achievement of the primary behavioral outcomes (whether reduced misconceptions about IUD side effects were linked to greater IUD use)?
- How the program achieved these outcomes?

As with process evaluation, determine in advance what the primary questions of your outcome evaluation will be. Then decide which methods to use to get that information.

OUTCOME EVALUATION - QUANTITATIVE

Options	Quantitative studies can tell you if your desired outcomes were achieved and the scale of that achievement. A key advantage of using quantitative surveys for outcome evaluation is the ability to develop population-based estimates of core outcome indicators, which MIS usually cannot do
Sample Questions	<ul style="list-style-type: none"> • Did women need to see our IPC more than once to adopt an IUD? • Did the program meet its targets in increasing condom use?
Methods, Existing Tools	<ul style="list-style-type: none"> • Exit interviews, • Mystery client surveys, • Reach-and-recall studies, or • TRaC surveys <p>» Monitoring Tables, which indicate change over time in key indicators</p>

OUTCOME EVALUATION - QUALITATIVE

Options	Qualitative techniques for outcome evaluation can help you understand how the program has actually achieved its outcomes. People sampled for qualitative outcome evaluations may include program beneficiaries and/or stakeholders.
Sample Questions	<ul style="list-style-type: none"> • <i>How</i> was IPC scale-up achieved? • In what way are all the statements in a particular behavioral factor related? What do they really mean to the target audience? • What differences did IPC make in the lives of people who participated in the sessions? • Why did people like participating in IPC
Methods, Existing Tools	<ul style="list-style-type: none"> • Flash FoQus <p><i>PSI does not currently have a FoQus study type designed for evaluation purposes, so speak to your local and regional researchers for guidance (and Katia Peterson).</i></p>



SPOTLIGHT ON
REAL WORLD

Thailand's Qualitative Outcome Evaluation

PSI/Thailand implements the Champion project to promote safer injecting and sexual behavior among injecting drug users (IDUs) using peer education and drop in centers (DICs). The project also employs a social marketing strategy to increase access to and availability of needles, syringes, and condoms; and to refer IDUs to HIV and Sexually Transmitted Infection (STI) testing and treatment services. Community advocacy and stigma reduction are also emphasized.

PSI/Thailand worked with Options Consultancy Services to undertake a participatory research study using the Rapid PEER (participatory ethnographic evaluation and research) methodology to understand the experiences of beneficiaries and staff involved in the project. The aim of the research was to help strengthen the project's efforts to improve the health and quality of life of IDUs. Project staff selected six project beneficiaries at each of five sites to be trained as Peer Interviewers. They then conducted conversational interviews with two people from their existing social networks who had some involvement with the project. Over two days the Peer Interviewers fed back qualitative interview data to a consultant who coded and analyzed the data.

The study found that the project made a difference by allowing beneficiaries to access harm reduction information and education plus safe injection equipment and condoms. Some beneficiaries reported changing their injecting behaviors after interacting with the Champion project. The project also helped IDUs access health services and gain knowledge of their rights to health services. Finally, beneficiaries reported that the project improved their emotional well-being by reducing social isolation and helping them improve relationships with their families and neighbors. One drug user said, "This project changes IDUs from ghosts to humans."

More information on the study's results can be found at <http://youtu.be/aXNfciR0qyk>.

3. Impact Evaluation

Goal: To assess the changes (intended or unintended) that can be attributed to a particular intervention such as a project, program or policy. They also seek to answer cause-and-effect questions. In other words, they look for the changes in outcome that are directly attributable to a program.

Impact evaluation looks at the full net effects of program participation comparing against a group of people who did not receive the program. This comparison is necessary in order to determine that any changes in key outcomes observed over the course of program implementation are due to the program, as opposed to other factors in the environment that could also influence outcomes. Impact evaluation may also attempt to measure longer-term outcomes of the program or changes in health status, rather than or in addition to changes in behavioral outcomes.

Study design is critical for impact evaluation to make sure that the comparison between people who did and did not participate in the program is clear. By definition, MIS alone cannot be used for impact evaluation, since it usually only track program beneficiaries. It may be supplemented by routine data collected from other settings, such as public sector HMIS.

The strength of a randomized evaluation is that if we see differences in the outcomes we're interested in between the program group and the control group, the only thing that could be causing this difference is the program itself. These types of evaluations often require a lot of advance planning, which may make them less practical. However, they are valuable for answering strategic questions.

IMPACT EVALUATION - QUANTITATIVE

Options	A quantitative impact evaluation will provide a specific, numeric estimate of the effectiveness of the program, for example, that women who spoke with an IPC worker are two times more likely to visit a clinic for an IUD consultation than women who did not speak to an IPC worker. It may also assess questions about the effectiveness of dosage (frequency and intensity) and/or specific formats or group sizes.
Sample Questions	<ul style="list-style-type: none"> • Did IPC cause people to reduce sexual partners? • How many times more likely is someone to wear a condom after seeing our IPC? • Are clinics that receive IPC support getting higher client loads than clinics that don't have IPC? • Is IPC linked to sleeping under an ITN on its own or do people also need to see mass media messaging?
Methods, Existing Tools	<p>Case control studies</p> <ul style="list-style-type: none"> • End-line TRaC with statistical matching. This approach provides a cleaner measure of program impact by comparing similar groups of people who did and did not receive the program. See more on CEM. • Modified case-control study: Similar to End-line TRaC's, a modified case control first finds people exposed to your program and then matches them with similar people who did not have exposure. One key difference is between this and a full case control is that this will be done with a smaller sample size, rather than a full population-based survey. Madagascar and El Salvador recently did IPC evaluations using this method. They interviewed people they knew were exposed and found similar people that weren't exposed and compared. Madagascar's results are discussed below. El Salvador's results are still to be announced. • Randomized evaluation: The strongest study design for an IPC impact evaluation would be to establish a control group of people who do not receive IPC and let chance decide who receives the IPC and who does not. • Stepped wedge/phased-in design: It is possible to make the most of phased in program implementation plans for evaluation purposes by using groups who receive the program in later phases as control groups compared to people who receive the program in the first phase. This is a type of randomized evaluation if you let chance decide who gets the program first and who gets it second. If you follow pre-set implementation plans for phasing in the program, the evaluation program is not as rigorous but can still give you a clear control group of people who get the program second. So if you're only doing IPC around 10 clinics initially and then plan to expand to 30 clinics in a year, we can research those groups.

IMPACT EVALUATION - QUALITATIVE

Options	Qualitative techniques can supplement a quantitative impact evaluation in order to provide insight into how the program achieved its impact and whether the quantitative impact study was accurately able to account for other factors in the environment that might have also contributed to any difference observed between people who did and did not participate in the program.
Sample Questions	Employing the "Most Significant Changes" approach. "What were the most significant changes over the time period?" and then identifying those changes that can be linked back to the intervention and analyzed.
Methods, Existing Tools	<ul style="list-style-type: none"> • Methods can be similar to what is planned for a qualitative outcome evaluation, but may also include sampling from people who did not participate in the program. • Policy analysis <p><i>Because PSI does not currently have established tool for this type of research, please contact your local and regional researcher to investigate how FoQus studies could be adapted for your needs.</i></p>



SPOTLIGHT ON
REAL WORLD

Madagascar's IPC Evaluation

In 2010 PSI/Madagascar used the Modified Case Control study approach to evaluate their IPC.

Research question: Is their IPC program correlated to increases in IUDs or other modern FP methods?

They took the names/contact info of every person they met through IPC for 3 months (with permission to do research). They then randomly selected women from that list to interview and asked them about their family planning behavior earlier (say 4 months ago) and their family planning behavior on the date of interview. They also asked how many other times they'd been exposed to the IPC program or if it was just that once. The research team then used the profiles of the women they talked to (age, etc) to find similar women to interview. It was assumed these women had not been exposed to the IPC but they checked in the interview and asked them the same questions. Then by comparing those exposed and those non-exposed they were able to determine that women exposed to the IPC in Madagascar were 5 times more likely to be using an IUD than those not-exposed. However the intervention had no effect on any other family planning behavior. See [Madagascar IPC Evaluation Results \(ppt\)](#) and [Lessons Learned from Madagascar IPC Evaluation \(doc\)](#).



Mixed Method Impact Evaluation

For Impact Evaluation specifically the best approach is to use both quantitative and qualitative methods. Why? The “mono-method approach” to Impact Evaluation is prone to “methods-induced bias”. Evaluators recognize that mixed-method designs generally produce more comprehensive coverage and more valid findings than either quantitative or qualitative methods alone.

Three reasons to employ mixed methods:

1. Decreases likelihood of selection bias or inappropriate selection of study population. *Qualitative formative research can inform the selection of study participants for the impact evaluation*
2. Results from impact evaluation are rarely useful without surrounding context. *Qualitative research can provide context into impact evaluation findings especially in the area of complex social situations that have many dimensions such as poverty, low education, gender discrimination, political violence, etc.*
3. Triangulation of results

If you believe you'd like to do a mixed method evaluation, talk to your national and regional researchers.



EXTERNAL EVALUATION
EXPERIENCE

The Willows Project; a Mixed Method Impact and Outcome Evaluation*

Once Willows had been operating for five years, it was important to measure precisely what the gains were and to what extent the gains were sustainable in communities throughout Turkey after outreach activities had ended. It was also important that an independent organization conduct the evaluation. Consequently, the Istanbul University Institute of Child Health organized a survey of over 2,000 married women, divided into intervention and control groups.

The intervention group consisted of women residing in ongoing and completed project sites in the urbanized areas of six provinces of Turkey—Istanbul, Ankara, Gaziantep, Diyarbakir, Van, and Adana, where approximately 300,000 women of reproductive age had received Willows services from 1999 to 2005. These six areas were in both developed and less developed cities and towns and were representative of 32 sites where the project had operated.

The main outcome indicators were changes in knowledge and use of effective contraception (modern methods and emergency contraception), and related preventive behaviors such as Pap smears, breast self-examination, and antenatal care. In addition, Istanbul University conducted focus group discussions and in-depth interviews with a subset of clients, field educators, project managers, and health personnel to further confirm and understand the findings of the Willows Project evaluation and provide valuable feedback.

This evaluation has outcome and impact components and used quantitative and qualitative methods.

*The Willows Reproductive Health Project: Reaching Poor Women in Turkey, p8

Sampling

Since IPC is usually used as a niche promotional strategy, one of the hardest parts of evaluating it is ensuring you can find enough people who have seen your IPC. Most TRaCs use population-based sampling, so if you've only reached 10% of your target population with IPC then only 10% of your respondents will likely report exposure. This might mean you won't have enough respondents who have seen the IPC to run an analysis. You address this problem by oversampling for IPC exposure, i.e. by adding more people into the sample from areas where IPC has been operating.

In order to help your research team figure out how to determine a sample size and design, check your MIS first to estimate the percent of the target population reached. For instance, if you think there are 20,000 women of reproductive age in your areas and according to your MIS records of contact, you have talked to 1000 women of reproductive age, you've reached 5% of your target audience. Work with your platform and regional researcher to establish a sampling strategy that accounts for program exposures.

For more on the types of questions you want to ask yourself that may influence sampling see [Talking to your Researcher about Evaluating your IPC Program](#).



SPOTLIGHT ON
REAL WORLD

Evaluating the Oicheke Campaign in Botswana

Botswana's National AIDS Control Authority decided to take on the risks of multiple concurrent partnerships in 2009 and asked PSI to serve as the technical lead in designing and implementing the National Concurrent Partnerships Campaign. The campaign included mass media, a variety of community mobilization activities, and IPC. After implementing the first two phases of the campaign, which focused on raising awareness and risk perceptions about concurrent partnerships, PSI and NACA wanted to evaluate the campaign's impact, specifically whether exposure to campaign messages among targeted adults aged 18-35 (a) reduced concurrent partnerships, (b) increased risk perceptions associated with concurrent partnerships, or (c) reduced factors known to be associated with concurrent partnerships.

PSI conducted a national cross-sectional survey in 2011 using two-stage cluster sampling in order to look at the impact of the campaign. A major challenge for the design of the survey was to recruit enough people who might have interacted with one of the campaign's outreach workers. To do that, the researchers involved classified communities into high and low exposure areas, based on the number of campaign activities that occurred, and they then matched communities on exposure status and coverage of radio and TV in those areas. This strategy ensured the communities included in the sample had enough people with IPC exposure. People were then randomly sampled from households within these communities.

The evaluation found that campaign exposure wasn't able to influence the practice of having concurrent partnerships. However, people exposed to the campaign were 30% more likely to use condoms consistently with any partners, compared to people who were not exposed to the campaign, and people exposed were also 60% more likely to have been tested for HIV.

See [Botswana's IAC Poster](#).

Measuring exposure to IPC

Many programs have a hard time determining whether or not people have seen the IPC activities. They may ask about talking to a “health worker” but PSI is rarely the only group in the community who could be described as such. They may also be asked if they’ve talked about family planning with someone, but that could be a friend that’s unrelated to PSI’s program. You can ask whether they’ve talked to someone from PSI but that requires them to both remember the interaction and remember that the person said they were from PSI. The simplest way to help recall is to have IPC agents wear a consistent, noticeable uniform – such as a brightly colored shirt with a logo on it. That way you can ask whether they’ve talked to the person in a ‘bright pink’ shirt, rather than a PSI agent.

Reach: How many people you’ve contacted (usually a % of the target population)

Recall: What percent of the target audience remembers seeing you (this could be higher or lower than actual reach, since memories often fail us)

Aided: When people recall the interaction after a photo is shown or a description given

Unaided: When asked a generic question like did you talk to anybody about family planning, they say “yes, the PSI person in the yellow coat”

You can see sample exposure questionnaires; [India](#) and [Madagascar](#) for ideas on questions but again, this will vary depending on how someone will be able to identify your IPC agents.

For more questions around exposure including measuring specific themes or frequency of exposure, please see [Talking to your Researcher about Evaluating your IPC Program](#).



SPOTLIGHT ON
REAL WORLD

India's Avahan Media Evaluation

As part of India's Avahan program (2003-2008), they conducted TRaC surveys every six months or so. They had high reach within a MARP population so finding people exposed to IPC was not a problem.

They found that TV, outdoor, street theatre and IPC were all effective at increasing treatment seeking for STI at franchised clinics. Outdoor was the most effective, with other media close behind.

They saw that exposure to IPC or street theatre once in three months was optimal and that seeing two types of media in 3 months was more effective than seeing the same media twice.

FREQUENTLY ASKED QUESTIONS

Do I need to evaluate my IPC?

A good rule of thumb: If you can monitor it through your MIS, don't ask it again in an evaluation. If you can see program outcomes through tracking referral cards, for instance – you probably don't need to do an outcome evaluation of your program.

When to do a separate evaluation:

- If you have higher needs – such as externally verified (from a donor or government request)
- You need impact results that can't be answered through MIS tracking
- You are working in self-reported behaviors, which are hard, if not impossible, to track through MIS

One of the reasons IPC evaluations are not widely done is that they often are designed to ask every possible question and therefore become expensive and time consuming. Be sure to design the evaluation to be as simple as possible. It should answer the basic questions or “Is our IPC working?” (meaning: without our IPC, would women be getting IUDs?), “Is it working better or worse than before?” and possibly “Are certain IPC strategies (aka group sizes, activity types, settings, frequencies – see [Data Dictionary](#)) working better than others?”

Also, TRaC is expensive and the options above can be done with in-house resources and can be standardized into the program operations.

What can I do if I didn't do any baseline research?

Evaluations are stronger with a baseline but often we realize too late that this hasn't happened. As part of the IPC Deep Dive R&M outlined three possible ways to evaluate IPC for programs that didn't have a baseline, ranked in order of their ability to provide strong evidence about the effectiveness of the IPC. If you are able to do a baseline, different options would be suggested. (See [Endline IPC Evaluation Options](#) for full descriptions.)

Option 1: Finding women at clinics who have received an IUD (or other FP method, if we choose) and determining exposure to IPC and then case matching them to women at that clinic or another similar one who have not received an IUD (or other FP method) and comparing their exposure to IPC.

Option 2: Taking contact information from women we talk to in IPC sessions. Contacting them some time in the future to determine if any behavior change has happened, and then finding similar women who were not exposed to IPC to compare behavior change.

Option 3: A variety of approaches are outlined here which utilize monitoring rather than formal evaluations, including tracking uptake rates for clinics that we support versus those we do not, asking patients where they've heard about the IUD and referral cards.

Do I need ethical approval or informed consent?

If this is classified as research and not just program work, you will need ethical approval. To determine if your IPC evaluation will count as research or program improvement you can submit a form to PSI's REB to request a determination of research or non-research. Please also keep in mind that although PSI's REB may classify something as not a research study, you may still need to seek approval from local ethical boards, the ministry of health, etc., as per your country's regulations.

Regardless of whether or not your evaluation is classified as research, you should follow ethical guidelines about protecting your participants. One key consideration is that if you will be having IPC agents collecting names and contact information that will later be used in the evaluation, IPC workers need to learn the basics of informed consent (for instance in the modified case control study described above) in order for the data collection to be effective. The IPC data forms need to demonstrate that we sought informed consent. While this seems simple, having a box to tick and a phrase to read on the data collection form is the difference between having to throw away 2 months of data. When in doubt, contact [PSI's REB](#) for advice.

We have evaluation data but I don't know how to use it?

One of the reasons many programs don't do evaluations is that they aren't sure how the results will help them. The following are two examples of real PSI IPC evaluations and what the teams did with the results.



eg.

BOTSWANA

Modified Case Control Study; Concurrency 2011

Table 1: Program exposure effects (vs. no exposure) on behaviors and behavioral

	Odds Ratio (95% CI)	Adjusted Odds Ratio ^a (95% CI)
<i>Concurrency Behaviors</i>		
Concurrency (at interview)	1.5 (0.9, 2.3)	1.3 (0.8, 2.1)
Concurrency (in last year)	1.1 (0.8, 1.6)	1.1 (0.8, 1.6)
<i>Concurrency Behavioral Factors</i>		
Peer pressure not to engage in concurrent partnerships	1.5 (1.0, 2.2)	1.7 (1.1, 2.7)
Negative attitude to having variety of partners	1.4 (1.0, 1.9)	1.6 (1.1, 2.3)
<i>HIV Risk Reduction Behaviors</i>		
Consistent condom use	1.3 (1.0, 1.7)	1.3 (1.01, 1.7)
Tested for HIV	1.4 (1.0, 2.0)	1.6 (1.1, 2.4)
<i>HIV Risk Reduction Behavioral Factors</i>		
Condom use self-efficacy	1.4 (1.0, 1.8)	1.4 (1.02, 1.8)
Perceived HIV risk	1.6 (1.2, 2.2)	1.5 (1.1, 2.0)
I'm not worried about multiple partner risks because I always use condoms	2.9 (2.1, 4.2)	3.1 (2.1, 4.5)
As long as I use condoms, having multiple partners shouldn't be a problem	2.8 (1.9, 4.2)	2.8 (1.8, 4.2)

*Results are statistically significant if in **Bold**.

^aAdjusting for age (yrs), gender (women), occupation (unemployed), education (primary and below)

What does it mean? The way to read the table is to look for items that are highlighted in bold as these are the elements that have been influenced by exposure. So the big take-aways are:

The campaign was not linked to any trends in concurrency, but was able to influence negative perceptions about multiple concurrent partnerships.

The campaign was associated with greater HIV risk reduction behaviors and attitudes about risk mitigation within concurrent partnerships. People exposed to the campaign were more likely to use condoms, get tested for HIV, and view condoms positively.

The odds ratios can be read as the size of the impact so using adjusted odds ratios (in other words, taking away the effects of age, gender, occupation, and education), people who saw the campaign were 70% more likely to feel peer pressure to not engage in concurrent partnerships, 30% more likely to use condoms consistently and 310% (or 3.1 times) more likely to believe that the don't need to worry about multiple partner risks because they always use condoms.

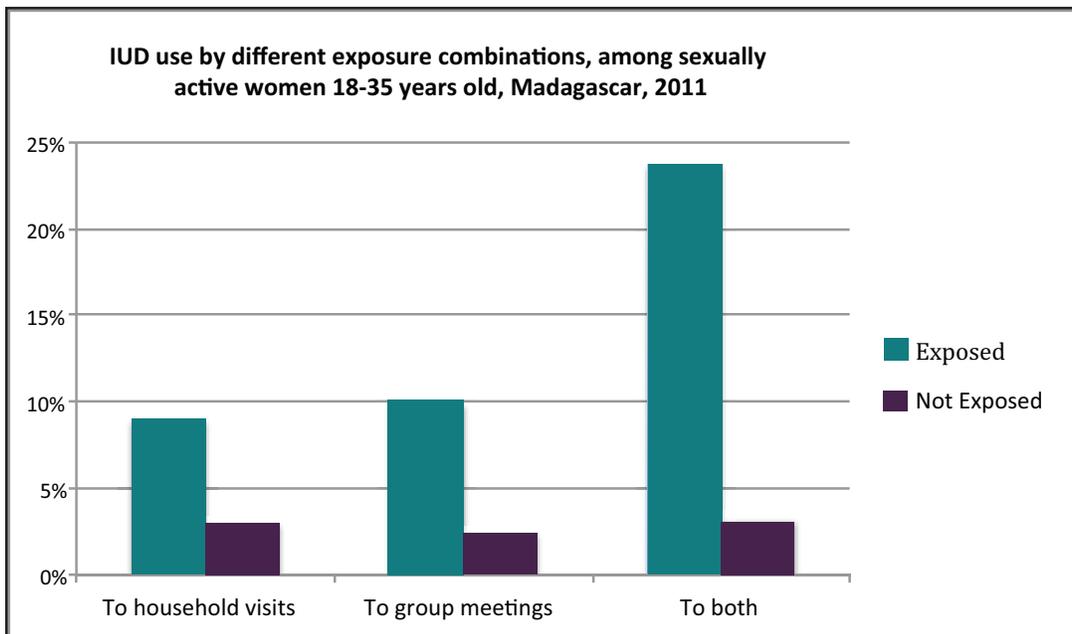
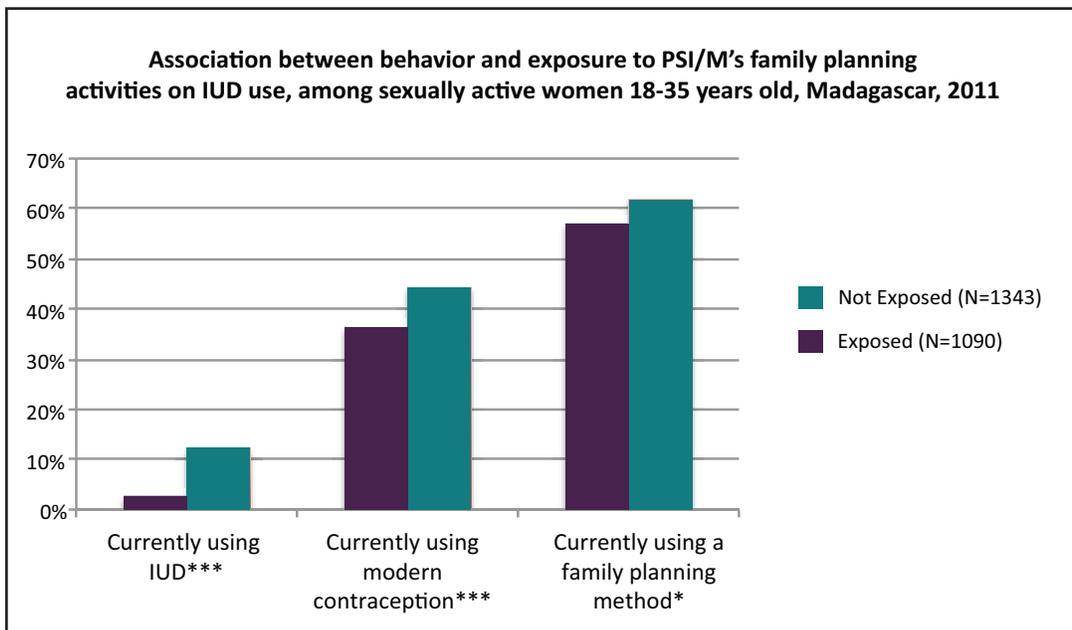
What did they do? Seeing this data they realized that they had not impacted the intended behaviors and rather it seemed that people were convinced to take action to reduce HIV risk but not convinced or clear that reducing partners was the way to achieve it. In looking at the campaign, the team thought the call to action wasn't clear enough and are re-vamping for the next phase to more clearly articulate that reducing partners is an effective way to reduce this risk.



MADAGASCAR

Modified Case Control Evaluation; Family Planning 2011

From a modified case control study approach, PSI/Madagascar received the following results.



The team used this information to feel secure that indeed their IPC program was correlated to IUD use. However, in its current form, IPC is not correlated to any other family planning behavior. They used this information to look at how they can better support other methods.

Additionally the second graph indicates that exposure to both household visits (which are typically one-on-one) and group meetings are correlated to increases in IUD use so they are keeping both group sizes. Additionally it shows that exposure to both is correlated with even larger IUD use, so the team used this to arrange IPC activities so that more women were exposed to both the household and group meetings with plans to scale up activities.

People talk about correlation versus causation, what does that mean and why should I care?

Correlation means that the two things are related; for instance as exposure goes up, so does use of FP methods, but correlation doesn't indicate one causes the other. It is possible that both are caused by a third thing (for instance older women might be more likely to see your IPC and more likely to use FP methods, but the cause is age not exposure). Causation indicates that one thing causes the other. To assess causation, it helps to have a comparison group of people who did not receive the IPC. This is generally the goal of impact evaluations.

Things to be aware of when interpreting results:

- Unless you control for exposure to other media or programs, these could also be influencing behavior
- Similarly, this only measures promotional activities, not price, distribution, etc. The best IPC in the world can't do anything if the service isn't available at an affordable price. One way to mitigate this is to look at behavior uptake anywhere the target audience has access to (public, private, etc.) and not just limit your success to your own clinics.

PSI is growing its experience in impact to be able to answer questions such as "Does IPC lead directly to greater adoption of IUDs". Endline TRaCs using statistical matching can help make an assessment that the program actually caused the behavior we're interested in, but they must be planned to accurately capture IPC exposure.

For more information, see [R&M's Evaluation pages on KIX \(TRaC or Impact Evaluation\)](#) or for a quick lesson on causation versus correlation see http://stats.org/faq_vs.htm

Is it realistic to measure IPC's effect directly on behavior?

There is a school of thought that believes that trying to link exposure to one communication method (or a whole campaign) directly towards behavior change is setting us up to fail. Commercial companies do not try to attribute sales increases directly to television advertising (not to mention the largely unmeasured social media campaigns). This is because of all the other non-promotional factors involved in behavior uptake as well as time lag between exposure and behavior.

If we were to mimic this, we would evaluate the *potential* of our IPC to succeed through post-exposure questions (and compare its potential to campaigns known to succeed). The Supervision Form that collects Target Audience Feedback ([English](#), [French](#), [Spanish](#)) is our recommended method, although you should feel free to adapt it.

How should I make sure my researcher understands what I need?

The most successful programs have researchers and programs who work closely together so that programs can design something that can be well evaluated and researchers know exactly the best ways to evaluate it and what information is needed. When this doesn't happen, we often get research measuring the wrong target audiences, or that don't ask key questions that we needed to answer. See [Talking to your Researcher about Evaluating your IPC Program](#).



RESOURCES

- See also the Monitoring section
- Don't forget your regional and national researchers. See [Talking to Your Researcher](#).

Internal Resources

- [Endline IPC Evaluation options.docx](#)
- Research briefs for IPC Evaluation (El Salvador, Madagascar) - coming soon
- [India's Avahan \(.doc\)](#) and [Madagascar's \(.doc\)](#) questionnaire on exposure
- Madagascar's [results \(.ppt\)](#) and [report \(.doc\)](#) on how the evaluation met the needs of the team and [lessons learned \(.docx\)](#).

External Resources

- [Willow Project report and evaluation report](#)
- [Causation versus correlation \(http://stats.org/faq_vs.htm\)](http://stats.org/faq_vs.htm)

IPC

QUALITY ASSURANCE

ORGANIZATIONAL SYSTEMS

IMPLEMENTATION

- 1 RECRUITMENT
- 2 TRAINING
- 3 ADMIN/ FINANCE
- 4 RESEARCH
- 5 COST EFFECTIVENESS
- 6 STAKEHOLDER BUY-IN

Organizational Systems are those elements that you must have strategies around and often consume most of the time of project managers but are not related to direct implementation.



1

RECRUITMENT

Selecting the right IPC personnel is crucial for the success of the program. Should you select peer educators, respected community leaders, or retired nurses? Should your IPC agents be male or female? Should you hire people to be full time staff, outsource to community-based groups or other NGOs, or hire an experiential firm? The recruitment challenge is significant, but the key is finding people that have the right mix of skills, personal traits and influence to successfully convince target group members to adopt the desired behavior.

BEST PRACTICES

- You have job descriptions for IPC agents.
 - » If your program has been operating for at least a year, your IPC job descriptions have been updated to reflect learnings on job responsibilities.
- You have recruitment criteria for IPC agents that emphasizes potential.
 - » If your program has been operating for at least a year, your recruitment criteria has been updated to reflect most successful IPC characteristics.
- You have linked interview techniques to match the traits in your recruitment criteria (i.e., have the interviewee visit the field, or do a presentation to you).
- Your organizational structure and administrative support is appropriate to handle in-coming IPC agents.
- If you are outsourcing IPC, you have clear guidelines on who does supervision and monitoring of them.
- If using peer educators ensure that they correctly reflect the age range, SES, etc. of the target audience so they are as close to peers as possible.
- Have a trial or “probation” period for new agents to weed out those who cannot adjust to the requirements of the job.

Recruitment Steps

Launching a new IPC program will require creating new positions and hiring new staff. This may include any or all of the following steps:

1. Identifying staffing needs and developing the program's management structure in the context of the overall platform's organizational structure (see country examples from [Cameroon.ppt](#) and [India.png](#));
2. Developing **job description** (sample [IPC agent](#) and [supervisor](#)) and agreeing on the hiring process and decision-making;
3. Identifying and recruiting a program manager/director (preferably local) to oversee the IPC program;
4. If relevant, identifying and recruiting regional coordinators to oversee the project from field offices;
5. Identifying and recruiting a cadre of IPC agents and supervisors per region, as relevant;
6. Build the capacity of or reinforce the existing Communications & Marketing and Research teams to meet the needs of the program to adequately, and in a timely manner, develop and produce support materials, and monitor and evaluate your program.
7. Identifying training needs developing a training and on-boarding plan **for all staff categories** at the onset of the program is fundamental. (See training section)

Possible Recruitment Criteria

Selecting the IPC agents can be challenging since the job requires a variety of skills and personal qualities. The IPC agents must have good communication skills, be able to quickly absorb information not only about FP, but other areas linked to sexual and reproductive health, including HIV/AIDS, and have a good rapport and credibility with the target population and health care providers. Investing time and resources into recruitment is well worth the effort, and can reduce turnover and costs associated with re-recruiting and training replacements.

In addition to acquired skills and experience in communications and/or the technical aspects of their health area, the following are some characteristics to consider (*this list is not exhaustive nor applicable to all programs but may serve as a guide during the recruitment process*):

- Established links with the community, target population and possibly with clinics and health providers;
- Respected by the community, target population and clinic personnel;
- Literate;
- Possesses effective interpersonal communication skills
- Possesses facilitating and moderating skills, and is comfortable speaking in front of others;
- Expresses interest and motivation about doing something about SRH in his/her community;
- Shares PSI core values and believes in the objectives of the program (e.g. the benefits of promoting family planning in the case of WHP);
- Driven by concern for the health of others;
- Mature and energetic;
- Ability to listen to other without bias or assumptions, non-judgmental;
- Available and accessible to the target population;
- Has natural leadership skills, yet not 'overpowering'/monopolizing conversation as per ETL principles (for more on ETL see Delivery Section);
- Self-confident;
- Possess good organizational skills;
- On-time and reliable;
- Ability to speak local languages.

To create your own list of criteria specific to your program consider the [Segmentation Exercise.docx](#) (appropriate for on-going programs, not for new IPC programs).

Role of the IPC agent

One of the main objectives of IPC agent staff orientation should be to make sure the agents fully understand their **role**, and the importance of conducting effective IPC activities for the overall success of the program. In particular, the following two programmatic functions should be stressed:

Agents of change in the community: IPCs will need to tackle barriers to behavior change among the community in order to achieve the health objectives set by the program. They will need to become well acquainted with BCC concepts, frameworks and other tools such as the stages of change, to assist their clients along the path to become adopters. IPCs should take on a leadership role, actively engaging participants in discussion, and seek to establish a sense of trust and credibility with target group members.

Diffusers of information and knowledge: IPCs are responsible for disseminating information to target groups, filling in knowledge gaps and correcting misconceptions and other barriers to change, in order to model new, healthier behaviors. They should seek to establish themselves as non-judgmental, trustworthy and discreet sources of valuable SRH information among the community.

Developing IPC Agent Skills: It should not be assumed that IPC agents will automatically have all the skills required to work with various target groups. It is important to foster these skills during initial participatory training sessions. Sending IPC staff to visit existing, well-performing IPC field sites is a great way to motivate and inspire them. It will also enable IPC agents to see what is expected of them, and provide them with real-life IPC role models. (See Training Section)

Recruitment Tips

Aspects you might consider in recruiting IPC agents include:

- *Recruit for potential not skills.* El Salvador had a very successful experience recruiting IPC agents from other fields, especially salespersons that have the right skills for the job.
- *Consider the commitment the person is willing to give to the project vis-a-vis your project's requirement.* Many times the experienced IPC agents in the community are also busy and overstretched working with multiple NGOs. They are unlikely to be able to commit a considerable amount of time to our IPC work *and you will have to evaluate choosing these against reach concerns.*
- *Selecting IPC agents from among satisfied users* can be a successful strategy. Long-acting reversible contraceptives such as IUDs, are a high-involvement decision and having a satisfied user for an IPC agent reassures the clients. It also lends credibility to the message because the testimony of the messenger overrides and testifies against myths and misconceptions. Another way to achieve this is to have satisfied users involved in the activities.

- *Recruiting health facility personnel as IPC agents have given mixed results.* Many programs want to use providers to have them promote family planning services to clients who show-up to the clinic for other services— i.e. avoiding missed opportunities or to go out into the community and recruit new clients. Cambodia found it was much more cost effective to hire doctors to go into the community for large group sessions, because of how trusted they were in the community. Whereas the providers have great knowledge about the service and are trusted and credible to the clients, they are often overwhelmed by the clinical work and are unlikely to find time for one-to-one or group discussions inside or outside the facility. It is also important to consider that the opportunity and ability for the would-be client to process family planning information when they are struggling with an ailment, is diminished. Finally, in places such as Uganda, they have found it incredibly difficult to find a medical provider that at the same time is communications savvy.
- *Pairing IPCs:* The role of the IPC is intensive and can get intense! One strategy to create internal support and ensure motivation levels stay high is to pair IPCs. When working in teams, IPCs can monitor each other, offer support when needed, and complement each other’s skills. The Cameroon program is an excellent example of this.

Finding the right talent is as much an art as is a science. Using a recruitment checklist with robust criteria is a great start but the selection criteria is by itself insufficient. You have to ensure that the staff who are using it have the skill to ‘sniff out’ good talent. In Uganda, they found it necessary to hire ‘expert’ recruiters from the capital for 10days to spend time with field staff, providers and some key community leaders “gatekeepers” interviewing candidates for the IPC agent role and observing them at work. For interview techniques see <http://learning.psi.org/course/introduction-interviewing>

- *Trial period:* It is recommended to institute a standard trial period for any employee, but certainly for IPC field agents. Recruiting the right people for fieldwork is not always straightforward, so having a few months as an on-the-job test is extremely useful and efficient. Some projects have not incorporated trial periods into their project and have been stuck with low-performing agents that they cannot dismiss because of stringent employee laws. Generally, a three month or six month period is sufficient to judge compatibility for the job. Contracts with IPC agents should be set up with a legal clause to reflect the trial period and to explain that continuance of employment is pending a satisfactory evaluation at the end of that period.

Outsourcing IPC (or working through CBOs)

A defining factor for setting up the administrative and financial procedures for IPC projects is the choice of outsourcing the recruitment and managing of IPC agents to another entity or doing so in-house. IPC projects are very resource and time-intensive, so outsourcing may be a good choice when resources are stretched at the platform level. It should be noted however that with outsourcing, PSI loses a degree of control over the quality of the work.

PSI may choose to engage another organization or entity to manage all or some aspects of IPC field agents. In this case, PSI will need to develop a contract with that organization that clearly outlines PSI's expectations and objectives. Beyond these and the sub-grant elements that need to be in any contract, other important issues to consider include:

The right for PSI to provide technical oversight: even in cases where IPC field agents are managed by another organization, it is imperative that PSI be involved in assuring the quality of IPC delivery through involvement in training, technical supervision and the MIS;

The parameters for assuring an adequate and timely flow of needed resources (transport, salary, indemnities) to IPC field agents: it is generally best to define these mechanisms upfront if possible so as to avoid obstacles later in the field;

Expected salary and benefits for the IPC agents: without stipulated guidelines on this aspect, some organizations may try to “cut corners” and maximize their earnings through low and de-motivating compensation for field agents. See more on salary options and pay-for-performance in the Admin/Finance section.

While PSI has been using this strategy for many years, we have not documented our successes or lessons learned yet. A case study on a national campaign in the US to raise awareness and motivate action on heart disease¹ in women listed the lessons learned in working through CBOs in the third phase of their campaign (summarized in Figure 1 on the next page):

Figure 1: Lessons Learned on Community Outsourcing



¹ Long, Terry et al. "Delivering the *Heart Truth*[®] to Women Through Community Education". *Social Marketing Quarterly*. Vol XVII. No.4. Winter 2011

There are several variations and combinations among outsourcing and in-house that will have implications on the administrative and finance procedures: there is no set model for success; this will depend on the specific context at the country and platform level. Within the WHP project in Mali, PSI has contracted with their partner clinics to recruit and manage the operational and logistical issues related to the IPC agents. PSI provides all the technical support for these agents through a dotted line relationship, clearly stipulated in the contract. As part of the COF/SALIN project, PSI/Rwanda put in place a sub-contract with a local NGO who trains and rolls out community health communications.

Grants and Contracts has many sub-contracting templates and guidance. See <http://kix.psi.org/display/contracts/Subaward+and+Modification+Templates> as well as tools for monitoring subrecipients, <http://kix.psi.org/display/contracts/Subrecipient+Monitoring>.

FREQUENTLY ASKED QUESTIONS

I have high turnover, what should I do?

Every program will have a slightly different definition of “high” turnover. The average turnover in a US company is 25%² so anything higher than that would be considered high. This will vary in your country and some turnover is understandable, expected and not a sign of trouble. However, if turnover is affecting your program negatively, there are a few things you might want to consider.

Recruiting the right people: A [Harvard University study](#) showed that 80% of turnover can be blamed on mistakes made during recruitment. While this study might not hold true for all of our programs, the point is that recruitment is key to retention. The first step might be to check what types of people make the best IPC agents in your program. There is no one best profile for an IPC agent. It depends on your program and country context. It really varies. (See above guidelines and question below on types of people for IPC)

See [Creating an IPC Profile: Segmentation Approach](#) for a simple exercise your supervisors can do to create a profile. The next is to learn how to interview for these traits and competencies. A University of Michigan study indicates that traditional hiring techniques - CV reviews, typical interviews, and reference checks only provide a 14% likelihood of a successful job hire. For better techniques you can try the [PSI-University course on recruiting](#).

Useful techniques specific to IPCs is to have them give a short presentation on any topic during the interview (you can have them prepare in advance) to judge their ability to speak well to others. Malawi, for instance, had short-listed candidates make a brief presentation, following a script, to the target group and observed this. You can also have shortlisted candidates accompany an existing IPC agent in the field so they are clear about what the job entails.

Benefits package: Both India and El Salvador found that their retention rates increased when they increased the salary package offered to IPC agents. El Salvador offers a salary that is 30% above what a person with the same skills might earn so people were interested even though the job is hard. That's not possible everywhere. Where it is not, consider smaller things like per diems, how quickly people are paid or reimbursed and supervisor relationships. Offering professional development through training may also be a valuable incentive.

²<http://www.therainmakergroupinc.com/employee-retention-articles/bid/80350/The-Real-Costs-of-Employee-Turnover>

Job Satisfaction: Job satisfaction can be the result of many things but a few are related to other sections of this toolkit; supervision and feedback, clear expectations, acknowledged success and the above-mentioned benefits package. Madagascar found that by clarifying the roles of the IPCs and ensuring that supervisors had enough time and skills to properly give feedback that retention rates improved.

Another area that contributes to job satisfaction is their capacity to be successful. This relates to training and on-boarding (how to get new hires up to speed). (See Training Section)

Which types of people are best for IPC?

Again, there's no *one* correct IPC profile but you do want to think through who will be most listened to by your target audience. There's great value in getting people who are *similar* to the target audience (peer educators) or who might be from the community themselves. However, as soon as they receive the training, they become unlike the target audience. Several programs have seen cost effectiveness of using people perceived to be experts, such as doctors, nurses or other key influencers, while others have found this to be less effective. And then there is the question of gender; some programs pair up male and female IPC agents and work as a pair, others only hire women for FP programs, others have a mix. This is very culturally specific. And often our own personal biases or assumptions about who should do this kind of work are the real reasons for our selections (and not the target audience's preferences).

Ultimately the choice is the target audience's. You may try some different combinations and see if there's a difference in effectiveness or efficiency. Or you could do a formal or informal focus group to see who would be most accepted. Several programs who have tried this have not found the focus group as successful as just sending some people out and seeing how it worked.

If you are seeing that a certain profile is having less success, or IPC agents themselves are reporting back that they are not being accepted, make sure that the issue is the profile and not a skill set or competency by that IPC. If it is because the target audience can't relate to the IPC agent or doesn't accept them, change the IPC profile.

Should I hire men or women to talk about family planning?

Selecting the right IPC agent will depend on need and contextual factors. In a community where it is not culturally appropriate to have men hold extensive discussions on sexuality and family planning with women (often one to one), it may be prudent to hire female IPC personnel. However, where the need involves getting men on board and having discussions with men as a entry point into family planning in the household, male IPC agents may be included in the team. Occasionally, you may find a great IPC agent with the talent, and the experience in mobilizing people (male and female) for health; who is also credible and

trusted by the community including the elders. You would not eliminate such a person on the basis of sex if they can do the job. Pairing men and women (discussed above) has been successful in places such as Madagascar and Cameroon.

In Uganda the ratio is about 90% female, 10% male, Kenya was initially about 50/50, Tanzania almost exclusively female, Madagascar pairs youth males and females that do sessions together (peer education), El Salvador is about 40% male, 60% female.

Can I just use unpaid volunteers or community health workers?

Many programs use or are encouraged to use unpaid community health workers. While this is tempting, we have far less success with this model. IPC is a job that takes high skill and as we've mentioned, solid supervision. This is difficult if we don't pay (or if a partner organization doesn't pay them). There is nothing as discouraging and de-motivating to IPC agents as not being paid when they did their work. To many, this communicates that their work is not valued besides seeing it as being cheated.

One option is pay-for-performance. For platforms that have performance based pay contracts for IPC agents there could be reason not to pay an IPC agent. Such contracts are written to explicitly explain that payment is not a fixed salary but will depend on the IPC agent's performance as per defined deliverables. For example, the supervisor may agree with the IPC agent that for the next six months, the IPC agent is expected to reach X number of clients, follow-up X number of clients, conduct X number of events and refer X number of clients. A base pay (threshold to take care of basic expenses like transport and meals) may have been agreed upon with an additional pay dependent on whether they have reached 50%, 80% or 100% of their target. The underlying principle is that such agreement needs to have been made earlier, understood and signed by the IPC agent prior to work commencement. Of course in setting the targets, you will need to consider the Tiahrt requirements and set deliverables not related to number of service acceptors. Such performance based pay approaches are the way to go given that with IPC agents it is not usually practical to have daily interaction with supervisors as would be with regular staff employed for an 8am-5pm job.



RESOURCES

- [Kenya Recruitment Case Study.pdf](#)
- [IPC Agent Selection Checklist.docx](#)
- [Segmentation Exercise for Creating IPC Selection Criteria.docx](#)
- [Sample IPC Agent Job Description](#)
- [Sample IPC Supervisor Job Description.doc](#)

PSI resources

- [KIX: Subaward and Modification Templates](#)
- [KIX: Subrecipient Monitoring](#)
- [PSI/U: Introduction to Interviewing](#)

Articles on Recruitment

- [The Real Cost of Employee Turnover](#)

“Selecting the IPC agents can be challenging. The IPC agents must have good communication skills, be able to quickly absorb information not only about their health area but also related ones, and have a good rapport and credibility with the target population and health care providers. Investing time and resources into recruitment is well worth the effort, and can reduce turnover and costs associated with re-recruiting and training replacements.”

2

TRAINING

Training quality is about both the **content** of training and the **quantity**. Because of how crucial the messengers (IPC agents) are to delivering the message, investing in their capacity is key. Good training is based on skills-assessments, and it is tailored to meet specific skills gaps. Follow-up training is extremely motivating to IPC agents, and it is important that they be brought together periodically to consolidate skills, to exchange and to problem-solve.

The content of the training is also, of course, related to the strategies, decisions made about message <see Message Section> and quality of delivery <see Delivery Section>. Several specific training curricula are referred to in those sections.

BEST PRACTICES

- Have an annual training plan that outlines:
 - » How often trainings will be done,
 - » Who will conduct them,
 - » What the topics will be, or how and when these decisions will be made, and
 - » Anticipated objectives of the trainings (e.g. program change, IPC skills set) – i.e. what tangible benefits of the training will result and how it will improve the program. Make your training objectives measurable.
- Trainings use participatory and experiential (adult) learning techniques rather than lectures.
- You plan for extra supervision and reinforcement for the 2 months following a training that introduces new skills or strategies.
- Use MIS (for instance, documented gaps in skills/successes) to determine capacity building plans.
- Evaluate your trainings (though something similar to a TRaC-T evaluation).
- Have an on-boarding plan (e.g., peer mentoring program) so that new hires can watch experienced, highly skilled IPC agents do the job *and* be observed and “certified” before doing sessions on their own.

Training Plans

It's important to create an IPC training plan at the onset of your IPC program to ensure you've designated time for initial training and follow-on. Things to address in your training plan include:

Who should conduct the training? Different contexts require different arrangements but it is critical that whoever does the training has a good understanding of the content and has the capability to pass on the skills through facilitating a training session. In some cases (e.g. for new programs) it may be necessary to hire external co-facilitators but the quality of the training has to be managed by PSI. The following are the options available to a program for conducting IPC training:

- *External training agency:* If budgets allow, an external agency that has expertise and experience in training IPCs can be contracted. In this case, it is very critical that a thorough briefing about the program and a proper brief is given to the agency. It is advised that the PSI Communication managers do the training on the thematic content and the agency focuses only on technical knowledge and skill development.
- *Internal training resources:* If your program has communication-training resources (training managers, communication trainers, etc.), then they can take the lead in IPC trainings. Communication managers, i.e., staff who manage IPC supervisors, can co-facilitate during the trainings.
- *Communication Managers:* PSI communication managers, after going through a training-of-trainers (ToT) on a communication training methodology (uch as ETL: More detail in Delivery Section), could do the training of IPCs. The managers could also train the IPC supervisors to co-facilitate or facilitate small activities or sessions.

How often and when should you do the training? Timely and frequent trainings are very important for the success of an IPC program. These trainings should be planned well in advance and executed as per schedule.

- *Induction training:* It is important that the IPC staff be properly inducted into the program immediately after recruitment. In this training, the IPC staff is oriented on the program goals, the various components of the program, activities, their roles and responsibilities, getting them to personalize issues, focus on personal risk assessments, basic interpersonal communication skills, the most updated technical information of the health issue they will work on, what is expected of their relationship with the affiliated clinics, IPC code of conduct and the current communication theme or strategy. This training will be an exhaustive one and will ensure that all IPC staff is on the same page, no matter what their background or prior experience is. [The Willows Project.pdf](#) trains their field educators for 3 weeks before starting.

You should have an induction plan for new hires that miss the regularly scheduled induction training. The IPC supervisor could use the module of the induction training and train the new IPC agents before they are sent to the field. This training can be for a day or two, followed by in-field training. See also On-Boarding below.

- *Refresher training:* Within 6 months after the induction training (some programs find this is required within 4 months), the IPC staff should be a part of a refresher training. This training, usually for a day or two is a wonderful platform for IPCs to share their field - experiences. The trainers would boost the IPCs confidence, acknowledge the IPCs successes and failures, revisit topics, provide them clarity and answers to objections they faced from the TG in the field.
- *In-field trainings:* When designing your training program, remember that the most important training is that done by the Supervisor every month during field visits. The feedback that is given after watching a session, or the modeling of how to answer hard questions is often more impactful than any classroom training. (See Supervision and Feedback section)
- *Strategy Change trainings:* These two trainings should then be followed up with regular periodic trainings as strategies change; for instance a change in themes and materials, or a change that includes follow-up visits. These trainings focus on the new communication theme and/or improving specific communication skills identified as an area of improvement. Training should happen at least every time when there is a change in theme/strategy.

How to On-Board New Hires? A best practice of medical detailing that hasn't been widely implemented in IPC to consumers is on-boarding. On-boarding is the idea that newly hired IPC agents will "shadow" other skilled IPC agents and watch them and then be watched as they begin to gain skills. For instance, PSI/ Kenya moved their original IPC agents to being IPC supervisors in order to hire exponentially more community IPC agents, called *Tunza Mobilizers*. Each *Tunza Mobilizer* was required to watch the IPC supervisor conduct 3 sessions and then have their supervisor observe them conducting 3 sessions and receive a "passing grade" on the supervisors' observation forms before they were allowed to do sessions on their own.

This can also be done using experienced IPC agents (not just supervisors) paired with new hires, to serve as mentors. Each new IPC can be paired with an existing IPC for a specific duration (15 days- 1 month). The new IPC can then observe sessions of the IPC he/she has been paired with or conduct joint sessions and learn. This will ensure that slowly and surely, the new IPC will gain confidence to conduct independent sessions on his own. The important part is to have an induction plan so it's clear what will be on-the-job and what will be mandatory classroom training so that we don't have IPC agents in the field who are not adequately prepared.

What roles should IPC supervisors play in the training? At a very minimum, IPC supervisors should attend all the trainings that their IPC agents receive. A better practice is to have supervisors attend an earlier training on their own (without IPC agents) so that they are able to learn in a “safe” environment (i.e., one where their direct reports aren’t watching them) and then be the experts on the subject matter. In several cases we train the IPC supervisors first, and then have them either facilitate or co-facilitate the trainings to their IPC agents or have them attend and practice giving feedback on key elements of the training (where the trainer is watching them and gives the supervisors feedback on their feedback to the IPCs).

Supervisors should also receive a supervision specific training to go over their role and responsibilities as coordinators, managers and mentors of IPC teams. Supervision forms should be presented, discussed and revised if necessary, during the training.

What are standard sessions? India’s guidance from previous successful HIV IPC programs is that trainings need to cover the following four areas: (from [IPC Guidebook – Avahan.pdf](#))

1. **Clarity on roles:** Training curriculum should include roles and responsibilities of the IPC staff, clearly define the target group, target locations, coverage plan, contact targets and reporting mechanisms
2. **Key concepts and knowledge:** The training curriculum should include relevant concepts and required knowledge. These concepts and knowledge help the IPC staff to understand the communication theme. It further helps him to become confident enough to address queries raised by the target group during the conversation.
3. **Skills:** It should not be assumed that IPC agents will automatically have the skills to recruit and work with various target groups. It is important to foster these skills in their initial participatory training sessions. To understand interpersonal communication they should help to write the session plans.
4. **Participatory IPC:** An effective IPC session would motivate the session participants to share their thoughts, ideas, and concerns and seek the information they need on the topic of discussion.

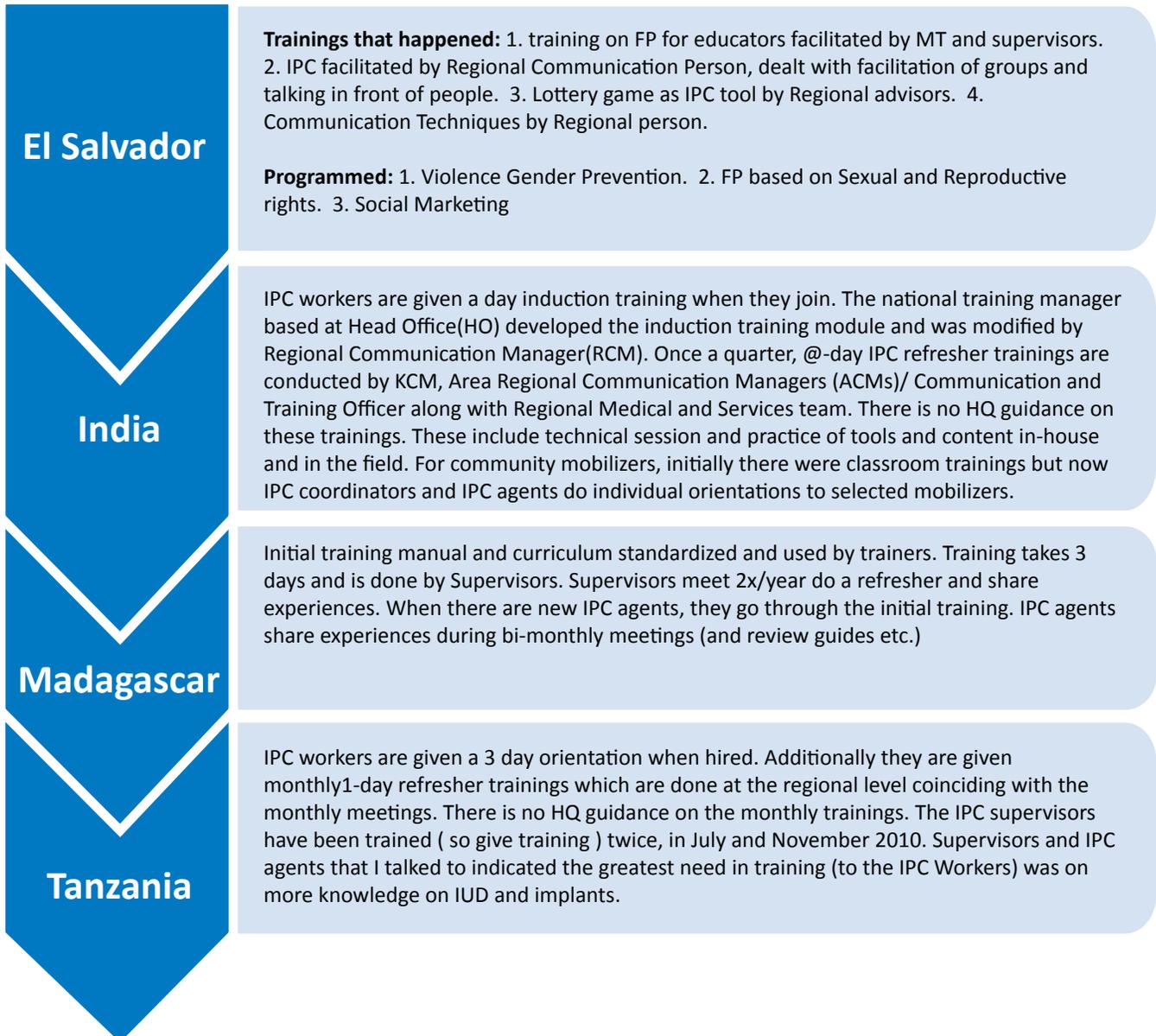
In addition, we recommend the following:

5. **Data collection:** filling out the MIS forms and how these are used.
6. **Values clarifications:** it’s important that we deal with any judgments that IPC agents have (for instance on emergency contraception, unmarried women using contraception, or sex work).

EXAMPLES OF TRAINING "PLANS" IN THE IPC DEEP DIVE

During the Deep Dive we saw the following models:

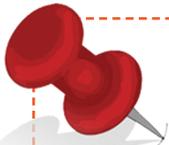
Figure 1: Training Plans from IPC Deep Dive Countries



Training Best Practices

There is a lot already written about how people learn. The overarching theme is that people don't typically learn by being lectured at. People learn best by working through problems in a self-directed or facilitated manner, which means all trainings should use adult learning techniques.

Additionally trainings should be evaluated. All of this is nicely summarized in the [Learning and Performance Department's KIX page](#). It might also be useful to join and peruse the [Trainers and Training SocialCast page](#).



TRAINING FOLLOW UP

The most important lesson we've learned in training IPCs is that the success of the training is only 40% reliant on the training itself. The remaining 60% of its success is whether follow-up is done. Per the supervision section, we strongly recommend that a post-training supervision plan be created that increases the frequency of each IPC agent being observed implementing the new strategy or practising the new skills. We recommend that at minimum each receives 7 field observations (With feedback) in the two months following the training. For the revised ETL/ Prime Prospects skills and strategies introduced as part of the IPC Deep Dive, Madagascar reports it took IPC agents an average of 150 sessions before they mastered . Otherwise we've found that knowledge of concepts increases post-training but nothing changes in the field. If Supervisors can't get each IPC agent more, you can use peer-feedback, head office people or any other strategy that gets them feedback.

We feel so strongly about this that we will not provide trainings unless a program can demonstrate that they can provide the necessary post-training follow-up.

FREQUENTLY ASKED QUESTIONS

Why do I need a training plan?

Too many IPC programs conduct trainings without an explicit plan. For better resource management and program follow-up it's smart to think through an introductory training and then regular refresher or follow-on trainings. These can be conducted regionally and designed by supervisors locally or can be larger trainings, depending upon the size and needs of your program. Ideally, training topics should come from the needs/gaps identified through MIS and regular program monitoring (see Monitoring Section). For more about training plans see "For New IPC Program" in Training section above.

Lack of coordination or quality controls of trainings

While most programs do a good job of counting number of IPC agents trained, and some manage to do knowledge pre- and post- tests, it is important to define what exactly we want to achieve through training, and how we would know that it was good quality. The Learning and Performance department has compiled [TRaC-T evaluations and guidance on how to plan for this](#). See also several of the articles in Training resources.

I've got a training scheduled but I'm not what the topic should be

Ideally, topics for on-going or refresher trainings should be evidence-based. Which skills or techniques are a large number of IPC agents still struggling with? We suggest that supervisor observations and target audience feedback be routinely collected (See Monitoring Section for more and sample forms). One reason for our suggestion that these be part of your regular MIS is that you can tell if there is a skill, such as open-ended questioning, that an entire team or majority of IPC agents are routinely scoring lower on. This becomes an obvious area for skill building or training.

How to accommodate or "catch up" new IPC agents

Please see the section titled, "How to On-Board New Hires?" in the For New IPC Programs in the Training chapter.

RESOURCES

- SBI training materials ([English](#), [French](#), [Spanish](#))
- ETL Facilitation Guides and Handouts.zip ([English](#), [French](#), [Spanish](#))
- [Willows Project.pdf](#)
- [IPC guide book- Avahan.pdf](#)

Training Tips and Resources: weblinks

- [Learning and Performance's Training Page](#)
- [Learning and Performance's Training Evaluation Resources](#)

Articles on Training

- [NPR story on physicists showing lecture not the answer](#)
- [Making the business case for evaluation trainings](#)



3

ADMIN/FINANCE

In order to ensure that IPC agents can effectively do their work, it is important to put in place a solid base of administrative and finance procedures. In some cases, the PSI platform will already have such procedures in place that can be readily applied to the IPC project; in others, procedures must be adapted or developed to fit the context of the fieldwork.

Procedures to consider will include such aspects as dealing with logistics and transport, salaries and indemnities, and incentives. The procedures should be easy-to-follow and not encumbering, so that IPC agents and their supervisors are able to access the resources they need in a fluid manner.

BEST PRACTICES

- Have mechanisms that ensure IPC agents are routinely paid no more than 30 days after implementation of job (or after submitting reimbursement paperwork).
- Ensure adequate support structures are in place for IPC agents for incentives, mentoring, promotion and recognition.
- Your systems for phone time, transport and other logistics are documented and not the majority of what the supervisor needs to deal with.

“IPC projects that seek to use unpaid volunteers will only find discouraging results as the IPC agents quickly lose interest and motivation.”

FOR NEW IPC PROGRAM

Compensation

The more that is expected of an IPC agent, the more compensation that agent should receive. IPC programs often fail to have impact when they do not invest in their field agents. All IPC agents should be compensated fairly for their time and efforts. IPC projects that seek to use unpaid volunteers will only find discouraging results as the IPC agents quickly lose interest and motivation.

The type of compensation offered to a field agent will depend in some part to the employee status bestowed upon them. At some platforms, IPC agents are recruited as either full-time or part-time consultants and will not receive the package of benefits that full-time employees do; at other platforms they are full-time employees. In either case, a salary or indemnity should be provided that is commensurate with their expected time and effort commitment, competitive within the job market, and motivating.



SPOTLIGHT ON
REAL WORLD

Getting Payment to IPC Agents in Uganda

“We do have mechanisms where the IPC funds are sent to the regional offices in advance but even with this we had logistical problems in getting the funds to the IPC agents on time. Some agents would go even for two month or more without payment, the results of course being drastic. We worked out an arrangement with a cell phone company to disburse these funds directly from headquarters onto the IPC agent worked and submitted their report. Although it took about four months for all involved to get used to the new system 9 a change management process had to be initiated we have found that this increases motivation to IPC agents, and eliminates/limits fraudulent and dysfunctional behavior. In the past, some supervisors and CBO partners would use these funds as leverage against IPC agents not for performance purposes but for selfish gain.”



Performance Based Financing/Pay-Per-Performance

Some IPC projects choose to provide additional incentives to IPC agents, in addition to salaries and indemnities. This is a useful way to instill more job satisfaction and to motivate better performance. There are several ways to reward IPC agents; based on sessions conducted, effective referrals, quality of IPC, etc. See [Paying for Performance in Health: A Guide to Developing the Blueprint.pdf](#) for an outline of the important decisions you'll need to make.

Within family planning projects, incentive plans must be carefully planned out. There cannot be any link between family planning method uptake and reward to project staff. Therefore, it is recommended that incentive plans for family planning IPC agents be linked solely to the quality of the IPC agent performance. This may include such criteria as using open-ended questions, following-up correctly with target segments, or even helping out fellow agents. It is recommended to incentivize top performers with non-monetary means. In this way, platforms can avoid situations that may be deemed non-conforming with the United States Government family planning legislative guidelines as outlined in Tiaht <[Tiaht on-line course](#) (look up FP Legislative & Policy Requirements)>.



SPOTLIGHT ON
REAL WORLD

Playing with Pay-for-Performance in Kenya

“Our *Tunza Mobilizers* (contract IPC agents, supervised by PSI employees and linked to franchised clinics that provide FP services) are paid a monthly fee of 7,000 shs (a little less than 70USD) which is essentially supposed to cover their transport fees, communication and some remuneration for work done. They all have an MOU with PSI that stipulates what they are supposed to achieve on monthly basis, i.e., the number of groups reached through IPC sessions. Failure to hit target consistently the fee is prorated as per performance.” See [Tunza Mobilizer Contract](#).



Loose objectives to allow for better tailoring to reality in the field

Coupled with the trial period for employees, it is also prudent to set up a trial period for objectives. During the initial implementation phase of any IPC project, it is best to set these objectives loosely and in a general manner. This allows project managers the time to adequately assess the realistic potential that field agents have in the field, for example with regard to: how many daily sessions an agent can conduct, how much transportation costs are really needed, how many people each agent can reach in a given time frame per area.

During the development of the IPC strategy, much of this is theoretical, based on other field experiences and what the project hopes to accomplish. Often the field realities are much different. In some cases, project managers who have set stringent objectives from the project start are frustrated once they see that IPC agents can actually do much more; in other cases the objectives are set unrealistically high and IPC agents become quickly overwhelmed and drop out. We suggest checking in at least quarterly to review targets.

FREQUENTLY ASKED QUESTIONS

What's the best way for IPC agents to get around? And what do I need to consider in terms of transport?

A key element to IPC fieldwork success is making sure that the IPC agents can get where they need to be. It is important to think through the transportation issue during the development of IPC agent objectives. Transportation will be an issue not just for the IPC agents, but also for all supervisors who will be monitoring fieldwork. At the initial implementation phase, the project will want to assess the real needs in the field before setting in stone a transportation policy.

Transportation solutions will depend on the context and locale where IPC agents are working. In some cases, the catchment area for IPC agents will be entirely within walking distance. In others, IPC agents may need to take public transportation or be provided rides by PSI office vehicles. It is recommended that projects do not stipulate that IPC agents have their own bicycle or automobile to use for project fieldwork. This tends to breed resentment among agents due to the wear and tear on their personal property.

The easiest solution, where applicable, is to simply provide a fair but modest transportation indemnity with no receipts required. The transportation issue is one that can be best assessed during the trial period of the project based on the field realities.

How should we ensure IPC agents get everything they need in a timely manner?

Logistical issues are linked to receiving the resources that are needed to implement the fieldwork. Since IPC agents are so reliant on these, and because they are often dependent on their salaries as a livelihood, assuring that they receive these resources in a timely and appropriate manner is crucial. Procedures need to be in place to assure that IPC agents can easily receive their salaries, indemnities, per diems, job aids and reporting forms, and other supports as applicable. Care should be taken to assure complete and proper documentation of all transfers of money and other resources, irrespective of the mechanism used to make the transfer.

Some projects have set up twice a month or monthly meetings between supervisors and their IPC agents during which these resources are transferred. These types of meetings serve dual purposes as an administrative/finance check-in as well as a planning and feedback opportunity. Other projects with regional offices may choose to base their IPC agents there and have regional managers take on the logistical responsibilities.

It is important that procedures be set up so that there is not a waiting period between turning in and processing paperwork and the reception of resources.

In some countries the lag time has become so vast between the IPC agent sending in reporting forms and the disbursement of funds for the next month, that IPC agents are reluctant or unable to work. Mechanisms should be set up so that supervisors or regional offices automatically receive advances as opposed to having to turn in documentation before receiving funds. Ideally agents would receive payment no more than 30 days after implementation; as this is one of the biggest de-motivators we see in the field.

New initiatives are burgeoning with the use of cell-phones for payments. Projects may be able to supply IPC field agents with portable phones that can then be automatically credited on a set basis; IPC agents can receive the cash at designated “cash-in” points associated with the cellular service. If cash-points are located in convenient areas, this may prove to be an efficient and simple method moving forward.



RESOURCES

- [Tiaht on-line course](#) (once logged in look up “FP Legislative & Policy Requirements”)
- [Summary of USG legislative guidelines on FP; in English, Spanish, French and Arabic](#)
- [Tunza Mobilizer Contract.pdf](#)
- [Paying for Performance in Health: A Guide to Developing the Blueprint.pdf](#)

4

RESEARCH

For this toolkit we are using the word research to mean studies done to explore areas that we don't fully understand, i.e., exploratory research. Two important areas are PRETESTING (of messages, tools and quality of delivery) and MESSAGE DEVELOPMENT (which could include further investigation into factors or better understanding the target audience).

In this case, research is NOT meant to include evaluations or monitoring of activities, which are each covered in separate sections.

BEST PRACTICES

- All messages and tools are pre-tested.
- You understand your audience and barriers enough to conduct effective IPC.

5

COST EFFECTIVENESS

If everything is going well, the final area of excellence is measuring cost effectiveness. Even from the beginning of a program, we will need to ensure that financial systems are in place to track this. Obviously if the program is not first EFFECTIVE (see monitoring and evaluation) it cannot be cost effective.

BEST PRACTICES

- You run cost effectiveness analysis once a year.
- Your financial systems are able to differentiate between IPC activities on different projects (and ideally between different strategies you are using).

“... A PSI/India cost study of “on-ground” activities; which included street theater and IPC showed that the cost of getting 100 high risk men to use condoms consistently in commercial sex over 2 ½ years was Rs. 13,900 (\$347)...”

FOR NEW IPC PROGRAM

Inputs

The inputs to a cost effectiveness analysis are the costs.

What to count?

We recommend that you only count costs that are almost exclusively attributable to IPC. What these means will differ a bit depending on you program but we typically include:

- IPC Supervisors' salaries/benefits,
- IPC agents' salaries/benefits,
- IPC and Supervisor Transport,
- IPC Meetings expenses,
- Training expenses,
- Tools and materials used by IPC agents (design, production, delivery), and
- IPC research/evaluation.

Costs that may be included depending on your program (only put the percentage attributable to IPC):

- Program managers' salaries: only include the part of their responsibility (time) is related to IPC (if IPC is a small part of their job, we recommend not including them and only counting IPC agents and supervisors),
- Cars: if you have bought cars that are used by IPC agents and/or supervisors, allocate the % of the annual cost based on the % of the time it's used by the IPC project.
- Rent and office expenses: if there's a regional office that's used for IPC-related staff and activities, you should count it, again only the percentage of it's use that's for IPC agents/supervisors.

If any of these optional costs apply to your program, you should count only the portion that applies to the IPC program. So if 80% of a Marketing Manager's time is spent on the IPC program but 20% is on mass media, charge 80% of their salary to your IPC cost effectiveness analysis.

Outputs

The output in a cost effectiveness analysis is the effectiveness. There's no single way to look at IPC effectiveness (and there are differences depending on whether it is a clinic-based program or self-reported behavior-based program). A few options for clinic-based programs:

- Cost per effective referral (clinic visit that can be traced to IPC).
- Cost per client at referral clinic (if you can't measure referrals, see Monitoring section for discussions on effective referrals versus all clients).

- Cost per agent (process measurement – not effectiveness).

For non-clinic-based programs, you may want to consider the following:

Table 1: Pros and Cons of Different Cost Effectiveness Measurements

MEASUREMENT	EXAMPLE	PROS	CONS	RECOMMENDATION
Per Reach/ Recall	It cost \$1 to reach each person	Easy to measure	Incentivizes the wrong thing – takes emphasis away from effectiveness	Measurement of last resort – only if you cannot measure effectiveness
Per Behavior Change %	It cost \$1 to see a 1% increase in IUD use (or to increase use in 1% of target audience)	Gets to effective IPC measures	<ul style="list-style-type: none"> • Hard to directly link IPC to behavior change • Using a percent minimizes the importance of scale (1% change in drug users in Laos is very different than a 1% change in condom users in India) 	Don't use
Per Behavior Change (per 100 people)	It cost \$1 to get 100 new IUD users	<ul style="list-style-type: none"> • Comparable across different population bases • Measures effectiveness 	Hard to directly link IPC to behavior change	Best option if you can do it

How to use cost effectiveness

It is necessary to track all costs associate with IPC and not just the IPC agent's salary/incentive. Good tracking will enable the IPC program to determine where the cost drivers are and make commitments to adjust the strategy so as to lower costs where possible. The tracking should answer questions like;

- How does this vary per region?
- How does this vary by strategy (for instance if you have some directly hired IPC agents and some outsourced, or you are trying a new strategy in one area or over time)?
- How does this vary over time?

Please note we don't have evidence at this point as to how cost effectiveness changes over time but we suspect that it will follow a bell-curve meaning there's more cost effectiveness early in a program (as it appears easier to be effective in the beginning) and then less cost effective as the behavior becomes more complicated to change and finally, more cost effective again as it moves towards maintenance.

FREQUENTLY ASKED QUESTIONS

What cost per x is considered cost effective?

We have limited data. [PSI/India cost study\(pdf\)](#) of “on-ground” activities; which included street theater and IPC showed that the cost of getting 100 high risk men to use condoms consistently in commercial sex over 2 ½ years was Rs. 13,900 (\$347), this translated into cost per recall of 7.69 rupees (\$0.19) per man.

How can we capitalize on economies of scale in IPC?

In business terms "Economies of scale" is a long run concept and refers to reductions in unit cost as the size of a facility and the usage levels of other inputs increase. For IPC this would mean that we would see reductions in cost per effective referral (for instance) as we increase the size of our IPC teams. This happens when "fixed costs" are a large part of the expenses related to a program. Fixed costs are expenses that are not dependent on the level of goods or services produced; such as rent. They are in contrast to variable costs, which are volume-related (and are paid per quantity produced).

As you can see from the costs we are tracking we have very few, if any fixed costs. If you are counting field office rents, cars exclusively used by IPC agents, or development of IPC materials - these are all fixed costs. If this is a big chunk of your overall expenses than you should see reduction in average cost per IPC agent reduce (and assuming effectiveness doesn't change, a reduction in average cost per effective referral). However, most programs have variable costs such as salaries, production of IPC materials and transport as the bulk of their costs and these will increase with every agent you hire.

For this reason, we don't often see economies of scale in IPC. In fact this might be related to corporate concerns around economies of scale as some argue that attempts to create economies from building scale is a myth in the service sector. Instead, (they) believe that economies will come from improving the flow of a service, from first receipt of a customer's demand to the eventual satisfaction of that demand. (See [Wikipedia's cost effectiveness page](#)).

Doesn't quality assurance make IPC expensive?

Yes, in general investments in quality assurance are expensive. However, it should lead to long-term cost efficiencies. For instance, the number of IPC agents that a supervisor can manage depends on the quality of supervisors you have and the time he spends on the field. If they are not very well trained and they spend too much time in the office they can manage 6 to 8 IPC agents. If they spend close to 100% of the time in the field and you train them on

supervision and feedback then than number can go up. That is why the El Salvador program reduced from three to two supervisors and they are still reaching their goals. You can decide to start with a supervisor managing a small number and then after you train them you can add more agents.

IPC is resource intensive strategy, how we can scale up and make it sustainable (with limited resources)?

Scale is definitely an issue in IPC. In many places it's not possible and when you want scale we recommend looking at other communication methods. However, India, Pakistan and Nigeria might be the places where we can achieve scale because of population density.

Scale is addressed in the following places:

- The above question on economies of scale:
- We discuss that scale is easiest in newer behaviors/simpler messages and then again in maintenance in the Exposure Section. In the middle of the curve (when you need frequency and personalized approaches) scale is particularly difficult.
- Using contracted/out-sourced agents is addressed in Recruitment and is done by many, if not most, of the WHP programs. Certainly using people already existing in the community and trained as community health workers is one way. Both Kenya and Cambodia do this extensively. Cambodia's Cost Effectiveness case study saw that the outsourced model was more cost ineffective, however it still has advantages for scale.
- Might contact Iulian in Mozambique who is trying to scale up through doing trainings and then limiting supervision and paying through referrals (<http://movercado.wordpress.com/>)
- Another suggestion is to employ part-time community mobilizers. Hire nurses or other folks with a medical orientation to work part-time in communities that have been saturated with IPC work to continue the work. This was tried in India but discontinued for other reasons related to change in strategy. See below example.



LEARNING FROM
THE FIELD

Cost Effectiveness of Using Medical IPC

- PSI/India piloted two different models of demand creation in the community for IUDs. The first is a full time IPC staff member hired by PSI who essentially works at a household level. The second is a retainer paid to influencers in the community to refer women for IUD insertions, called "community mobilizers". Preliminary data indicates that medical oriented influencers (nurse/clinic attendants/and even pharmacy attendants) are more successful in motivating clients as compared to others (school teachers, etc). Further, a quick back of the envelope calculation showed that while their efficiency was about equal (one IUD insertion for each 50 contacts), the cost per insertion was Rs. 916 for in-house IPC agents versus Rs. 540 for the community mobilizers.
- *Hence, it seems that the medically linked influencers were probably a better fit for this role rather than lay person's (linked to credibility).*
- On the other hand, the IPC program is able to reach out to a larger number of women (program deliverable).



RESOURCES

- [PSI/Avahan Cost Effectiveness Study.pdf](#)
- [Cambodia's Cost Effectiveness case study.pdf](#)

6

STAKEHOLDER ENGAGEMENT

As IPC often requires agents to go out into the community and find key target audiences, it is often necessary to gain permission of various stakeholders to conduct the work.

This is not meant to be a complete description of all types of stakeholder engagement you could do – just the part that directly affects IPC programs.

BEST PRACTICES

- Have a stakeholder engagement strategy
- IPC agents are authorized legally to work in their areas.

"... consider the role the stakeholder must play for the success of the IPC project and the likelihood that the stakeholder will play this role as well as the likelihood and impact of a stakeholder's negative response to the project."

FOR NEW IPC PROGRAM

Define your objectives

Key objectives that might apply to your program:

- A. Improved cost effectiveness
 - Better targeting of available resources
 - Limiting disruptions or wasted time for your IPC agents to do their job
- B. Improved quality of all IPC in a country
- C. Being a good partner
- D. Increasing access to the community

Determine who your stakeholders are

The most important stakeholder is often the government. This could include local authorities, police heads, public health officials, etc. If you are dealing with sensitive topics you may want to consider community leaders and religious leaders to ensure they understand what you are doing, why and ideally will support you if people object. Stakeholders can also help directly recruit people you can talk to or encourage people to support your efforts.

It is important to identify who the stakeholders are and assess where they stand in support of the project and how they may significantly affect the success of the IPC improvements/changes. Below is a hypothetical stakeholder analysis example; you may need to conduct a brainstorming session with a select team to build this for your program.

You need to consider the role the stakeholder must play for the success of the IPC project and the likelihood that the stakeholder will play this role as well as the likelihood and impact of a stakeholder's negative response to the project.

Table 1: Sample Stakeholder Analysis

STAKEHOLDER	OBJECTIVE	LEVEL OF INFLUENCE	HOW SUPPORTIVE (ON A SCALE OF 1-5)	ASSESSMENT OF IMPACT	POTENTIAL STRATEGIES FOR OBTAINING BUY-IN OR REDUCING OBSTACLES
CR	B	High	5	Extremely important	Share monthly progress reports
District Health Officer	A, C	Medium	4	Extremely important	Share National Health Officer Support Letter
National Health Officer	A, C	Medium	3	Fairly important	Show government support, explanation of program
Police Chief	A	High	2	Fairly important	Explain rationale
Providers	D, C	Medium	1	Extremely important	Involve them in the planning process. Highlight testimonial of increased clients in IPC savvy clinics.
Local Imams	D, A	Medium	3	Fairly important	Involve them in the planning process, provide Koran-based support of FP
Women's Groups	D, A	Low	2	Fairly important	Involve them in the planning process
MOH/District leaders	A, C	High	1	Not very important	Share monthly progress reports

Determine what permissions/authorizations are required

Most projects do this well without guidance, as they understand the local context. However, if you are starting a new program be aware that many communities require permissions to do door-to-door IPC or to gather groups in public spaces. Think about the levels of permission you may need.

Internal stakeholders

One key stakeholder is the IPC team, especially since they react negatively to changes on the strategy. You have to manage change by explaining upfront to the team what the new strategy is, what it can do and what it can accomplish. In the beginning in El Salvador there was some negative expectations about it but through good communication afterwards it was solved. In retrospective if we had explained that the outcome better it would have created less tension.

In many cases doing excellent IPC means that the platform might have to do organization wide changes and no change process comes easy. There will be resistance mostly arising from the fear of the unknown or worry about increased workload and accountability/scrutiny for the staff involved. Without the 'hinge players' on which things turn being brought onboard concerning the changes in the IPC strategies and/or organization they may even with good intentions or otherwise fail the improvement drive.

Depending the overall assessment (how supportive the entire team is) a change management process can be designed to bring stakeholders on board. [Karen & Karen 2010.pdf](#) offer guidance on how to manage a change management process.

FREQUENTLY ASKED QUESTIONS

How should I predict resistance to change?

Usually people are happy with the status quo and are unlikely to welcome changes with open arms, especially those that require additional demands on their time and efforts. It is important to spend time with the key stakeholders highlighting the vision of the improved IPC program and selling the benefits thereof. It may also be necessary to work with the team to identify the setbacks the IPC program is facing and what the likely causes could be. Often the team may be apprehensive in looking for where the problem areas are in fear that they will be blamed for past failures. An appreciative inquiry approach (see [Jane Brookes, 2011.pdf](#)) could be used or through careful facilitation you could identify the issues together. By identifying these together and generating solutions as a team, the team is more likely to buy into the changes. You may draw on 'facilitation' techniques to lead the team where you believe they should go without denying them the opportunity to get there by themselves.



RESOURCES

- [Jane Brookes, Engaging Staff in the Change Process.pdf](#)
- [Karen & Karen, Linking Change Drivers and the Organizational Change Process.pdf](#)

IPC

QUALITY ASSURANCE

ORGANIZATIONAL SYSTEMS

IMPLEMENTATION

- 1 MESSAGES
- 2 FORMAT/SETTING
- 3 DELIVERY
- 4 EXPOSURE
MANAGEMENT

Results from the formative research and other community assessments should allow you to make decisions about the structure of your activities. The following questions provide examples of the types of decisions that can be made.

- Do you want to use small group discussions, individual-level interactions, or a combination?
- How best to communicate with the age group, literacy level of your target audience/s?
- Will you focus activities on target group influencers or other groups in target groups' social networks?
- Where does your target group socialize or work? How will you reach them? Will you go to them, or will you bring them to a central location?
- What messages are important? What services should you establish or promote?
- Are IPCs or PEs best equipped to liaise with target group members?
- What combination of channels will you use? Which IPC techniques? What materials need to be developed?
- How often will you conduct outreach? How frequently will your messages change?

Don't forget to loop these decisions back into the monitoring and evaluation of the program.

Adapted from PSI's IPC Toolkit from 2005 created under AIDSMARK

1

MESSAGES

Depending on the messages and target audience, it's important to identify which behavioral factors (marketing objectives) require promotional activities. This generally happens as part of DELTA. Messages should then be developed that will impact the factors. There are generally two approaches to messaging; theme creation (or giving a set message to everyone) or segmenting/ personalizing the messages.

BEST PRACTICES

- Messages address most significant behavioral factors as determined by your marketing plan.
- If addressing a new behavior, you are using theme-based messaging (i.e., just get out there and do it!).
- As efficiency ratios decline (and convincing people becomes harder) introduce a personalized approach (see Exposure Management for a parallel need to increase frequency).
- Limit the number of messages delivered in one IPC session to maximum of two.

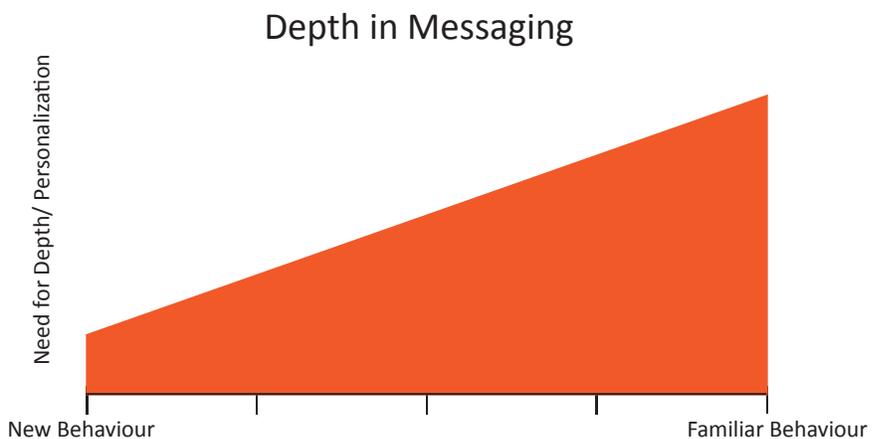
FOR NEW IPC PROGRAMS

It seems that for new projects that are embarking on their first family planning IPC endeavor that theme-based approaches (that is where IPC agents work with a set message and talking points that may change every 3-6 months) work well. At start-up, many FP programs report efficiency ratios of less than 10 women met for every insertion seen at a referral clinic, which is a good ratio. Find out what the target audience knows about the methods and then fill in any important gap. Emphasize the need for, and benefits of spacing/planning for populations where this continues to be an issue. (Hint: look at unmet need and knowledge, if it's high to start with we can assume that most people desire family planning and we just need to give them the appropriate offering).

You can look at a family planning TRaC or do a literature review to develop messages. Potential sources for messaging may be the DHS, FP and RH strategies of the country or research from other NGOs. [Research & Metrics can help you with this.](#) However, if you don't have a TRaC, you can default to the idea that family planning and all the methods are "safe, effective and easy", which has come out in most TRaCs to be the over-riding issues. [See RH Marketing Plans here](#) or [search for Reproductive Health TRaC Summary Reports here.](#)

For more on message development; please refer to the module in the [DELTA+ Promo toolkit.](#)

Figure 1: How Message Depth Changes with Behavior Types



FREQUENTLY ASKED QUESTIONS

Theme-based approach no longer getting returns, what should I do?

After a year or two of theme-based IPC in an area, most teams were finding it harder to get new clients. This makes sense if we assume that the people who were just waiting for availability and a little information have already adopted a method. Now that the low-hanging fruit has been picked, the work gets more complex. The evolving situation seemed to warrant a more personalized or segmented approach. Therefore the IPC Deep Dive team developed a training guide for using a Stages of Change approach to segment our audience (and created priority categories for follow-up) using ETL (motivational interviewing) techniques to identify the stages. See Delivery section for more discussion on ETL.

Using this approach, messages are tailored to the person while the IPC agent has a “kit” of likely issues and strategies of how to best help the person to overcome them. For the IPC agents to identify and properly address a variety of issues takes additional skills which requires training followed by high quality supervision and feedback (See Supervision and Feedback Section).

Table 1: Example of Segmented Approach

PRIORITY SEGMENT	LIKELY ISSUE	GUIDANCE
DISSATISFIED USERS	Undesirable side effects from current method	Discuss side effects, if they are likely to end soon (i.e., for new users) explain that. If the side effect will last and is not bearable discuss other methods that may not have such side effects.
NEW MOTHERS	Not yet interested in FP method	<ul style="list-style-type: none"> • Discuss return to fertility. Explain when fertility returns and when people should use back-up method of FP (beyond breastfeeding). • Discuss how breastfeeding does (and doesn't) work for FP. • Emphasize benefits of starting FP immediately and risks of not. • Give handout on “FP for New Mothers”.
	Interested but not sure which method	Discuss methods appropriate for breastfeeding women and when they can be started. Give handout on “FP for New Mothers”.

I'm not comfortable just emphasizing one FP method, should I be promoting the full method mix?

This dilemma has been plaguing programs since the beginning of WHP: how do you meet IUD projections while adhering to the Tiaht Amendment which encourages discussing the full range of available products? The Willows model (in Turkey) seems to show that offering IUDs as part of a mix can create great demand for IUDs. [Balanced counseling](#) recommends counseling only on methods that meet the needs and desires of the client. Because the IUD is the only female-controlled non-hormonal method, an approach that focuses on the woman's needs, will often result in IUD selection. See [Tiaht Guidance.doc](#) (created by PSI/India for their IPC) and links to Tiaht courses on right.

What's the difference between a behavioral factor (determinant) and a message?

Messages are a way of addressing behavioral factors that incorporate a call to action and an understanding of underlying insights into the target audience rather than just "self efficacy". Telling someone that the IUD is safe, effective and easy is not the same as a message that's been adapted for your target audience. See [The DELTA Companion](#) for more info on building messages.

Is it okay that messages focus on medical facts or knowledge rather than behavior?

The most common way to start an FP IPC program is to go out and counsel women on all methods, going through the benefits and drawbacks to each method. This is great for raising knowledge (and a good way to start so that IPC agents can gain comfort with talking about FP in the community and learn how to find women) but we know that knowledge increase does not equal behavior change. The goal of IPC agents and IPC programs should be adoption (or continuation) of a method. We need to be thinking about how to address issues beyond knowledge (motivation, social support, self-efficacy, accessibility, etc.). See Delivery section for more discussion on ETL.

Additionally, remember that IPC is a high resource method of communication that is weak at accurately and consistently addressing factual message. [One-pager on when to use IPC](#) General knowledge type messaging may be better addressed through less expensive channels.

How do I keep my IPC agents from straying from the given message?

We've found that if you supervise an IPC agent at the beginning of the month you will find them more on topic than if you supervise them at the end of the month; people get bored saying the same thing again and again. This can be addressed by a more personalized approach, so that by design every session is different. If you are using a theme-based approach, ensure that themes are changed frequently enough (often every 3-6 months) to keep IPC agents engaged. Also vary supervision to ensure that the same IPCs aren't always seen at the beginning of the month. Finally, getting target audience feedback

will help you understand if people are deviating off message so much that the message isn't communicated. For instance, if you ask a group for what they learned after a session and they talk about emergency contraceptives and your intent was to motivate people towards more effective methods, you know the IPC has strayed. (IPCs can and should do this kind of questioning themselves after every session to evaluate themselves). <[Target Audience Feedback form.doc](#)>

How do I integrate multiple behaviors/health areas into my IPC program?

As we move further into integrating health services, our IPC agents are increasingly being asked to integrate their approaches. This is still new territory for PSI who had tended to adopt a "less is more" approach to messaging. Some programs have used different teams for each behavior (i.e., one IPC team will work on increasing adoption of modern methods and another will work on increasing safe delivery practices) and others are trying to have one team do it all. The more you ask the team to do, the more they will likely "stray" from the message and the more difficult their job becomes.

One approach we are trying is to develop a few starter questions that lead an IPC agent to pick which health behavior to cover. Then they would be equipped with a 'kit' for each behavior.

Another approach, used by Willows, is to map an area and then bring the information back to the supervisor and then they together would prioritize health issues for each person mapped.

What should I do if my IPC agents do not understand well on client stages of change?

First, IPC programs do not need to use stages of change. It's one approach but not always the best. Having said that, if your team has decided to use stages of change and IPC agents are struggling with it, the best answer is supervised practice. In the ETL training we've created ([English.zip](#), [Spanish.zip](#), French) we use "Target Group cards" which give data about typical clients they may meet in the field to do role-plays. The IPC agent is to ask questions of the role-played "client", which are answered according to the card. The IPC agent then guesses the stage of change and tries to implement the correct strategy accordingly. We encourage practice, such as this, with a trainer, supervisor, or peer giving them immediate feedback and discussion. Madagascar found that their IPC agents became comfortable with the strategy after 150 IPC sessions, El Salvador found it took two months of intensive supervision after the initial training. Supervision and reinforcement of the new skills are key to adopting any new strategy.

RESOURCES

- [Priority Segments Case Study](#)
- [ETL Training guides](#) (in [English](#), [Spanish](#) and French)
- [Stages of Change handout.pdf](#) ([English](#), [French](#), [Spanish](#))
- [Stages of change poster.pdf](#) ([English](#), [French](#), [Spanish](#))
- [Write Up on Tiahrt for India](#)
- [Willows Write Up](#)
- [Countries doing integrated IPC programs](#) (Madagascar, Somaliland, Kenya)

Websites

- [Summary of USG legislative guidelines on FP; in English, Spanish, French and Arabic](#)
- [Course on Tiahrt guidelines](#) (once logged in look up “FP Legislative & Policy Requirements”)
- [Balanced Scorecard](#)



2

FORMAT/SETTING

IPC format describes a variety of indicators: **Group Size**: one-on-one, small group (2-10 people), large groups (11-20 people), and forums (>20 people); **Activity Type** defines how the activity was conducted such as the theme used, type of session (such as user groups or neighborhood meetings) or activity conducted (skill building games versus conversations). **Setting** refers to where the activity happened; either where you find people (universities, clinics, household visits) or geographic locations.

BEST PRACTICES

- Up to 3 IPC activity group sizes/ activity types in a campaign.
- Your format and setting decisions fit your strategy!
 - » Group sizes balance needs for reach versus frequency (see Exposure Management).
 - » Your setting is when and where you can reach a large number of the target audience, in an appropriate environment and when they can actively engage with you.
 - » Activity type, setting and group size are appropriate for your delivery and message decisions.
- Your MIS forms and evaluations differentiate contacts made through your different group sizes, activity types and settings so you can compare effectiveness.

Group Size

This is a choice between reach versus depth. The larger the group the less depth of conversation you will have (and the less you'll be able to personalize the interaction).

A common misconception is that one-on-one is always better. Early results from the family planning IPC evaluation study in Madagascar indicates that their group interactions are more effective than their one-on-one interactions (which are also successful, just to a lesser degree). This is likely due to the importance of social support in their particular situation. For instance, research in India and many other countries has found that when choosing a contraceptive method, women often check with their friends before making a final decision and if their friends speak negatively, this will trump even a doctor's recommendation.

You will likely want a mix of these. At the beginning of an IPC program, group interactions may work well because the barriers are relatively simple (such as basic myths, or lack of awareness or access) and social support is key. So you could start with 50% of sessions being large group, 30% small group and 20% one-on-one. As the program progresses, the barriers change and may be more individualized and therefore you'd want to switch to 10% large group, 40% small group and 50% one-on-one. As you move towards more personalized IPC, you may want to use the group interactions to prospect for key target audience segments that you want to follow-up with on a one-on-one basis. For instance, if you prioritize women who are currently dissatisfied with their method and satisfied IUD users, you can use group discussions to identify women who fall into those categories and then approach them after the discussion to see if they'd like to talk to you further or later at an agreed upon location.

Supervisors should recognize that their teams would get more comfortable with the types and settings that they use the most. Spending time planning the group sizes/activity types with the IPCs is critical when moving from one to another, for example, from mostly group to one-to-one sessions. IPCs have more confidence when changing formats if they have materials to show. The need for materials will diminish as the IPCs gain confidence in their communication skills. Introducing new IPC materials specific to the formats, especially during a team meeting where IPCs can practice using materials for the new formats, is a subtle, encouraging method of switching formats.

Table 1: Advantages and Disadvantages of IPC Formats

GROUP SIZE	ADVANTAGES	DISADVANTAGES
One-on-one	<ul style="list-style-type: none"> • Can completely personalize interaction and address that person’s specific situation • Can track follow-ups • Effective for target groups sensitive to others knowing they are using FP 	<ul style="list-style-type: none"> • Low reach • More expensive cost per contact • No social support • Important that you’ve found the “right” person for this interaction or it’s a waste of time
Small Group	<ul style="list-style-type: none"> • Great for games/ contests • Can engage small interpersonal networks (like families) for social support 	<ul style="list-style-type: none"> • Requires skilled facilitators: one participant may hold great influence so others won’t talk (e.g., husband, mother-in-law)
Large Group	<ul style="list-style-type: none"> • Can build social norms • Great for social support, likely to have diverse experiences to draw upon • Can prospect for people for follow-up 	<ul style="list-style-type: none"> • Requires skilled facilitators (often the level of a IPC supervisor) • Can’t ask personal questions • Can be easily taken off topic by more vocal participants • Data collection is a challenge – may require teams of 2 IPCs
Forum	<ul style="list-style-type: none"> • High reach • Can build social norms 	<ul style="list-style-type: none"> • Least interactive and personalized – often turns into “health education”/ teaching style • Very hard to manage; “crowd control”

Donors often define these terms differently from our definitions so we would need to ensure we’re properly adhering to donor guidelines.



LEARNING FROM THE FIELD

Adjusting Format for Reach/ Frequency Goals

(El Salvador) you need to understand at which stage are you on the program. At the beginning more iec is needed so a lot of one-on-group activities hep creating awareness. As you move on, one-on-group activities help you propect potential users to follow up on based on the stages of change or any other methodology.

Planning your goals on reach and frequency is key since you have to choose the right format in each stage. If you are more focused on reach the group activities might work better but as you need more frequency you have to shift to a mode where you can find users that you want to follow up with.

Activity Type

This will be related to the decisions you make about messages. If you use a theme-based approach (See Messages section), you will want to create targets and plans about how long and with what mix to use each theme. There might be several different types of interactions you design for each theme; such as games or role-playing or conversations. For instance, an Indian theme on condoms not breaking included a street theatre performance (not technically IPC) that talked about the importance of correct use, depicting bicycle tires and cameras as an analogy; a kiosk did small group games showing how difficult it is to break a condom and IPC agents conducted one-on-one conversation using flipcharts with the analogies from the street theatre performance.

If you don't use a theme based approach you'll want to pick a type based on the likely needs of the target audience. For instance, you may realize that when you meet with a woman and her husband, it takes a bit to "break the ice" and so you create a game or story telling session in the beginning. For other interventions like one-on-one conversations with new mothers you might create a discussion guideline emphasizing return to fertility or do role-plays for practicing how to introduce family planning to her husband.

Setting

Setting is related to group size, in that household visits are likely to be one-on-one or small group while talks in a clinic during ante-natal days are likely to be large group or forums. But the choice is going to depend on your target audience categories (pregnant women for instance are likely to be found in ante-natal or immunizations clinic days, while young women might be best found at universities) and their daily activities (for instance, are they allowed to leave the house? Do they visit markets as customers or vendors?). Ultimately you want to look at the profile of your target audience and determine **when and where they are likely to have time to talk with you** in an **appropriate setting** (consider noise levels, privacy, etc.) and then **density** – will you be able to find enough women to make the trip worthwhile for your IPC agent? For instance, household visits might make sense in highly populated urban slum settings, while it might make sense to reach out to women in workplaces or markets if they reside in sparsely populated rural areas, which would take 30 minutes or more to move from one house to the next.

Table 2: Examples of Format and Setting Considerations from El Salvador and India

SETTING	FORMAT: GROUP SIZE AND ACTIVITY TYPE
Markets – women are busiest in the morning, better to go in the early afternoon.	<p>Small group meetings after the rush is over, while women drink a coffee.</p> <p>One-to-one follow up visits are more effective (result in referrals) once the IPC has established relationship.</p>
Factories – women only have short breaks, yet due to shifts, they come and go at the same hour each day.	<p>Set up a stand at the entrance/exit with a regular schedule. After a few days, more and more women stop by the table. One-to-one sessions result in referrals. Follow up is easier if PSI can say, “I am here every Tuesday”. Select several factories in one area to visit several in one day.</p>
Universities – morning classes tend to be younger women who aren’t working, afternoons are women who work and have more money	<p>Younger women want information in a small group, but referrals “for their friends” in one-to-one setting. After small group sessions, IPC goes to a corner where she meets women one-to-one and refers mostly to the university clinics (very low cost).</p> <p>Afternoons’ women are older, career minded and want to know “where to go”. Direct referrals to private sector clinics – sometimes accompanying the woman to the clinic.</p>
National health insurance clinics are busy in the mornings, empty after lunch.	<p>IPCs do large group activities in waiting rooms in the mornings (like in public sector before.) Afternoons they move to work outside factories.</p>
Residential areas - Women are free in the noon as husband and children would be at work and school respectively and they would have finished their household duties.	<p>IPCs can do one-on-one, small and large group sessions</p>

FREQUENTLY ASKED QUESTIONS

How do we balance the need for personal interactions with large targets?

At the beginning of the project (or a new phase) the management team should determine the ideal mix of group sizes, settings and activity types (and combine these with frequency/reach targets <See Exposure Management Section>). For instance, you may set a target of 50% large group (split between in-clinic activities and neighborhood meetings), 30% small groups (split between university talks and user groups) and 20% one-on-one, which can be in any of the above (clinics, neighborhoods, universities and post-user groups). The total contacts an IPC can achieve in a week by doing the following, would be 214 contacts (but 210 people “reached”).

- 10 large group activities (typically 18 women) = 180 contacts
- 6 small group activities (typically 5 women) = 30 contacts
- 4 one-on-one activities, among women from any of the groups above = 4 contacts

If you need higher contacts but know that people need the follow-up and depth, then you want to determine whether one-on-one or small groups is best for giving depth in your situation and then reduce the other, while possibly adding one forum event per month to get reach.

How many Group Sizes/Activity Types should I have at once?

Ultimately, this should be something you look at in MIS (Monitoring) or evaluation, which activities and which combination of activities are having the most impact. In India’s Avahan program, an evaluation of the first 5 years of activities concluded that the state with the most IPC-type activities was the least effective (and cost effective). The hypothesis was that it is too hard to maintain quality control on many different formats and activity types. **Therefore we recommend 2 to 3 formats or activity types at a time** (for example, having one-on-one following street dramas, and a table where IPC agents play games in a small group). This will likely change over time (i.e., which activities and combinations are most effective), hence the need to monitor their effectiveness and adjust your plan.

- Different settings require different types of activities so IPC workers need several “tools in their toolkit.”
- Having too many different types of activities means that managing (IPCs) and supervision of the content is more difficult (harder to keep quality high).

How should we adjust activity type to the group sizes?

The approach to one-one-one interactions (group size) shouldn't be the exact same as for groups. While group activities can be very interactive and follow techniques such as ETL (see Delivery Section for more information) there are still adjustments that should be made. For instance, you should not be asking the same level of personal information in a group setting that you would during a one-on-one session.

eg.

EXAMPLE:
EL SALVADOR

How to Build an IPC's Daily/Weekly Schedule to Account for a Variety of Group Sizes, Activity Types and Settings?

Early in the project, nearly all the activities were groups inside public sector clinic waiting rooms. The IPCs would give a large group or forum presentation in a clinic, where women were waiting to see the doctor -- a captive audience. If a woman was interested, she would approach the IPC for a referral – on the spot. Due to unmet need for non-hormonal methods, unmet need for information on FP, and the ability to work inside the clinics where large numbers of women waited, this strategy was quite effective. As the program moved from public to private sector, and as the “low-hanging fruit” disappeared, the supervisors realized that they needed to change strategies.

Supervisors analyzed where women are most receptive to IPCs, and then revised the schedules to be most productive. Supervisors looked at:

- WHERE women are receptive to interacting with IPC
- WHEN women are receptive to interacting with IPC
- Goals:
 - Number of women to be reached
 - Number of repeat visit (frequency)
 - Number of effective referrals

Talking to the IPC workers, observing IPCs and analyzing settings, the supervisors set goals.

The key to making the schedule was asking when women were receptive to IPC – asking IPCs, asking the target audience and then going to the field to validate. When supervisors ask the IPCs to make their schedules, they can ask – what activities (type) are you going to do? Why did you choose this time/location? After 2-3 months, of very close supervision, the IPCs now do their own schedules successfully.

As mentioned earlier, large groups and forums would be require 2 or more IPCs/IPC supervisor, for the session to be effective. Hence, the IPC supervisor should make IPC teams and lead the planning and implementation.

3

DELIVERY

Delivery includes the methods and quality of communication (adhering to best communication practices) and using appropriate tools (including new technologies and appropriate for reinforcing the strategies, such as participatory).

BEST PRACTICES

- Follow a standard set of delivery guidelines.
- Avoid teacher-student like lectures and make it interactive.
- Tools follow message strategy and assist the IPC agent rather than leading the IPC agent, including:
 - » Your tools encourage or force interaction during the IPC sessions;
 - » You have tools that enable new IPC agents to easily remember what to say and when;
 - » You have flexible tools for more advanced IPC agents; and
 - » You do not require “use of tools” – for example, on a supervision checklist. IPC agents are only encouraged to use tools when it aids the discussion.

Training

One of the first trainings that IPC staff will need is on communication skills and techniques. This is in addition to training on protocols, messages, and daily planning and reporting. Communication skills will make up the foundation of what IPC agents do. Supervisors will also need to be trained on these skills, so that they may give relevant feedback. Numerous communication techniques are applicable, from asking open-ended questions to making eye contact and using proper body language. It is important that IPC agents and their supervisors have some common set of agreed upon techniques and skills that will be used and evaluated in the field. Here are the set ([English.docx](#), [Spanish.doc](#), [French](#)) our team recommends but there are other acceptable ones.

The strategy used in the Deep Dive Pilot was to adopt the communication technique of Education-through-Listening (ETL). This technique emphasizes the skills of Open-Ended Questions, Affirmations, Reflective Listening or paraphrasing, and Summarizing. It secondarily underlines the importance of engaging social support so that other group members answer questions instead of the IPC agent being the only 'expert' in the discussion, asking permission and establishing an environment of trust and confidence. ETL is a combination of motivational interviewing techniques, adult learning and stages of change and was created by Bobbie Person at CDC. As a strategy ETL is very client-oriented and open: this means that IPC agents tailor their interactions to the needs of the client, not according to a set format. This type of technique is generally most applicable for well-trained and experienced communication agents, especially in settings where barriers to behavior change are complex and personalized. <ETL resources (large zip files); [English](#), [French](#), [Spanish](#)>

Session Guides

In contexts where IPC agents will be providing basic knowledge or straightforward skills building, it is sometimes useful to use a standardized session format. This entails developing a session guide that IPC agents follow to get specific key messages across. Formats can be more or less restrictive and scripted, depending on the specific situation and skill level of the IPC agents. <[Session guide examples.zip \(from Vietnam\)](#), [Adara session guides and tools for sex workers/IDUs in Central Asia.pdf](#)>

Tools

Any IPC delivery can be supported and even optimized through appropriate tools and job aids. Just as multiple channels in a communication campaign reinforce a specific message, the correct tool can strengthen an IPC session. The most basic supporting tool that should be included in any family planning IPC session is the actual contraceptive product under discussion. Allowing participants the opportunity to fully examine the relevant contraceptive method, ideally in

conjunction with an anatomical model or picture, is considered an important best practice.

Tools may take the form of a job aid, such as a discussion guide, testimony from a satisfied user or scripts for role-plays. They may also take the form of visual or other sensory aids, including among others: flipcharts, games, sample products and anatomical forms, brochures, posters, music, video, photo images. The essential issue with tools is that they be useful in supporting a key message and do not detract from the message. Tools should be practical, adapted to the type of interaction, and relevant. Tools should always be pre-tested before widely implementing.

In summary, the tools should reflect the message strategy and *assist* the IPC agent rather than *lead* the IPC agent.



LEARNING FROM
THE FIELD

Tools

(El Salvador) One key learning on tools is that at the beginning of the program both the IPC agents and the target group need a lot of generic tools. As the program evolves the need for tools change as the IPC agents become more experienced they can focus less on the tools and more on the interaction so the tools need to evolve as well. Tools depend on the stage of the program and the experience of the IPC agent so if you replace an agent a new one might need the more generic type of tool.

Finally, you should consider how IPC agents get around when developing tools and visual aids. We've seen tools destroyed by carrying them inadequately or worse, they aren't even brought to an IPC session because they are so inconvenient to carry. If they need to be carried on buses or walking, make sure they are as small and convenient to carry as possible. You may want to budget for invest in a bag that can carry all the visual aids, detailing materials, etc. if appropriate. And consider whether it needs to be rain proof as well.

Leave Behind Materials

Leave behind materials are similar to tools but are meant to be kept by the audience member. These can be simple reminders (point-of-sale things like key chains with a hotline number, clinic address or IPC phone number) or more in-depth materials (such as a brochure detailing return to fertility for women who have just given birth, or a family planning brochure aimed at her husband) depending on what the target audience needs.



SPOTLIGHT ON REAL WORLD

Importance of Leave Behind Materials

(India Avaham Program) I was in bed when the phone rang, it was 10.15p.m. The call was from an unknown number. When I answered the phone, there was silence on the other end. As I said “Hello...hello...” I could hear some noise in the background. I had a hunch that the caller was a STI patient so I tried to sound reassuring as I said, “Don’t worry, I am a Key Clinic person. I will definitely help you. Tell me the problem.” I could hear the person at the other end crying. I said, “Don’t cry. I will definitely help you.” Finally, the person spoke. “A few months ago I had sex with a sex worker without using a condom. Now I’ve got AIDS. I am going to take sleeping pills and kill myself. But I’ve seen your show and I have your telephone number in a pocket calendar, so I thought I’d call you up as my last hope before I commit suicide.” “How do you know that you have AIDS?” I asked. “I have a discharge from my penis and an ulcer,” the caller said. My heart beat slowed down, “Brother, These aren’t the symptoms of AIDS. Have you heard about STIs?” I asked. We spoke for a few more minutes and I asked him if we could meet the following day so that I could take him to a Key Clinic.



These materials can serve as a nudge. Nudging is a concept that we make it easier for people to adopt behaviors through reminders or giving them a final, small push. It is similar to how a sales person would “close a deal”. A well-known example of using nudging was from Leventhal, Singer, and Jones (1965) on the campus of Yale University. The subjects were Yale seniors who were given some persuasive education about the risks of tetanus and the importance of going to the health center to receive an inoculation. Most of the students were convinced by the lecture and said they planned to go get the shot, but these good intentions did not lead to much action. Only 3% actually went and got the shot.

Other subjects were given the same lecture but were also given a copy of a campus map with the location of the health center circled. They were then asked to look at their weekly schedules, make a plan for when they would go and get the shot and look at a map and decide what route they would take. With these nudges 28% of the students managed to show up and get the shot. ...The students were all seniors and surely knew where the health center was located (Yale is not a huge campus).¹

¹ Thaler, Sunstein. Nudge: Improving Decisions about Health, Wealth and Happiness. p72.

FREQUENTLY ASKED QUESTIONS

What should I do about the fact that my IPC agents talk more than listen?

A common problem seen with interpersonal communication sessions, whether individual or small group, is the use of one-way pedagogic techniques. Sometimes IPC agents have a tendency to approach sessions as a “teacher” providing a lesson. Some IPC agents like to use the sessions to demonstrate their expertise rather than draw out the participants’ concerns and questions. Some of this is driven by a fear of being asked a question that they don’t know the answer to and feeling embarrassed and exposed. Ironically, when an IPC agent begins with a technical lecture, the participants, picking up on their cues, generally ask more technical questions, rather than exploring personal barriers. This technique reduces the participation of the target audience and puts distance between them and the IPC agent. The target audience is less able and less likely to offer personal information that will help the IPC agent tailor his or her interaction to actual needs; this translates into less opportunity for behavior change. Further this is a missed opportunity to use IPC for what it is best for; personalization. [Implementation Brief; When to Use IPC.pdf](#) It is recommended as a best practice to avoid the “teacher-student” type of interaction and instead use techniques that encourage the most participation from the target audience. Through audience participation, the IPC agent will gain valuable insight into their needs and barriers, and can more readily address them.

Audience participation should be solicited carefully and thoughtfully. In an individual interaction it may be reasonable for the IPC agent to ask personal questions, however in a small group or medium group setting it may be embarrassing and off-putting to do so. In small and medium group settings it may be more appropriate to ask non-personal open-ended questions. IPC agents should be well trained on how to gauge the level of intimacy to use in each setting, in order to assure that everyone is at ease and feels comfortable participating. This is part of ETL and should be practiced during role-plays in the training.

Why do audience members leave the IPC sessions, what can I do about it?

One key challenge is when you see significant numbers of people not staying for the IPC interactions. There are a few reasons this could happen:

Inappropriate Locale: With regard to the loss of participants during a session, it may be instructive to assess the appropriateness of the locale. For example, a street campaign may prove to be ineffective if the target audience is uncomfortable discussing topics in full view of others. Additionally, if the location is too crowded or noisy, participants may decide

to quit if they cannot see and hear well. For family planning issues, it is generally appropriate to conduct IPC in a quiet, less frequented location.

Sessions are too long: We are generally talking to people who are busy. This is particularly important if your setting is a place where people are doing other things. In a market, bus station, or other busy place, sessions should be kept to a minimum length. Even when you have a captured audience, people's attention span is limited, therefore sessions should not be longer than 45 minutes. One-on-one can follow.

People believe they have seen it before or know everything you'll say:

This is a particular issue when IPC agents do every session the same; use the same tools, in the same way. People begin to feel they have seen this before and either mentally disengage or physically leave. The more personalized the interaction, the more it will change every time and therefore be more engaging. If you are using a theme-based message approach, you'll want to make sure you change not only the message in each theme but the look and feel of the sessions.

They aren't interested: It is possible that family planning isn't a topic they are interested in (maybe because they are sterilized, actively trying to get pregnant, ardently against family planning, or have other pressing needs). IPC can serve as a great self-selecting targeting mechanism, meaning that people who are interested and in the target audience are more likely to stay than those who aren't. This is a good thing in most situations. The people most interested are those most likely to attend the whole session and stay afterwards to talk. In India, when they did sessions on male STIs (promoting franchised clinics), they found that they could tell which men were currently experiencing symptoms by watching who stayed after and milled around. This means that having people leave isn't always a bad thing – it could be self-selection. However, if you want to interest non-interested people, then it's a problem.

Supervisors who observe audience members leaving should try to ascertain the reasons, so as to better tailor future sessions.

What should I do when my audience doesn't seem to remember the messages?

As an overall best practice, it is recommended to solicit feedback from the audience regarding their interest and understanding of the theme covered. This is a good way of confirming the quality and impact of IPC agent delivery. If target audience members consistently have a problem grasping or retaining the key messages from a session, it should signal a red flag to both the IPC agent and the supervisor. It may be that the agent is not staying on topic or not using tools appropriately. When the problem seems widespread across multiple IPC agents, it may mean that the messages being transmitted are inappropriate or that

sessions aren't properly designed. To avoid these types of problems, it is best to initially pre-test both messages and IPC delivery. As a follow-up, conducting appropriate ongoing supervisory visits and soliciting audience feedback will help keep IPC delivery tailored to the needs of the target group. <[Target Audience Feedback form.docx](#)>

How can IPC agents manage dysfunction and stay on message?

IPC agents should be trained to stay on message and to avoid diversions during interactions. Sometimes IPC agents may be too focused on following the interests of their target group, to the detriment of the objectives of the IPC session. It is important that IPC agents be capable of referring target group members to other resources for issues that are entirely off topic, and to not be taken off the tracks by such diversions.

IPC agents should be discouraged from providing information on issues unrelated to what they have been trained on. They may be tempted to provide their personal views or beliefs on an unrelated topic, but they are representatives of the project and as such should refrain from off-topic discussions. In certain cases agents have done so and provided wildly inaccurate information that could have put PSI in danger of liability suits.

On occasion, IPC agents may encounter audience members who deliberately disrupt sessions: IPC agents should be trained to manage these types of situations appropriately and with grace. <[Handout on managing dysfunction.docx](#)>

How do you set up an IPC program in which IPC agents are exposed to the same target audience every day? Say for instance CHWs serving as distributor and communicator in their community, what kind of IPC tools do they use so the audience does not get bored/tired?

There are two elements to this question; a) how do you keep your IPC agents motivated and b) how do you plan frequency? For the frequency answer see the Exposure Management section.

As to the motivational aspect – there are no easy answers, however here are some that PSI/India tried and tested:

1. Keep changing the message.
2. Ensure the IPCs have different tools and techniques to keep themselves interested (to begin with).
3. If possible, build their credibility by having posters/banners in the areas they work.

4. Have regular formal meetings/trainings to keep them motivated. Even if there is no formal training, just getting them together and listening to them, giving them an opportunity to share stories and interact with senior staff is motivating.
5. Finally, pay them well. We make this mistake all too often.

For more on these lessons, see the [Lessons Learned from OPL](#).

It's worth reinforcing that it is the IPC workers that may be the greatest challenge to keep fresh but stay on strategy. They can get saturated with the agreed messaging, bored with tools, tired and move on. Marketers (like IPC workers) are also notorious for getting bored with their own work after lengthy exposure (to themselves) and wanting to do "new things." Yet more often than not the target audience is nowhere near a level of over-exposure. Internal research at Coke suggested that marketers routinely over-estimate when campaigns are reaching "wear-out" levels.

What if my IPC agents are using the tools inappropriately?

The right tools can be a huge asset for an IPC agent, but only if he or she uses them appropriately. We have seen many IPC agents flipping back and forth through a flipchart looking for an image, indicating that they are clearly not familiar enough with the flipchart to easily navigate it. While correct manipulation of the tools is an important element to using them appropriately, it is also important that the IPC agent tailor use to the audience at hand. It would be inappropriate, for example, for the IPC agent to insist on distributing a brochure on the contraceptive pill to a small group of women who have already used the pill and are no longer interested in it. Therefore, the IPC agent must know *how* to use each tool and *when* it is appropriate to do so. Trainings should include a thorough practice and review of using the tools. Supervisors should evaluate the use of tools during their field visits.

How do I keep my IPC agents from answering questions inaccurately?

Family planning IPC agents in the field get all sorts of questions, from how cervical cancer is spread, to whether reported side effects are real, to whether women can have sex during menses. Too often, observations of our agents show that they confirm myths or answer questions they are not knowledgeable about. This is incredibly dangerous, as we reinforce myths and spread misinformation.

There are two key ways to minimize this; supervision and training. Supervisors should always be listening for the accuracy of information spread (of course this means that supervisors must be well-versed on the subjects). If there is any concern, team members with medical backgrounds should be occasionally asked to supervise the sessions to give feedback on accuracy. In training there are three areas to concentrate on.

- Ensure that there are full discussions of all the side effects of family planning methods. And be clear that other side effects have not been proven.
- Practice with frequently asked questions. Often just spending a few minutes at the beginning of training or meeting with the IPC agents asking them to write down their hardest or most commonly asked questions will get to the main issues. You can then role-play and hand out these questions to ensure there is discussion on how best to answer them. IPC programs often have agents record the questions asked during sessions to track the most frequently asked and incorporate those into regular training.
- Emphasize that it is okay not to know the answer and practice how to answer a question when you aren't sure of the answer. Often we see agents making up answers because they feel it will reflect badly upon them if they don't know an answer (and harm other parts of the interaction). Demonstrate how to address this (for example, "that's a good question, but only your health care provider can determine what you are dealing with" or "I have heard that before from the community but it's not listed in the common side effects, let me look into that and I'll get back to you") and then ensure that during roll plays IPC agents practice saying this. Obviously getting back to someone is easier when there is a follow-up plan, and they shouldn't say that if they cannot get back to the person. However, they can ask for a phone number or other way of getting in contact.

How can I ensure that my tools are adapted to my context?

All tools should be pre-tested before widely using. This will help assure that they are adapted to the context. In addition, it is important to solicit feedback from the IPC agents on an ongoing basis with regard to target audience reactions to tools. Tools must be adapted to the needs and understanding of the target audience: when the target audience is confused or misinterprets the message of a tool, the entire interaction may end up a failure.

My tools that are systematically not being used, what should I do?

Most tools that are not being used have three reasons:

1. The IPC agents have not been well trained on their use,
2. The tools are not found to be useful, or
3. The IPC agents find them difficult to carry so they leave them behind or end up damaging them

The first thing to review is the training they have received on use of the tool. Go and observe. If they don't seem knowledgeable about where various information is contained within the tool (flipping back and forth looking for something or not knowing what's coming next) this is an indication that they

need more training. It could also indicate that they are only using the tool when the supervisor is around, possibly due to 2 or 3 above. Anytime a new tool is introduced you should be training the IPC agents (and supervisors) on its use. If the IPC agents have been trained on the tool and seem comfortable and knowledgeable about it but no one seems to be using it you should have candid conversations with the IPC agents about what could be improved.

When designing tools, project managers should take into consideration how the IPC agents will be traveling and carrying the tool/s and provide IPC agents with necessary supports, such as an adequately sized backpack and a way to keep the tools safe from the weather.

How can I ensure that my tools encourage interaction rather than “teaching”?

The most common tool in family planning IPC is a flipchart with each page showing a different modern method. Typically the IPC agent goes through the flipchart page by page with each session and discusses the benefits and side effects of each method. While IPC agents may ask for questions this tool often dictates the flow of the conversation rather than serving as a visual or true aid for the discussion.

Tools that can better assist a conversation could include the following:

- Resemble counseling cards rather than a flip chart, so that the IPC agent can pull the appropriate one as it comes up in conversation (rather than being in a set order)
- Games/activities: these can encourage participation by asking people to place the side effect into the proper “known side effect” or “myth” categories or put a picture of a method under a benefit category (such as can keep private from my partner, or won’t effect bleeding, or prevents HIV also).
- Incomplete stories: stories that end with a dilemma that the target audience can try to solve can help people think through their own situations.
- Samples that can be passed around
- Tools that are grouped to be used when specific issues come up; for instance, materials for women who aren’t sure they can convince their husband, pregnant women or who are concerned about the insertion process of an IUD. The IPC agent would determine through conversation which one to use.
- A series of questions the IPC agent can ask to elicit a conversation or determine how best to address this person

- Testimonials from others in the community who have overcome a common barrier

Should supervision criteria include “use of tools”?

The most advanced and skilled IPC agents will often not use tools – they are often best for newer IPC agents. Advanced IPC agents will use their judgment as to whether the tool is useful for changing the person’s behavior or not. A simple check box that asks people to use the tool will reinforce using the tool even when inappropriate. A more appropriate supervision criterion would be “*appropriate use of tools*” where supervisors would observe whether agents are using visual aides when the question requires a better understanding of where an IUD sits in a women’s body, for instance or hands out the appropriate brochure or leave behind materials.

What literacy considerations should I make in designing tools or leave behind materials?

There are three basic considerations of literacy; literacy levels, visual literacy and readability. The most important thing to know about **literacy** is that just because people are educated, it does not mean they are literate. Typical reading ability is about 3 levels below the last year in school they completed. Another key concept is that illiteracy is not visible or apparent when talking to people. It is always better to err on designing materials for lower levels of literacy. **Visual Literacy** is almost never taken into consideration but we should not assume people can read images such as maps, and know that the more a person can personally relate to the images, the more they’ll understand them. Finally, there are many design concepts including font, kerning, color and placement that increase or decrease **readability**. For a summary of all these literacy and readability concept see [Health Communication Materials: How commercial marketing techniques can aid design.pdf](#)



RESOURCES

- [Implementation Brief; When to Use IPC.pdf](#)
- [Example Sessions Guides from Vietnam \(zip\)](#)
- [Adara session guides and tools for sex workers/IDUs in Central Asia.pdf](#)
- [Handout on managing dysfunction.docx](#)
- [ETL facilitation guides and handouts.zip \(English, French, Spanish\)](#) - note these are large files
- [Health Communication Materials: How commercial marketing techniques can aid design.pdf](#)
- [Lessons Learned from OPL.pdf](#)

3

EXPOSURE MANAGEMENT

Just as we suggest that audiences need repeat exposure to television and radio ads, they also often need repeat exposures to IPC messages. High frequency often means a sacrifice to reach (how many people are exposed) or coverage (which geographies you'll cover). Making these decisions will define your program and may be dependent on your messages (e.g., [Willows model](#)).

BEST PRACTICES

- Determine a frequency and exposure plan from the beginning of the program that includes:
 - » Reach,
 - » Which prime prospects you will follow-up with,
 - » At what intervals,
 - » When you will stop following-up with them, and
 - » Geographic coverage
- You're meeting your exposure targets.
- For new behaviors, you follow a reach strategy (versus frequency).
- As efficiency ratios decline (and convincing people becomes harder) you employ a frequency or follow-up strategy (versus reach).
- Every time you change the exposure strategy (e.g., reach versus frequency), you adjust message, delivery and/or format & setting strategies.
- Advanced: You know what level of exposure and mix of mediums is optimal for changing behavior.

You'll want to start with a frequency and exposure plan that combines all media (TV, radio, interactive, mid-media, IPC) you are using (see Promo tools).

An often-stated "rule of thumb" says we need about 3 exposures to campaigns to change behavior. However, this rule is increasingly challenged and was created in relation to television exposure so may or may not be relevant to IPC.

What we know about exposure management from commercial advertising

Several studies were done on specific campaigns or brands (mostly on television) in the 1950s and 1970s that showed that one exposure, two exposures, three exposures or 15 exposures maximized impact.¹ More recently research is trying to tease out what variables or situations might account for these differences. One theory (Teller, Gerard, "Effective Frequency: One Exposure or Three Factors?" *Journal of Advertising Research* July-August 1997; 75-80) says that you need to take into account brand familiarity, message complexity, and message novelty. As Teller says in summary:

- "Brands familiar to consumers may achieve peak response at lower levels of ad frequency. New or unfamiliar brands may require higher ad frequency to break through the clutter and achieve positive response.
- Complex Messages, including soft-sell or emotional appeals, may be able to sustain and benefit from higher ad frequency. Hard-sell or rational appeals may achieve peak response at lower ad frequency.
- Novel messages may achieve immediate positive response without wearing out. Wearout may be delayed by spacing out exposures within a period. Wearout may also be delayed by using novel executions on the same theme. However, all campaigns are likely to wear out ultimately, as early as two months from the start. At that point, a novel message or campaign may be the best alternative." (p79)

Millward Brown argue that media clutter (how many messages people are exposed to) greatly impacts the effectiveness of media buys (again, mostly of their discussion is on TV) and suggests that this results in "rules of thumb" about required exposure levels being useless across international borders. They suggest a few considerations; you want the same share of voice in your category as your market share, that media planning for short term sales goals is different than for brand building, that spreading out your ad buys over time (what they call a "drip strategy") including times with no ads running is effective and that higher frequency early on is recommended. (Millward Brown. "Knowledge Point: How Should You Take TV Advertising Clutter Into Account? 2011)

¹All of these are referenced in the Teller article

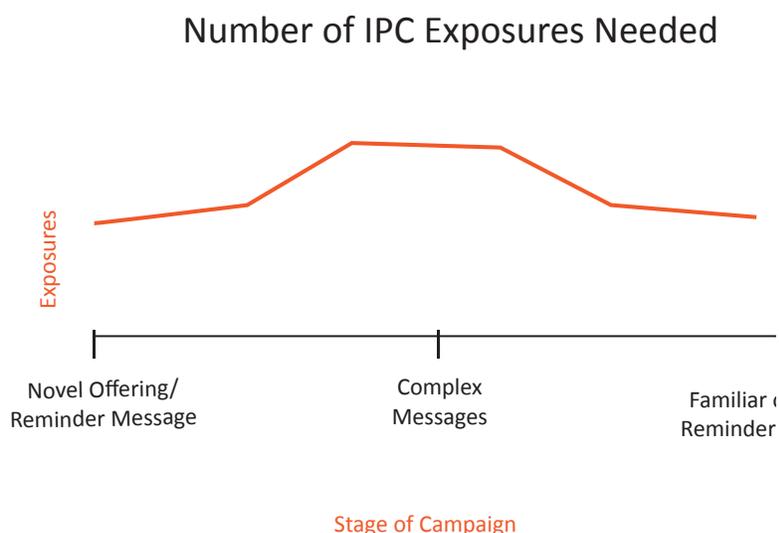
One of the few studies to examine exposure in social marketing (or public health) campaigns makes a case for high exposure. It describe five ways in which repeat exposures help; to allow a person to learn the message, to increase a person’s assessment of the importance of the message, to increase a sense of social norms around a behavior, to increase discussion on the topic and indirectly, to influence policymakers. (Hornik, Robert C. “Exposure: Theory and evidence about all the way it matters”. Social Marketing Quarterly. Vol. VIII, No. 3, Fall 2002)

What we’ve learned about IPC exposure

IPC guidance is more varied and depends on the behavior in question but most campaigns need multiple exposures. In the beginning of most WHP IPC programs, we are seeing many women come to a clinic for IUDs from just one session. These are likely women who wanted family planning but had a small barrier; didn’t know about the IUD, didn’t know where to get it, couldn’t afford it, or were scared. Often a good session can drive these women straight to a clinic (especially if the location, hours and cost of the service is right). To relate this to the above commercial theory, we could hypothesize that with a “novel message” or offering, we need fewer exposures.

However, we find it gets harder over time as the so-called “low hanging fruit” are reached and “picked”. Women with deeper barriers or those already exposed or with less social support (this might also relate to the associated need for more complex messages, beyond just awareness and availability) will often need multiple exposures (exposures from well linked other media are also useful). At the end of a campaign, we find that the need for exposures reduces. For instance in the condom promotion campaign in India we found that one exposure in three months was sufficient by the end of a three year campaign (it was at least once a month in earlier years). This leads us to hypothesize the following trend.

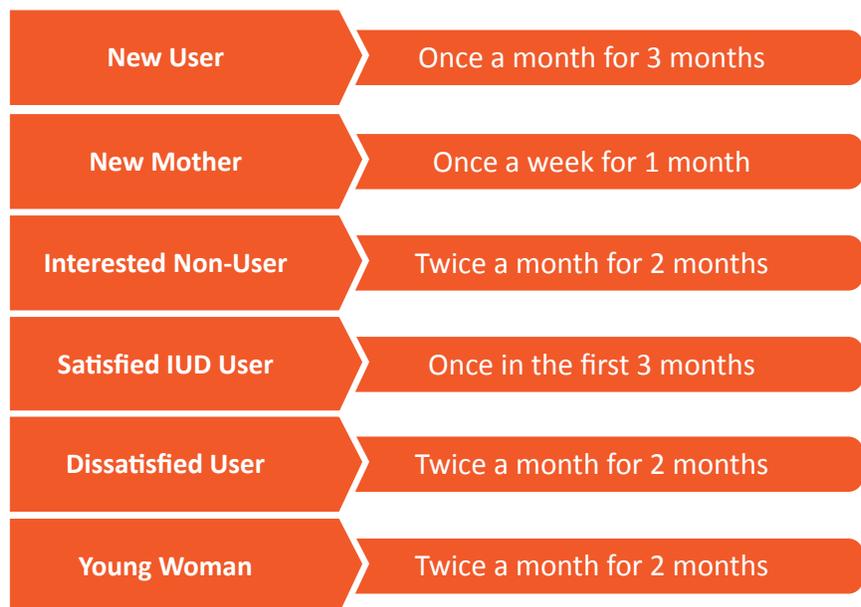
Figure 1: Hypothesis of Number of IPC Exposures Needed at Different Stages of Campaign



All programs, even new ones, should have an exposure plan. For new programs you may decide that for 6 months or even a year you think single contacts are appropriate. But have the plan for when that stops working (and have an MIS system that will tell you when it stops working – see Monitoring Section).

Tanzania and Pakistan ([Write-up on Tanzania.zip](#)) used geographical mapping to achieve frequency. They divided their territories into areas and made plans to revisit areas. In India, they mapped all women of reproductive age in specific areas, and made a plan to see each non-user 3 times per year ([India write-up.zip](#)). Another approach, used by all IPC Deep Dive countries is to select people to follow-up with to ensure they get multiple exposures (see Prime Prospects discussion of Prerequisites to Planning an IPC Strategy Section).

Figure 2: Follow-up plan for Madagascar using Key Segments strategy



FREQUENTLY ASKED QUESTIONS

I've promised the donor I'd reach x women

In far too many countries and programs we see donor commitments to the number of women the program will “reach” with IPC <for definitions see [data dictionary.docx](#)>. The issue here is that we often want to see people more than once, but the deliverables incentivize large scale without repeat visits. The best idea here, especially if you're setting targets without having all the information (such as at the beginning of a project) is to commit to “contacts” which can be interpreted as seeing one woman twice (2 contacts) or seeing two different women one time each (also 2 contacts). This leaves you some flexibility.

Finding the right balance between reach and frequency

While the above issue addresses how to design program proposals and deliverables on IPC, it doesn't address what to do. Even without a donor mandate we know that scale is important in all our programs. The best program with wonderful effectiveness and efficiencies is useless if it only affects 1% of the target population.

A few ways to achieve balance:

- Find another medium for reach, focus IPC on frequency.
- Use forum or large group settings to “prospect” for key segments you want to achieve frequency with (see Format/Setting section).
- Do high frequency interactions within a small geographic area for a set amount of time (say 6 months) and then move to the next – will have high reach but only after a few years. This works best in densely populated areas, where reach is still reasonably okay by focusing on a key geography.
- Don't personalize or do one-on-one; do a theme-based approach with an emphasis on groups or forums and keep going back to the same place.

How many times do I need to follow-up a woman before giving up?

In the same way that there is no clear answer to the minimum number of visits needed, there is also no one answer for the maximum. But it's an important question as we don't want to waste time on target audience members who don't need or want our help. With TRaC Evaluation Table results we have seen that there's a point where an additional contact did not result in any further behavior change. Data like this is the only way to *really* know the maximum for your program at that time. However, IPC agents should be trained and empowered to stop visiting a client when it is deemed that they are not likely to change in the near future. The agent can always give out their phone number or another way of getting in touch with them should the client change their mind and want to discuss it further in the future. Prioritization is difficult but absolutely necessary, time wasted talking to people too often is time that they aren't talking to someone who might change after one or two visits.



SPOTLIGHT ON
REAL WORLD

Over-Exposure

An IPC agent in India asked for help in handling a situation she was facing. She had approached a woman she knew was a non-user of family planning who told her she couldn't talk to her without the permission of her mother-in-law. She never heard back and visited two more times. Finally the mother-in-law called the IPC agent and asked her to stop bothering them and threatened to call the police if she didn't stop. The IPC agent wanted to know how best to convince them. Her supervisor suggested taking over written materials, including the permissions they'd obtained from local officials to work in the area.

This is a case where the person (or at least her mother-in-law) does not want our help. We suggested that she stop visiting completely. The time it took for the follow-up visits and then the concerns and conversations she was having could have been spent seeing two or three new clients who might have been immediately convinced (as we had just seen her do). Additionally, by creating new social norms in the neighbourhood, by quickly conversion her neighbours, the woman (or her mother-in-law) may be convinced.



How do you set up an IPC program in which IPC agents are exposed to the same target audience every day? Say for instance CHWs serving as distributor and communicator in their community, what kind of IPC tools do they use so the audience does not get bored/tired?

There are two elements to this question; a) how do you keep your IPC agents motivated and b) how do you plan frequency? For the motivation answer see the Delivery section.

As to how to plan -it probably depends on what they are selling? Assuming they've been trained and asked to provide advice to the community for a variety of health issues. The answer has many elements; how should you plan the program (including what should she say (messages), how should she say it and with what tools (delivery), how often (exposure management), where (setting)). If they are truly community-based agents their first important role is to create awareness of what they can provide (so that's a high reach strategy with some

basic awareness building messages).

Once people know them and what they offer they won't need to talk to everyone constantly. They can remind women who bought OCPs to buy next month's cycle of pills or approach a woman who they might hear has an infant with diarrhea to help her understand proper treatment and prevention. She wants to be aware of what's happening in the community and offer services/advice when needed. The tools associated might be a series of cards each on a different health area that she can pull out if that's the issue at hand. If she keeps going up to people lecturing them with flipcharts, they will get bored.

Some trainings that might be useful could be on 'up-selling', the concept that if someone comes to her with one question (for instance child's health), she can answer it and then ask what the family is doing to address another issue (FP or immunizations or malaria). In this way they can sell more of the products they offer (which I assume is their main motivation) and get new messages to people. (The concept of up-selling is like when you order a burger and the person asks "do you want fries/chips or a drink with that?" You come for one thing and leave with that and more -and you've spent more).

What is the minimum duration of IPC coverage for effective behavior change communications?

The short answer is that there is no short answer. It's very dependent on the program's message and the type of behavior in the community (new, well-known, common). There are many instances where one contact is enough (tends to be early in a behavior or later in maintenance stage) but many where it's not...



RESOURCES

- [Write-up on PSI/India's Mapping exercise 2011.zip](#)
- [Write-up on Tanzania's geographic exposure planning 2010.zip](#)
- [Poster from PSI/India's research on exposure results.pdf](#)

External Articles on Exposure Management

- [Teller, Gerard, "Effective Frequency: One Exposure or Three Factors?".pdf](#)
- [Millward Brown. "Knowledge Point: How Should You Take TV Advertising Clutter Into Account?.pdf](#)
- [Hornik, Robert C. "Exposure: Theory and evidence about all the way it matters".pdf](#)

