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The ECOM Work Programme 3

Toolbox Compendium

Checklists, Reminders and Guides for planning and evaluating a more effective and efficient pandemic behavioural and communication programme

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Effective Communication
in Outbreak Management for Europe

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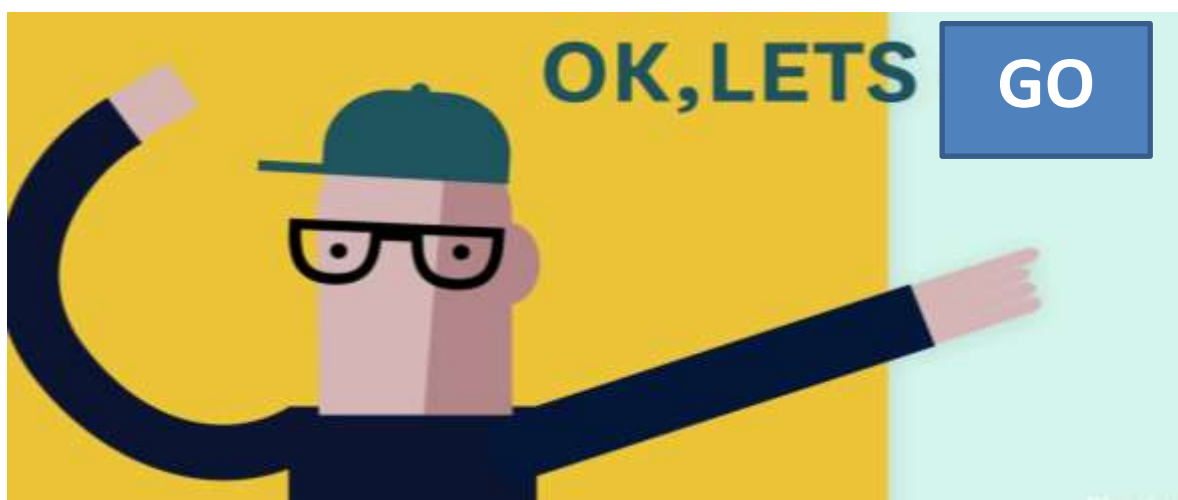
30 point summary of principles that Influence behaviour

Recent findings from a variety of fields of study have all helped to expand and enhance our understanding of how and why people behave as they do and what can influence them to either maintain positive social behaviour or, change undesirable social behaviour. This learning gives us a powerful set of principles, which can be used to help design social change interventions.

What we now know is that many of our choices and the decisions we make that influence our behaviour, are not the result of active decision making, decisions and choices are often influenced by unconscious and automatic thinking. These 'decisions' are influenced by our social contexts, emotional engagement, social influence and environmental prompts, and also by factors such as timing, and our physiological state. However, we are capable of making rational choices. It is well known that when people have a chance to actively consider a problem or, are engaged in thinking through the best course of action, they make better decisions. Such approaches can also have a significant impact on how people behave and the choices they make in the future.

The following set of principles summarise much of what we currently know about influencing behaviour, drawn from fields of study that include, but are not limited to management, psychology, policy development, economics, design, sociology, biology and communication studies. These principles are clustered under four headings.

Potential Intervention Approach

External conditions for change

1 People prefer to be involved and engaged. Participatory involvement often creates bigger behavioural change effects. Wherever possible, involve, consult and engage people in the selection, design, delivery and evaluation of interventions.

2 Social relationships are key. Approval and social support have a strong and persistent influence on behaviour. Working with and through key influencers improves the impact of behaviour change programmes. Use the power of group norms and behaviour to inform and engage people in change, let them know that others are changing and use the power of group action. Significant people in a person's social network can be used to influence their behaviour. For example, working through grandparents can be a good way to influence the behaviour of grandchildren, and the whole family.

3 People influence and are influenced by their physical, social and economic environments. There is a limit to a person's capacity to change if their environment militates against this. It is often necessary to deliver programmes that tackle the underlying environmental, social and economic barriers to change as well as personal factors.

4 People can be helped to change by designing services, procedures and environments that encourage people to act in a way that does not involve complex decision making. Design services and environments that encourage behaviours by removing the need for complex choices, for example making only low or non-alcoholic drinks available at social functions will encourage less people to get drunk. Removing unhealthy choices or other socially harmful options is often called 'choice editing'.

Internal conditions for change

5 A desire or at least an acceptance for change in the target audience will enhance efforts to bring about change. It is possible to enforce change that people do not support or actively oppose but there is a bigger chance of success if a target audience can be persuaded of the validity, necessity and plausibility of change.

6 Beliefs and values have a strong influence on how people behave. Programmes should start by understanding the target audience beliefs and attitudes and use these to inform the development of behaviour change, systems and environmental change, communication tactics and products that will assist change.

7 Behaviour is influenced by physiological and somatic state. If people are physically aroused this will often have an impact on their behaviour. Tiredness, physical arousal, anger, joy or a sense of relaxation will all have an impact on behaviour. People's somatic state, for example the shape of their body and how they perceive it will also have an impact on their behaviour. People who perceive themselves to
be fat often don't exercise because their weight impacts on their enjoyment.

8 Genetics can have an influence on behaviour; For example, there are some differences in the way men and women as a population, if not individuals behave differently in specific situations. For example, many young men are aggressive because they have high levels of

testosterone.

9 People are often motivated to do the 'right thing' for the community as well as themselves and their families. Interventions that appeal to people's sense of being good, for example, fairness, justice and community togetherness can be powerful. Programmes that stress that the behaviour is one that is a norm in the community and one that is valued by others also tend to be more successful.

10 People's perception of their own ability to change can either enhance or detract from attempts to change. Programmes can be developed that focus on providing support that will build people's confidence and knowledge and skills. For example, teaching people how to recycle in a hands on way can increase both their understanding and confidence about recycling behaviour.

11 People often use mental short cuts and trial-and-error approaches to make decisions, rather than 'rational' decision making. An understanding of these short cuts or 'heuristics' should be used to develop interventions. For example, if people explain their view of the causes of unemployment as being due to new people moving into their area and taking all the jobs, it is possible with this insight to develop and suggest to them new heuristics such as, new people who move in take some jobs but they also spend money and so create more jobs.

Barriers to change

12 Habit is a key barrier in many change processes. People can be locked into patterns of behaviour and need practical help to break free or 'unfreeze' current behaviour. Programmes that provide practical support to change, are easy to access and those that require small first steps, tend to be more effective. Sometimes it may be necessary to 'unfreeze' long established behaviour by confronting the problem in a direct and robust manner.

13 Change is more likely if an undesired behaviour is not part of an individual's coping strategy. Avoid 'telling people off' for 'bad' behaviour if they are using it to cope with life. Demonstrate an understanding of the reasons for their behaviour and offer realistic and attractive alternatives that give practical support to change.

14 People's perception of their vulnerability to a risk and its severity is key to understanding behaviour and developing effective interventions. Programme developers should focus on understanding people's perceptions and how they view the risks associated with the behaviour that is to be targeted. It is also necessary to frame risks in ways that people can understand and are meaningful to them. The way that information is framed can have a big impact on behaviour. As an example people are more likely to decide to have an operation if they are told there is a 90% chance of success as opposed to being told that 10% of people die who have the operation.

15 People's perception of the effectiveness of the recommended behavioural change is a key factor in decisions to act. This means that we need to set out in terms that people value the effectiveness and benefits of the change that is being promoted.

16 People are over optimistic. Most people tend to believe that something good will happen or that possible negative consequences of actions or situations will not happen to them. People tend to overestimate their chances of being fortunate. This means that we need to communicate in terms that people can understand the probabilities of both negative and positive

consequences of social behaviour.

17 Many people are bad at computation and risk assessment. Many of us do not understand numbers, risk ratios, odds or even percentages. Programme planners should always test the use and understanding of numerical and risk based messages before using them. It is best to convey risks and factual numerical information in ways that the target audience can both understand and find compelling. For example, the number of Olympic sized swimming pools full of water that can be saved by fitting a low volume flush toilet is more understandable than a numeric number of gallons.

Triggers to change

18 Change is more likely if the actions that have to be taken are easy, specific, simple and clear. Keep interventions specific and promote them in a way that the target audience views as relevant and appealing. For example, rather than general appeals to promote civic engagement it is better to work to bring about specific behavioural change in areas such as the number of people who sign up to do voluntary work for a specific charity or NGO.

19 Making the first step to change 'easy' helps engage people in the change process. Making the first step to change easy encourages more people to start a behaviour because the initial commitment is small and in so doing reduces the inbuilt status quo bias that many people have. People also like to be consistent, once they have started on a change path, with a small step they are more likely to continue with bigger changes. For example, asking people to donate a very small amount will increase the chance that they will donate more the next time they are asked to do so.

20 People can be taught critical thinking and appraisal skills that can help them take more control over their behaviour and resist media, social and environmental influences. Active consideration of a change issue often leads to more permanent change. If people have a chance to explore and consider issues, this often helps them both reconsider attitudes and beliefs. This can help them change their behaviour or maintain a positive behaviour. Critical thinking skills once taught also begin to have an impact in many other areas of a person's life beyond the original focus of a programme and so can have many beneficial spin off effects in terms of promoting social good.

21 Behavioural experiences can influence beliefs and values. Programmes that move people to experiencing a behaviour as quickly as possible for example, giving them a chance to try the thing that is being promoted work best. It is not always necessary to rely on shifting attitude first. Behaving differently often leads to a shift in attitude. For example, providing a financial reward to recycle in the short term can increase recycling behaviour even when the incentive is removed.

22 The more beneficial or rewarding an experience, the more likely it is to be repeated. Maintaining positive behaviour can be assisted by reinforcement. Behavioural interventions should seek to reward desired behaviours and when appropriate penalise inappropriate behaviour. Interventions should also seek to support positive behaviour by maintaining a relationship with people which affirms their new behaviour and encourages them to build on it.

23 Change in behaviour is usually a process not an event and often entails several attempts before success. When delivering intervention programmes there is a need to be persistent, sustain interventions over time and offer multiple paths to success. It is also important to design

in the possibility of multiple attempts to change and support for every attempted change.

24 People are loss averse. We will put more effort into retaining what we have than acquiring new assets or benefits. Therefore it is important to stress potential losses associated with the behaviour as well as the positive gains that can be accrued from change. Many people are often more concerned with short-term gains and costs, and tend to place less value on rewards or costs that might happen in the future. Programmes should emphasise short-term as well as long-term benefits and seek to reduce short-term costs. For example, when seeking to encourage young people not to get sun burnt emphasising immediate damage to their appearance as well as the longer term risk of skin cancer can be an effective strategy.

25 People perceive themselves to be and wish to appear to be consistent in their attitudes, beliefs and actions. This preference for consistency can be used to help people change. For example, if we ask people to make a public declaration to do something they are more likely to do it. People like to be consistent and when they have made a public commitment or pledge to act in a certain way, this pledge helps them to stick with the thing they have committed to, for example, getting someone to write down their next appointment on a card rather than doing it for them is a way to increase the likelihood that they will attend. People are also influenced by people that they like and can relate to. Liking is a key factor in how influential someone is on another person's behaviour. Liking is related to a sense of commonality with a person, a sense of being appreciated and listened to, and the exchange of compliments. Spokes person's, front line staff and representatives can be trained to develop their ability to foster good relationships with target audiences by demonstrating these characteristics.

26 People are influenced by authority figures. We are influenced by people that we perceive have legitimate authority by virtue of their status, position and/or physical characteristics. When using authority figures it is also important to test that they are perceived as having this status by the specific target audience of a programme.

27 People will usually change behaviour if they value what is being offered or in the case of a negative penalty that the penalty has meaning and significant consequences for them. Offers and penalties need to be presented in a way that people find meaningful and understandable. They should also be proportionate and seen to be fair. Rewards also need to be seen as desirable and do not necessarily have to have a large monetary value. For example, giving people who attend a cardiac rehabilitation service a different colour badge or pin as they graduate each stage of a class can act as a powerful incentive.

28 Communications and media including social media can have a powerful effect on people's attitudes, beliefs and consequently behaviour. However, this effect is not only confined to information transmission. The real impact of mass and social media on people is often more subtle. Media can build up impressions of relationships between issues, set the agenda for public debate and create emotional responses as well as transmit information.

29 People often exhibit decision and choice fatigue, and prefer not to have to act or make large numbers of complex decisions. Interventions can be designed that make the 'good' choice the easy and desired choice. For example, having a system that automatically enrols you into a social beneficial scheme rather than having to make an active choice to do so will increase the number of people who enter the scheme.

30 Feedback is a powerful way to assist people to change. Feedback is a special type of incentive and reward. It can be used to encourage people and provide them with additional help, guidance and support. Feedback in verbal, written or via direct physical instruction helps to sustain change. For example, using check lists, diaries and review meetings are all ways of both

Behavioural Economics
Principles Assessment Questions Checklist

This tool is a combination of key principles of behavioural economics that planners can use as a check list of potential ways to influence behaviour as part of the tactical execution of programmes.

Making it easy

How can we make the message easy to understand and the behaviour easy to do?

Consistency

How can we ensure that the first step to change or compliance is a very easy one?

Benefit now

How can we make the benefit of the action something the audience gets now or very soon?

Messenger

Is the messenger we have chosen seen as likable and authoritative and can do people relate to them?

Incentives and Penalties

What can we offer as a positive incentive and how can we frame losses that will accrue if action is not taken?

Habits

How can we set up new habit that supports the public health objective?

Engagement

How can we engage people in the planning delivery and evaluation of the programme?

Social Norms

Is there a social norm that we can use to influence the behaviour?

Salience

How can we make our message, advice and support interesting and exiting?

Scarcity

How can we position the offer as one that is limited and time dependant?

Reciprocity

What exchange can we offer that will set up an obligation to act?

Framing

How can we frame the message or ask so that it is appealing and reduces loss?

Priming

How can we influence the subconscious by using cues such as design, images, sound, colours smells etc.

Emotion

What emotional appeal will work best with our target audience?

Commitment

How can we get the audience to make a public commitment to the behaviour we are targeting?

Consistency

How can we get people to view the action as being consistent with their current views beliefs and / or actions?

Simplicity

How can we get rid of difficult calculations and the need for complex risk assessment?

Self-expectations influence how they behave

How can we help people with develop the skills they need to act?

Risk perception

How can we frame the risk so that it is perceived to be relevant, likely and serious enough to warrant action?

Ego

What can we do to frame the ask so that it makes the audience feel better about themselves?

Key Influencing Factors Check List

Based on the most frequently utilised behavioural models and theories for public health communications and the preceding papers included in this section of the paper, the following proto tool suggests an analysis of factors that often influence human behaviour as the starting point for understanding how a health behaviour might be influenced by communication and marketing programmes. This tool sets out many of the key factors that should be considered when designing a health communication or behaviour change programme.

Influencing Factor	SUMMARY	Relevance to the Selected Intervention
Understanding	Investigate what the audience understand about the behaviour and what do they not understand. How is this understanding demonstrated?	
Conscious and Unconscious Decision Making	Analyse how the target audience makes decisions in respect of the behaviour. Are choices the result of unconscious rapid cognition or more considered choices?	
Intention	To make a successful behaviour change an individual must form a strong positive intention or make a commitment to performing the behaviour.	
Motivation	How motivated are the target audiences and what is the source and nature of their motivation.	
Heuristics and biases	What psychological biases, beliefs and heuristics scripts are influencing the target group in relation to the behaviours to be influenced?	
Environmental Barriers and Enabling Factors	Identify perceived and actual barriers or enabling factors in the environment affecting the target behaviour.	
Skills	An individual will need to possess the necessary skills to carry out the behaviour. Identify the specific skills needed and how prevalent they are in the target population.	
Attitudes	A positive attitude towards the behaviour change, particularly a belief that the advantage of making the change will outweigh the disadvantages, is an	

	important step on the way to behaviour change.	
Social Norms and Customs	The influences of support groups, as well as wider social influences in promoting behaviour change are important for programme planning and evaluation. Understanding the perceived attitudes of friends, family and 'society' will also be important.	
Social Networks and Support	Identify social support networks, social capital and social assets that are available to prompt or maintain targeted behaviours and attitudes.	
Self-image	Assess if the change being promoted is consistent with an individual's self-perception and self-image.	
Emotion	An individual's reaction to performing the behaviour change needs to be more positive than negative, so perceived emotion before performing the change and actual emotion once trialling it are good indicators of likelihood to continue with the behaviour change.	
Agency and Self-efficacy	An individual's belief that they are able to make and sustain the behaviour change. Assess the extent of self efficacy in relation to the target behaviour.	
Habit	Identify what habitual patterns exist amongst target audiences and what triggers and maintains them. Identify potential break or change points.	
Physiological State	Identify what somatic, hormonal, or genetic factors including age and gender impact on the behavioural issue.	
The Public Agenda	Identify what issues in the public discourse space and media are influencing or could influence attitudes beliefs and behaviour.	
Value / Exchange	Assess what value the target audience place on an existing pattern of behaviour and what level of value would need to be offered and in what form to produce a change.	

Guide to adopting a Goals and SMART Objectives Approach to Specifying Specific Behavioural Targets in Social Marketing Programmes.

This tool sets out an approach for establishing what specific behaviours will be the focus of an intervention programme or campaign. The term 'behaviour change' is widely used and while a useful short hand for discussions about ways to influence behaviour, it can constrict and does not adequately describe the range of issues that need to be considered. Often the target is not to 'change' a behaviour but to find ways to: encourage the adoption and establishment of helpful and positive behaviour; and or how to avoid the adoption and establishment of harmful or problematic behaviour.

The approach set out in this proto tool starts by recognising that behaviour is inherently 'dynamic', i.e. behaviour is not a fixed state or static, but changes overtime. Behaviour is inherently 'dynamic' i.e. subject to variation and is often not an isolated single action, but part of a pattern of actions over time' .The approach set out in this proto tool starts with the development of a clear understanding of 'what' behaviour is occurring, and what different people know, think and feel about it.

Before going on to analyse what theory or models that might help inform or develop insight into why people are adopting a behaviour and the potential insights that might provide ways for effectively intervening. A focus on specifying precisely target behaviours informs the development of a theoretical perspective rather than the other way round.

As stated above there can be a tendency with traditional 'behaviour change' approach to focus specifically on the 'problem behaviour' and what can be perceived as 'problem people', and to concentrate on trying to get them to change. A key consideration is to understand what range of factors are influencing both the positive and the problematic behaviours.

Establishing Behavioural Goals and SMART Objectives

The task is to be able to describe the issue being addressed in terms of specific behaviours both those behaviours that are problematic and those that are positive and need to be encouraged. This will help ensure that the methods or interventions used can be geared to addressing the specific behaviours with specific target groups. Behavioural goals are overarching aims or statements of intent, behavioural objectives are more specific and should ideally be able to be expressed in SMART form (SMART; Specific , Measurable, Achievable, Relevant, Time bound) and also expressed in terms of the focus of the objective: Cognitive, (Knowledge, and understanding) Affective (Emotional , beliefs and attitudes) or Psychomotor (Physical doing observable actions)

The following checklist sets out a number of issues that need to be considered for both positive behaviours and problematic behaviours **Defining Behaviour and Setting SMART Objectives Proto Tool**

An AIM is:

A broad strategic purpose of a project, AIMS can be long term, medium term or short term.

An Objective is:

A specific, measurable goal, whose achievement will contribute towards the aim.

1. **Defining the problem:** Think of your health problem as the gap between what should occur in your community and what is occurring, or the gap between an acceptable/desirable health status and the current status.

   Problem definition statement:

2. **What is the aim of the intervention?**

3. **Objectives can be focused on three different issues:**

   – **Affective** objectives, focused on feelings.

   – **Cognitive** objectives, focused on learning.

   – **Psychomotor** objectives focused on doing or observable or reported behaviour.

4. **Objectives should be set out in a SMART format. SMART stands for:**

   – **S**pecific: not open to different interpretations.

   – **M**easurable:

   – **A**chievable: with the resources that are available.

   – **R**eliable: durable and consistent data can be gathered.

   – **T**ime bound: can be measured within the time frame of the intervention.

5. Objectives must be specific and answer the following questions:

- • What you are evaluating?

- • What are you aiming to achieve?

- • How will change be measured?

- • Who is the intervention aimed at?

- • Where is it taking place?

- • What is its time scale?

- • Who will deliver the intervention?

E.g. The programme will increase the current attendance rate of 12% at the East Rd Vaccination Clinic by white middle class men aged 25-35 from the Small Town area, to a rate of 15% by the end of December 2013.

6. Behavioural Feasibility Assessment

Use the following check list of questions to assess the likelihood of the desired

behaviour being adopted:

1. Is the current behaviour seen as a problem?

2. How rewarding is the undesirable behaviour?

3. How costly is the current behaviour?

4. How complex is the behaviour (does it involve several elements)?

5. How frequently must the desired behaviour be performed?

6. How compatible is the desired behaviour with the target audience's behaviour?

7. Is the current behaviour approved of socially?

8. Are their major barriers to engaging with the desired behaviour?

9. What information does the audience need to perform the behaviour?

10. What skill does the audience need to perform the behaviour?

11. What resources does the audience need to perform the behaviour?

12. Are there some members of the segment who already do the desired behaviour?

7. List the potential target audiences

- **Primary audience** (The key people you want to help change)
- **Secondary audience** (The people who you can help and who can help the primary audience)
- **Tertiary or other audiences** (Others who have influence on the primary and or secondary audiences)

8. Current Behaviour

Describe current problematic behaviour (Set out in specific and quantifiable terms the behaviour)

List and describe related problematic behaviours.

List and describe current beneficial behaviours to be maintained.

Specify the behavioural goals for each target group? Specify positive behaviours to be maintained, negative behaviours to be changed and new behaviours to be adopted.

Positive behaviours to be maintained:

Cognitive

Affective

Psychomotor

Negative behaviours to be changed

Cognitive

Affective

Psychomotor

New behaviours to be adopted:

Cognitive

Affective

Psychomotor

Under each behaviour set out the specific behavioural objectives that relate to that goal, (There may be several) for positive, negative and new behaviours. Specify how each behavioural objective can be expressed as a single specific observable behaviour and how it could be measured. Each behavioural objective should be expressed in terms of a SMART objective.

Positive behaviour objectives:	Cognitive	Affective	Psychomotor
1			
2			
3			

Negative behaviour objectives:	Cognitive	Affective	Psychomotor
1			
2			
3			
Etc:			

New behaviour objectives:	Cognitive	Affective	Psychomotor
1			
2			
3			
Etc:			

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Checklist of Potential ways to measure behaviour and behaviour change
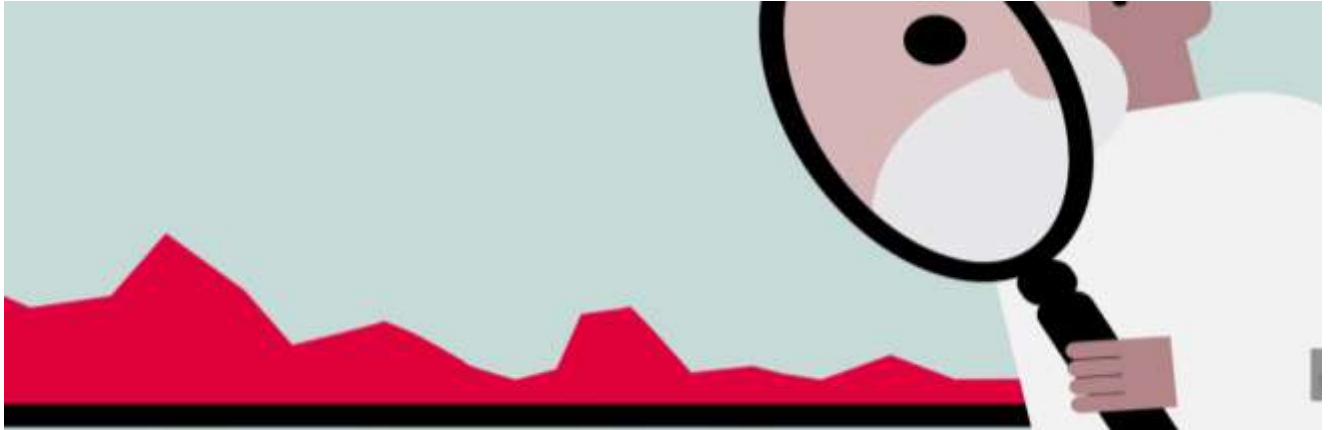
Methods and Measures
1. Logging the number of calls and enquiries to a public helpline
2. Count of the number of vaccines administrated to healthcare workers
3. Count of the number of vaccines administered to the public
4. Count of the number of people completing a course of anti-viral medication
5. Count of the number of vaccines administered to specific sub-groups at increased risk of infection or the consequences of infection
6. Survey of public knowledge, awareness and opinions on pandemic messages heard or seen
7. Attitudinal and behavioural survey or census of a sample of households in a specific area
8. Type and form of media reporting on the pandemic; a review of all channels including radio, television, newspapers and social media with type and tone of reporting
9. The number of information materials distributed (to healthcare workers, to the public, to specific sub-groups)

10. The number of individuals receiving pandemic information materials from a healthcare worker

11. The number of individuals asking questions of healthcare workers

12. The amount of information material requested and distributed by healthcare workers

13. The number of online hits to a website

14. Number of pandemic champions and/or vaccination advocates recruited and trained

15. Number of speaking engagements undertaken by champions/advocates/healthcare workers

16. The number of households visited in door-to-door outreach communication campaigns

17. Monitoring of synchronicity of web posting between World Health Organisation and sampled web sites

18. Monitoring of Facebook, YouTube and other social media reaction to and coverage of the event by country and region

19. Monitoring twitter feeds and blogs and other forms of social networks re reaction to the pandemic event.

20. Staff survey of healthcare worker knowledge, attitudes and behaviours

21. Count of installation of hand sanitizer equipment in entrances to public buildings

22. Observation of public use of hand sanitizer equipment in a sample of buildings

23. Survey of traveller behaviours and numbers

24. Observation of traveller behaviours

25. Sales of face masks and other prevention orientated goods such as disposable tissues, cleansing gel etc.

26. Patterns in distribution and uptake of vaccines

Generic Programme Planning and Weaknesses Check List.

The following check list can be used to assess the existence of common weaknesses in planed programmes designed to influence behaviour in relation to pandemic events. If the programme exhibits one or more of the elements set out below remedial action will need to be put in place to lessen or remove the impact of the weakness.

Characteristic	Indicate if and how the characteristic is present in the current plans	Set out possible mediating actions
Programme constructed by experts and policy planners only.		
The programmes aims and objectives are non-specific.		
Citizen insight research has not been used to define target groups and approach.		
The programme has not made use of theory, evidence and or data to inform its planning.		
The programme has not developed a strong business case for the allocated or proposed budget.		
A weak or incomplete situational analysis has been completed of influencing factors.		
The programme does not have a sufficient time scale to achieve its objectives.		
The programme is a short-term campaign and will not be evaluated in terms if target audience behaviour change.		
The programme does not have a clear and robust performance management system.		
Little or no evidence of plans and resources to ensure widespread stakeholder engagement can be delivered and maintained.		
A review mechanism is not in place to ensure that the programme messages and approach are refreshed on a regular basis.		
The programme has weak mechanisms to co-ordinate efforts within the originating country and with relevant organisations at a European level.		
The programme cannot demonstrate that it has human resource systems in place that will ensure that programme staff are trained and supported to deliver the programme.		
The programme uses a limited intervention mix of approaches		
Ethical issues have not been addressed and clearances, approval obtained.		

Checklist for Assessing the Strength of Planning for a Behavioural Intervention

CHARACTERISTIC	YES	NO	UNSURE	COMMENTS
1. CAMPAIGN GOALS/OUTCOMES: Specific, actionable, and measurable behavioural goals have been set that use a SMART format.				
2. CAMPAIGN RATIONALE: Presence of a clear rationale and need for the campaign and why particular interventions have been selected.				
3. SITUATIONAL ANALYSIS: Systematic scoping has been done to analyse environment, social, technological, economic and legal perspective. All relevant data, evidence and experience of the issue has been gathered to inform planning.				
4. FORMATIVE AUDIENCE RESEARCH: Evidence of primary or secondary formative research, including, audience knowledge, attitudes, practices, and behaviours in relation to topic area.				
5. BEHAVIOURAL THEORY: Behaviour change model/s and theory has been used to segment/target the audience and inform the intervention.				
6. STRATEGIC PLANNING: The intervention has clear written systematic, short, medium and long-term plans that are endorsed by stakeholders programme staff and target audiences.				
7. BUDGET: The recommended budget is based on a full business case and is adequate to achieve the objectives of the intervention over the required time frame.				
8. PRE-TEST/MONITORING RESEARCH: Intervention has been developed pretested and monitored with the target audience and stakeholder involvement.				
9. EXCHANGE and VALUE: Analysis has been completed of what audiences value and what the target audience has to give up (e.g., financial, physical, time-related costs) to get the benefits or value proposed, and this is built into the intervention approach. (E.g. Incentives, recognition, reward, and/or disincentives are built in) Consideration of the use of products, services and messages that deliver value has been completed.				

|				
10. COMPETITION & BARRIERS TO CHANGE: Factors competing with the desired behaviour are considered and addressed (e.g., environment, economic factors, psychological, media/consumer-related factors, physiological factors such as addiction, etc.).				
11. INTERVENTION MIX: An integrated approach is evidenced by the presence of a valued 'proposition' product or service to the target audience that is offered and promoted through a co-ordinated approach to information, education, service design and execution, and supported by systems and policy. Interventions may involve both active and passive decision making.				
12. STAKEHOLDER ENGAGEMENT AND MANAGEMENT: Presence of mechanisms for on-going stakeholder relationship development is evident - including internal/external stakeholders, partners, sponsors, allied organizations interest groups, communication and management.				
13. ETHICS: The ethical implications of the plan are clear, and the programme is designed in such a way to address relevant issues. All necessary and appropriate ethical approvals have been obtained.				
14. MONITORING/EVALUATION FRAMEWORK: Short, medium, and long-term evaluation plans are in place to track process impact and outcome results.				
15. ACTIVE DISSEMINATION: Plans are clear for disseminating the results and ensuring learning is fed into the development of future interventions.				
16. SKILLED & SUPPORTED STAFF: The Programme is staffed by experienced people who have high level commissioning, planning management and evaluation skills. There are staff review and development systems in place. Programme leadership is robust and well regarded.				

Checklist for Assessing the Strength of Planning for a Behavioural Intervention

CHARACTERISTIC	YES	NO	UNSURE	COMMENTS
16. CAMPAIGN GOALS/OUTCOMES: Specific, actionable, and measurable behavioural goals have been set that use a SMART format.				
17. CAMPAIGN RATIONALE: Presence of a clear rationale and need for the campaign and why particular interventions have been selected.				
18. SITUATIONAL ANALYSIS: Systematic scoping has been done to analyse environment, social, technological, economic and legal perspective. All relevant data, evidence and experience of the issue has been gathered to inform planning.				
19. FORMATIVE AUDIENCE RESEARCH: Evidence of primary or secondary formative research, including, audience knowledge, attitudes, practices, and behaviours in relation to topic area.				
20. BEHAVIOURAL THEORY: Behaviour change model/s and theory has been used to segment/target the audience and inform the intervention.				
21. STRATEGIC PLANNING: The intervention has clear written systematic, short, medium and long-term plans that are endorsed by stakeholders programme staff and target audiences.				
22. BUDGET: The recommended budget is based on a full business case and is adequate to achieve the objectives of the intervention over the required time frame.				
23. PRE-TEST/MONITORING RESEARCH: Intervention has been developed pretested and monitored with the target audience and stakeholder involvement.				
24. EXCHANGE and VALUE: Analysis has been completed of what audiences value and what the target audience has to give up (e.g., financial, physical, time-related costs) to get the benefits or value proposed, and this is built into the intervention approach. (E.g. Incentives, recognition, reward, and/or disincentives are built in) Consideration of the use of products, services and messages that deliver value has been completed.				

25. COMPETITION & BARRIERS TO CHANGE: Factors competing with the desired behaviour are considered and addressed (e.g., environment, economic factors, psychological, media/consumer-related factors, physiological factors such as addiction, etc.).				
26. INTERVENTION MIX: An integrated approach is evidenced by the presence of a valued 'proposition' product or service to the target audience that is offered and promoted through a co-ordinated approach to information, education, service design and execution, and supported by systems and policy. Interventions may involve both active and passive decision making.				
27. STAKEHOLDER ENGAGEMENT AND MANAGEMENT: Presence of mechanisms for on-going stakeholder relationship development is evident - including internal/external stakeholders, partners, sponsors, allied organizations interest groups, communication and management.				
28. ETHICS: The ethical implications of the plan are clear, and the programme is designed in such a way to address relevant issues. All necessary and appropriate ethical approvals have been obtained.				
29. MONITORING/EVALUATION FRAMEWORK: Short, medium, and long-term evaluation plans are in place to track process impact and outcome results.				
30. ACTIVE DISSEMINATION: Plans are clear for disseminating the results and ensuring learning is fed into the development of future interventions.				
16. SKILLED & SUPPORTED STAFF: The Programme is staffed by experienced people who have high level commissioning, planning management and evaluation skills. There are staff review and development systems in place. Programme leadership is robust and well regarded.				

Senior Responsible Officer Review Checklist
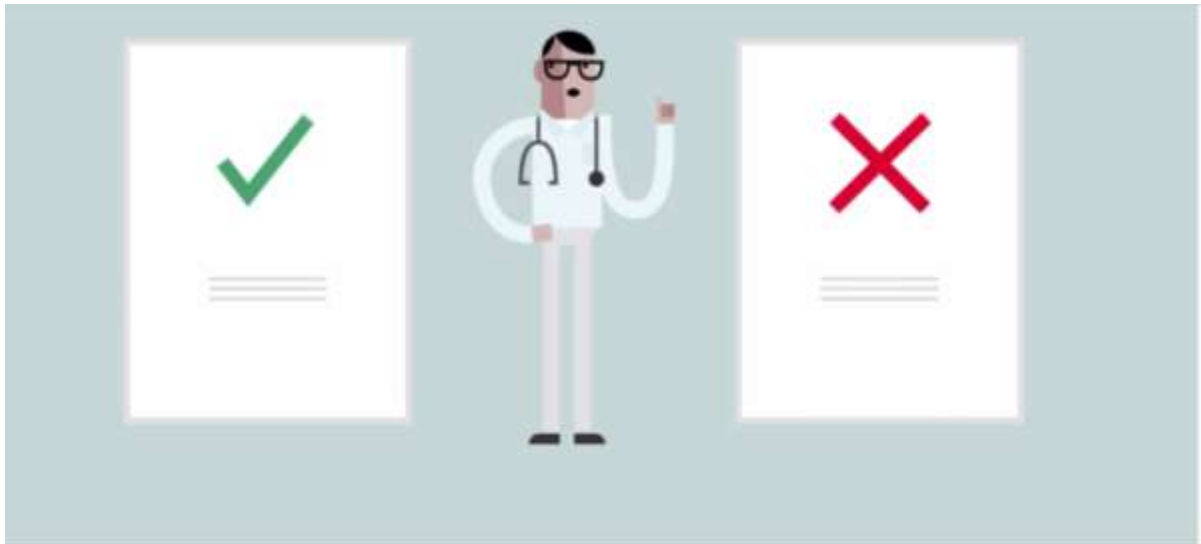
1. **Behaviour change programmes need long-term strategic planning. You should seek to ascertain if the proposed programme includes**:
   - Plans and strategies to integrate and align policy, strategy, delivery.
   - Communications, setting objectives against which to evaluate success.
   - Selecting an appropriate mix of interventions.
   - Longer-term and robust budget allocation process.
   - Principles of good impact assessment, such as setting clear objectives, considering a range of outcomes and estimating the likely costs and benefits.

2. **You should be provided with evidence of understanding and insight into the factors that will motivate different segments of the target population to change their behaviour or sustain a positive behaviour through the proposed programme.**

   *G*enerating insight into the motivations, influencers, understanding, attitudes and behaviours of target audiences is a key to success. Segmentation of an audience recognises the diverse needs of different groups and allows for targeting of interventions based on what different people really need and want.

   Segmenting on the basis of not just geography, demographics and socio-economic factors but also attitudes, lifestyle and life stages, understanding, beliefs, values and behaviour will inform a more effective targeting for the behaviour change programmes.

   Officials should be able to provide you with information about which theories and models of behaviour have been used to shape the proposed interventions. Officials should also be able to demonstrate that they have carried out a thorough situational analysis that considers social, political, economic, technological and legal issues and a strengths and weaknesses assessment of current and proposed plans.

3. **Have you been assured that all existing evidence and insight relevant to the behaviour change and target audience across government has been brought together before you authorise any new research to be conducted?** Identify opportunities for joint interventions to target the same audiences. Make sure insight informs the behaviour change programme from planning through to evaluation. Ensure that any new data that is captured is shared as widely as possible with relevant stakeholders and partners.

4. *Working together and reducing duplication of effort.*
   Value for money can be improved by greater joint working between departments and other national regional, European and International and local public health bodies. Ask for details of joint working, stakeholder management plans and plans to form and manage coalitions to tackle the threat (See Proto Tool 14). Greater leverage can also be gained by identifying partners in the private and voluntary sectors to support behaviour change interventions. (For example, the Department of Health Flu vaccination team has formed partnerships with the British Lung Foundation and various other voluntary organisations to use their expertise in targeting 'at risk' groups).

5. *Are you clear that the evaluation model proposed is robust and appropriate?*
   Behaviour change programmes are best evaluated against a range of measures from longer term shifts in eventual outcomes and observed behaviour and short to medium term indicators of progress on programme objectives. Public health bodies need to employ appropriate methods to evaluate success in the long term such as econometric modelling, observation studies, epidemiology and reported behaviour. The mix of evaluation tools depends on the type of behaviour, relative costs and the availability of data. Additionally, short to medium term milestones should have been identified and the means for capturing and reporting on the data established.

6. **Have you required that the evaluation will monitor actual behaviour change and the resulting health outcomes?** Progress against short and medium term milestones such as levels of claimed behaviour, attitudes, and awareness should also be measured. These milestones should be based on an understanding of what drives the behaviour of the target audience. Is there commitment and plans to make evaluation results publicly available and ensure they are fed back into planning and development?

7. **Is the budget adequate and proportionate?** Many behaviour change programmes will require budgets allocated on a longer-term basis – at least 3 years to allow for research, piloting and delivery. In the case of pandemic events there may be a need to substantially increase budgets.

   a. Are there contingency plans in place and has scenario planning been completed that allows for different levels of budget to be allocated?

   b. Is there a proposed use of economic analysis to measure the impact of the programme in terms of VFM (Value For Money) ROI (Return On Investment) SORI (Social Return On Investment) and CBA (Cost Benefit Analysis)?

Normally substantial budgets should only be allocated if prior research and piloting work indicates that the full implementation budgets will deliver acceptable levels of impact.

8. **Have you put in place or authorised the mechanisms to ensure that there is integration and alignment between all aspects of the proposed behaviour change programme and existing and or related interventions at Local, National Regional, European and International levels?** Other intervention types can include legislation, fiscal measures, service and vaccine delivery methods, and other related communication programmes such as those related to transport and work.

Ensuring Effective Engagement in Pandemic Communication and Behavioural Influencing Programmes Checklist

Important characteristics for designing effective behavioural interventions that have fully engaged stakeholders, partners and communities of interest.

1. Ensure interventions are citizen focused and driven by theory, evidence and research. Understanding of the everyday lives and aspirations of the audience is essential. Use theory to ground and inform development learning from previous work. Draw from a wide range of different types of evidence. Look beyond the visible iceberg of published evidence to evidence locked in the experience and expertise of stakeholders, potential partner organizations, practitioners and communities themselves. Use a range of research methods to get a rounded understanding of what people do and why they do it.

*2. Ensure explicit behavioural goals are agreed by all key stakeholders and Partners including community groups. E*xpress the overall aims of the work in terms of specific behaviour SMART objectives. Avoid reliance on broad and general behavioural goals and instead tailor these to specific sub-groups and segments of the population. Ensure that all stakeholders and partners have had a chance to input into and shape the goals and objectives of the programme and that any disagreement or contentious issues have been fully explored and if possible resolved.

3. Work to actively engage individuals and communities. Recognize that engagement is far more important than broadcast communication. Active involvement strengthens development, delivery and evaluation of any intervention. Ensure that a full stakeholder and partner analysis has been completed and that an ongoing management plan is developed. Ensure that a community engagement strategy is developed and sufficient resources are allocated to enable it to be fully implemented.

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4. Invest in multi-sector partnership and mobilizing 'delivery coalitions'. Partnership working significantly extends the reach, impact capacity and capability of interventions. Partnerships bring different perspectives, intelligence, evidence and expertise that can significantly enhance customer understanding and insight generation. Ensure that resources have been allocated to deliver effective communication and co-ordination between all coalition members. Ensure that communication systems allow and facilitate the exchange of information such as data, research findings, tracking impact data and situational opportunities and threats.

5. Commit to a sustained approach that mobilizes resources and assets. Ensure all smaller-scale, time-specific interventions are developed and framed in the context of a broader, longer-term strategy or approach. Do not focus exclusively on financial resources. Map and build human skills and capacity and work to mobilize community action. Do not just focus on 'deficits' and problems. Instead, frame interventions around mobilizing coalition and community assets and building latent strengths and capacities within individuals and communities.

6. Use an integrated model to connect national, regional and local efforts. Connecting interventions at different levels can significantly enhance potential impact and effectiveness. Focus on building links, connections and synergies between work at different levels. Recognize that this will take time, effort and the investment of sustained resources. Organizing and planning interventions can be complex, and investing in co-ordination is critical. Summarizing, disseminating information and updates and co-ordinating work are key to ensuring effective stakeholder engagement and coalition delivery.

7. Build a 'learning and reflective' culture. The greatest resources available are the people, communities and practitioners involved in pandemic preparation and delivery systems. Capturing, valuing and sharing evidence of effectiveness and experience is important for programme evaluation, strengthening and sustaining work and for motivating people. Evidence and learning should be captured in a systematic way and disseminated actively.

ECOM

When to use mass and digital media checklist
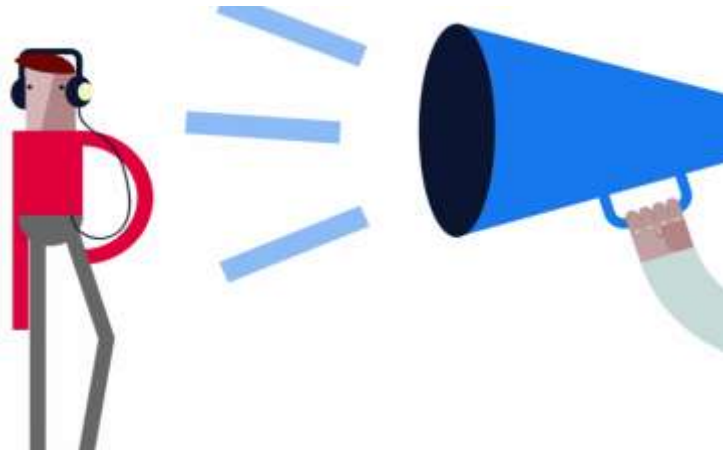
Some of the situations in which media have been found to be most appropriate are:

1. *When wide exposure is desired.* Mass media and digital offer the widest possible exposure. Cost-benefit considerations need to be considered when selecting channels.

2. *When the time frame is urgent.* Mass and digital media offer the best opportunity for reaching either large numbers of people or specific target groups within a short time frame.

3. *When public discussion is likely to facilitate the educational process.* Media messages can be emotional and thought provoking. Because of the possible breadth of coverage, intrusion can occur at many different levels, stimulating discussion and thereby expanding the impact of a message. However, planning needs to be put in place to address counter arguments and views that may arise as part of this process.

4. *When awareness and attitude change are main goals.* All forms of media are awareness- creating tools. Where awareness of a health issue is important to the resolution of that issue, mass and digital media can increase awareness quickly and effectively.

5. *When the mass media sector is 'on-side'*. Where journalists, editors and programmers are supportive and well briefed and open access has been established to on-going expert briefing from public health authorities

6. *When accompanying on-the-ground back-up can be provided.* Regardless of whether media alone may be sufficient to influence health behaviour. Impacts will be more pronounced with the support of back-up community based programmes and services. Most health behaviour changes require constant reinforcement. Media programmes are most effective where the opportunity exists for long-term follow up. This can take the form of short bursts of media activity over an extended period, and or follow up activities related to media intervention.

7. *When a sufficient budget exists.* Paid advertising, especially via television, can be very expensive, and the development and maintenance of bespoke interactive digital services also require substantial funds. Even limited reach media such as pamphlets and posters can be expensive, depending on quality and quantity and the population penetration required.

8. *When the communication goal is simple.* In general, the more complex the targeted change, the more back up is required to supplement informational health programmes.
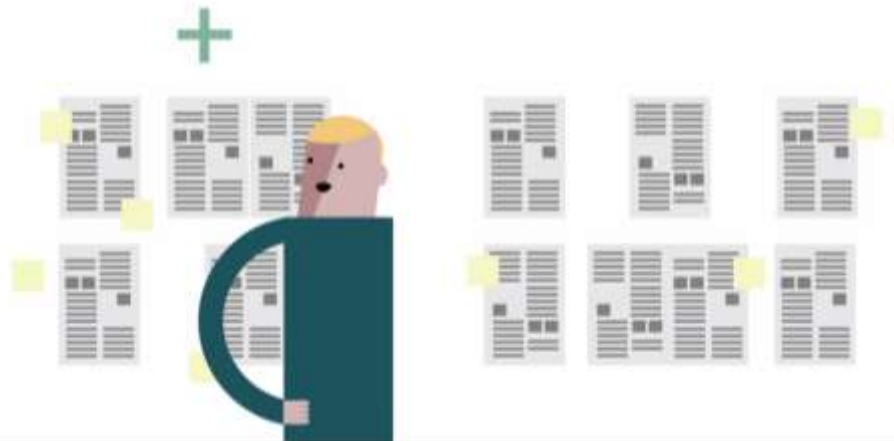
Checklist for Designing Information Programmes:

1. ***Carry out formative research to understand existing attitudes, beliefs knowledge and behaviours.*** *To assist the development of approaches,* research should be undertaken by skilled formative researchers (i.e. run focus groups and surveys).

2. ***Understand the audience.*** The extent to which a message is attended to, comprehended and used by an audience is largely determined by the extent to which the messenger understands the audience. Detailed profiles of an audience need to be established as a preliminary to media development if a message is to be optimally received.

3. ***Communicators and agencies need to be fully and continuously briefed about the topic being communicated and any changes occur during an outbreak****.*

4. ***Use skilled creative personnel to develop possible interventions and message strategies.*** Determining and executing that message in a way that is optimally received and acted upon by a target audience is a highly skilled process. Pre-testing and evaluated during exposure should also be incorporated.

5. ***Target the message.*** Different sub-groups have different needs, interests, beliefs and attitudes. Hence, different messages – or at least different message executions should be tailored for different groups.

6. ***Take account of interpersonal and peer influences****.* Campaigns should attempt to stimulate interpersonal contact such as the promotion of group and community activities, and the activation of interpersonal communication networks.

7. **Maximise contact with the message.** Concentrated bursts of spot messages often work better than the same quantity of messages over a long period. Maximising contact also means optimising media within the constraints of available budgets. On-going campaigns are necessary to maintain awareness and to reinforce attitude behaviour change.

8. **Use multiple channels**. Multiple communication channels (i.e. different media and digital media vehicles plus various non-media channels) tend to have a synergistic effect and can carry different types of information.

9. **Set a realistic duration for the campaign.** Many campaigns have not matched the duration with the desired outcome. Longer campaigns are required to achieve more complex or substantial shifts in attitudes and beliefs, whereas shorter campaigns may be sufficient for changes in awareness and understanding.

10. **Build trust: Use a credible source or spokesperson**. Source credibility is a major factor affecting message acceptance. Spokespersons should be selected based on research results that indicate that they will be credible to the target audience. Pre and on-going testing for credibility is essential.

11. **Do not confuse logic and emotion.** A basic distinction should be drawn between rational and emotional messages in health. A clear rational and if possible evidence and target audience research should be used to devise and select the focus of communications.

12. **Set realistic goals**. Major shifts in attitude and belief are not common in large populations over short periods. Hence it is important that intermediate goals are set. Realistic immediate small changes in attitude, beliefs and knowledge can be used to track progress over time.

13. **Provide environmental supports for change**. Research has shown consistently that most media campaigns require 'on-the-ground' back-up support for optimum effect. To accomplish this, media and social media should be accompanied by strategies associated with community organisations and opportunities for face to face interaction.

14. **Confirm that an information campaign is justifiable**. If an information campaign is justifiable and viable this should be determined early on following the formative research phase. Mass media should be looked at in terms of costs and benefits and these should be compared with other information strategies. If an alternative strategy is projected to be slightly less successful but at much less cost, the goals of a campaign may need to be re-examined.

The Cost-Value Matrix Tool

The Exchange Matrix is a conceptual device or 'Proto Tool' that can be used to represent four different 'Forms' of social exchange that can be designed to promote change in individuals and groups. The assumption is that whilst 'Nudges' can be effective in promoting some behaviours in some situations they do not represent a full toolbox. As well as 'Nudges', governments and other organisations can also use, Shoves, Hugs and Smacks. Social interventions may well use a combination of all four.

4 Forms of Intervention:
The Value/Cost Exchange Matrix

Active Decision
Conscious / Considered

eg: Financial Reward vaccination

e.g.: Verbal warning for non compliance

Hug   **Smack**

Incentive Reward

Disincentive Punish

Nudge   **Shove**

eg: Default vaccination

e.g.: Penalty for non vaccination

Automatic / Unconscious
Passive Decision
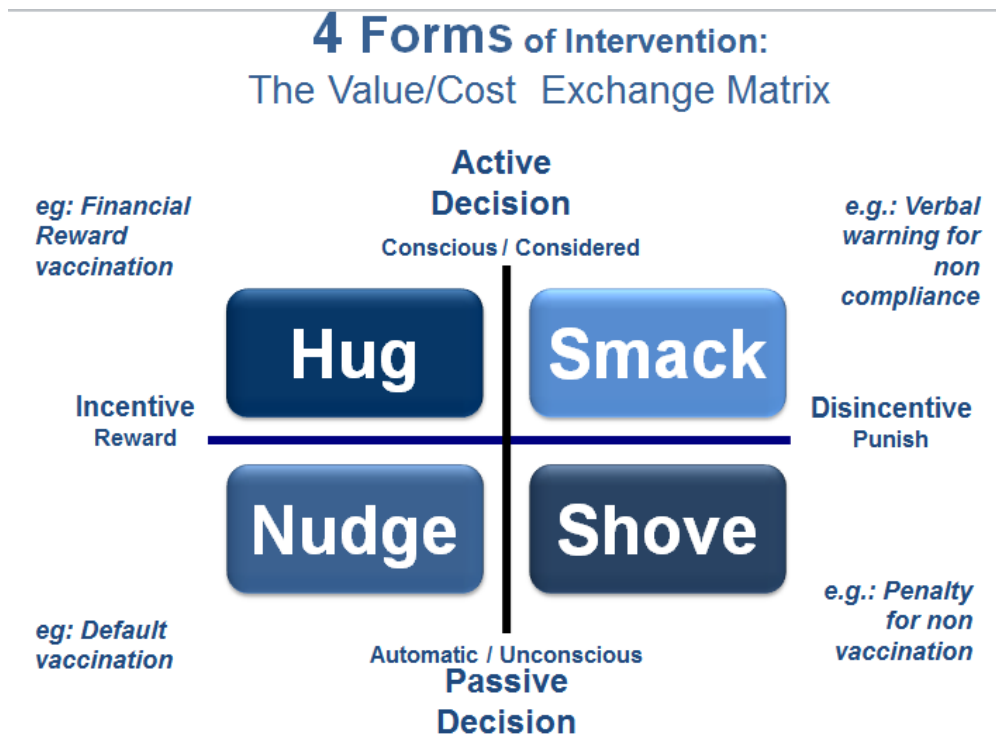
It should also be noted that the four 'Forms' are not absolutely distinct categories rather they represent more of a continuum of options. The matrix is constructed using two axes, the first: active and passive choosing, and the second: positive and negative rewarding or penalising.

The selection of which 'Form' of exchange or combination of them should always be driven by evidence of effectiveness and target audience insight. Whichever combination is selected there will be an on-going need to evaluate the impact they are having in terms of behaviour change and how they are perceived by the intended target audiences if the impact is to be sustained.

The Exchange Matrix is ideologically neutral, it depends on input from experts and target audiences to define the nature of rewards or penalties. These in most countries will be developed through existing legal and representative systems of public engagement, for example the level of fines that might be applied to penalise driving too fast will be informed by due legal and economic considerations. The Matrix indicates the importance of 'Mindful Choosing' as well as 'Mindless Choosing' as being an important option for tackling some behavioural challenges and as a mechanism for many long-term social attitudinal and behavioural change programmes.

The Exchange Matrix can be used to map a variety of 'Forms' of intervention, it can also be used as a device to communicate the range of interventions deployed in a project or programme as a model to help review the comprehensiveness of social programmes.

Whilst the Exchange Matrix can help to describe the variety of 'Forms' of exchange that can be used as part of public health behavioural and communication programmes or other kinds of social intervention it is not intended to represent the full range of 'Types' [1] of intervention that can be employed by organisations wishing to bring about social good.
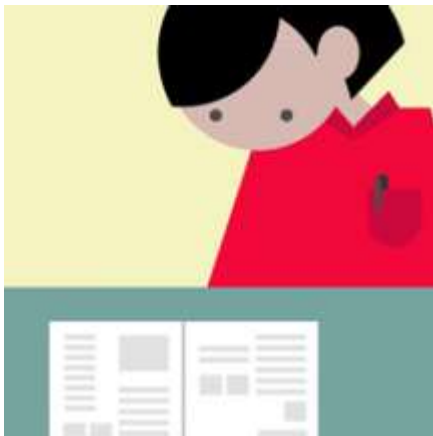
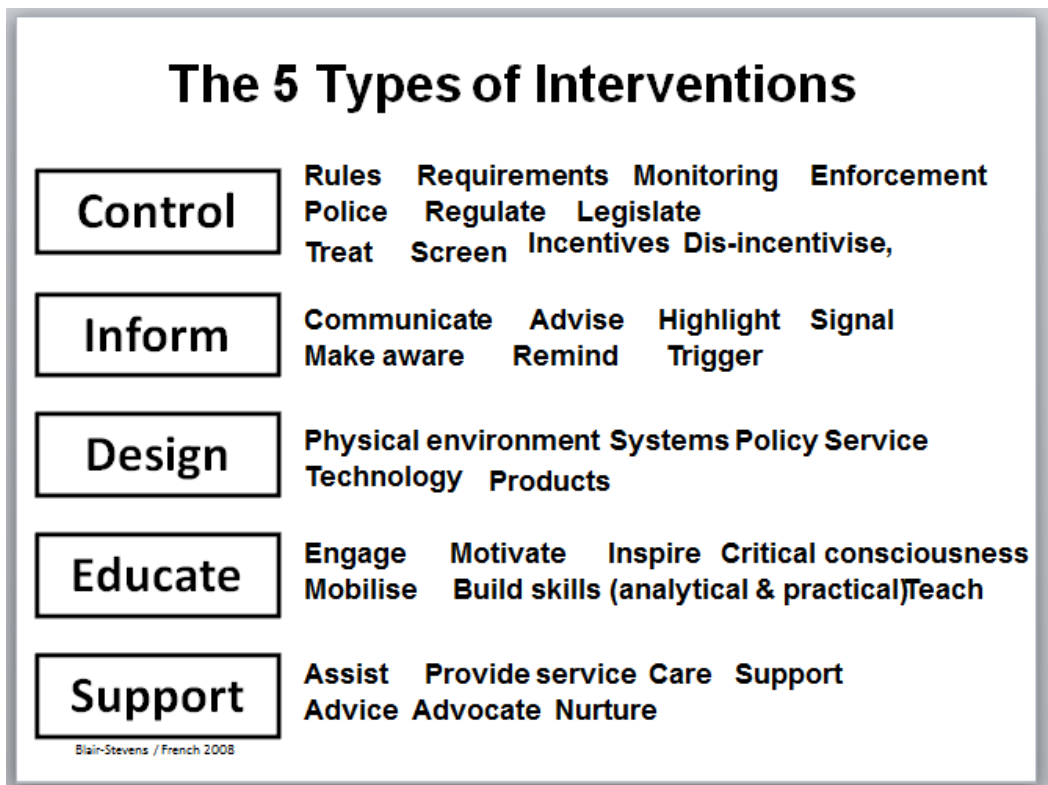[1] The word 'Type' of intervention is used in this context to mean different approaches that governments and public sector institutions can use to bringing about social change or maintaining social benefits. The five Types of intervention open to these organisations are considered to be: Education, Support services provision, Design interventions, Information provision, and Control systems including the law.

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The de-CIDEDS Framework Tool

A key principle of effective health promotion is to apply tailored evidence and insight informed mix of intervention to bring about the desired behavioural goal. In most cases a single intervention is less likely to be effective than multi-component interventions. For example just 'informing' someone of something may have some limited effect, but if this is combined with practical support and a chance to critically consider it with guidance (Education) it may well be more effective. A key task then, is to establish the right mix of interventions given the available resources and time.

The de-CIDEDS framework tool, French and Blair-Stevens (2010) sets out five 'Types' of intervention that can be used to encourage and foster social good.

The 5 Types of Interventions

Control
Rules   Requirements   Monitoring   Enforcement
Police   Regulate   Legislate
Treat   Screen   Incentives   Dis-incentivise,

Inform
Communicate   Advise   Highlight   Signal
Make aware   Remind   Trigger

Design
Physical environment Systems Policy Service
Technology   Products

Educate
Engage   Motivate   Inspire   Critical consciousness
Mobilise   Build skills (analytical & practical) Teach

Support
Assist   Provide service Care   Support
Advice Advocate Nurture

Blair-Stevens / French 2008

MANUAL

The Intervention Matrix Tool

If the Exchange Matrix is combined with the de-CIDEDS framework tool it is possible to construct an Intervention Matrix that combines 'Forms' and 'Types' of intervention that is capable of representing the vast majority of possibilities available to governments and public organisations when they are developing social interventions.

Those who seek to apply marketing principles to assist with social issues may be able to use this intervention matrix tool to reflect on and analyse the range of intervention 'Types' and 'Forms' of exchange they might develop to achieve their goals.

	Hug	Nudge	Shove	Smack
Control				
Inform				
Design				
Educate				
Support				

The matrix also has descriptive utility in that it may be used to describe the range of 'Forms' and 'Types' of intervention that may be necessary in any programme. As stated above those who use a marketing approach can also help inform and shape broader social interventions that may use a combination of 'Forms' and 'Types' of intervention by ensuring that the 'Form' of exchange and 'Type' of interventions that are selected are based on user understanding and insight

Open Analysis guide to Selecting Models and Theories of Behaviour Change

The following four domains of influence appear to be key when selecting theory and models of behaviour:

- **Bio-physical**   e.g. Biology
- **Psychological**   e.g. Psychology
- **Social**   e.g. Sociology
- **Environmental and Economic**   e.g. Environmental Studies and Economics

BEHAVIOUR: Integrated Theory Framework

Step One:
Recognise the Multiple Influences on Behaviour

For each of these four domains there are a range of disciplines that inform or are grounded in that perspective. Each of these disciplines has their own range of theories and ideas about what influences behaviour and often each feeder discipline has a number of competing or antagonistic theories. The first step in the process is to accept the influences from these four domains and begin a review of potential influences on behaviour from this perspective. Using this frame of reference potential models and theories can be sought that inform understanding about the impact of each of these four domains on behaviour.

This first stage should be as unrestricted as possible; theory should be sought not just from each domain but also from fields of behavioral influence outside public health. Valuable models and lessons can be learnt from fields such as environmental behavioural influence, transport use, financial decision making and planning and from areas outside the immunisation and pandemic preparedness fields; for example for the fields of smoking, obesity and accident prevention.

BEHAVIOUR: Integrated Theory Framework

Wide range of different disciplines that can contribute
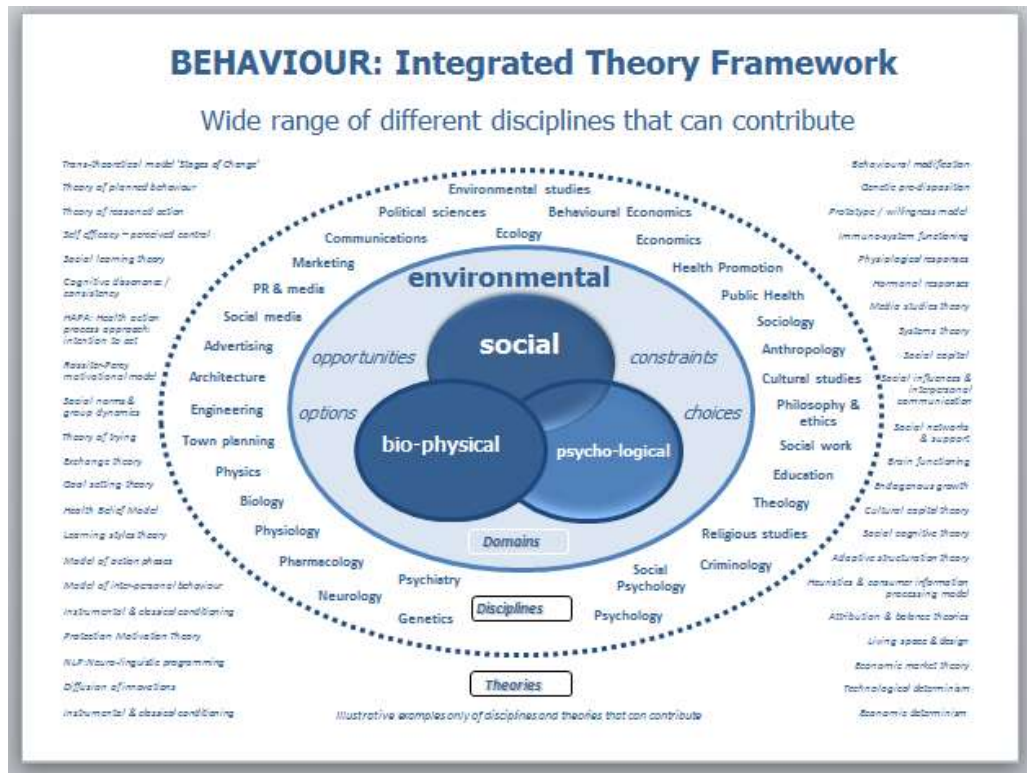
Step Two:
Assemble a Multi-Disciplinary Team

There is also a need to be pragmatic and recognise that it is impossible for practitioners to be expected to have detailed understanding of so many disciplines and theories and to conduct exhaustive reviews of theory prior to any strategy or action being delivered. One way to reduce the effort required and to increase the theoretical frame of reference that can be applied to understanding particular issues is the tactic of bringing together multi-disciplinary teams from different backgrounds. This approach will increase the range of theoretical models that will be applied in any given situation.

Each profession within the public sector has its own assumptions about how behaviour is best changed and how best it can be built into their policies, be it through information giving; education; regulation; service provision, or 'enabling' measures. Some professions assume that the public make rational choices based on evidence, while others recognize that users are often troubled, or emotional. For example trading standards works through regulation and enforcement, while planners may try to 'design in' behaviour change (e.g. building flats without car parking spaces to discourage car use), while children's services may put more emphasis on talking, interaction, support and advice. Recognising and understanding these different approaches is a first step to making good choices about which approach to use in each situation.

Step Three:
Apply an Open Analysis rather than a start from Fixed Ideas or a Fixed Theory

As discussed above and recommended in the 2008 GSR review if theory is to be used to inform practice it is necessary first to start by trying to get a clear understanding of 'what' behaviour is occurring, and what different people know, think and feel about it. Before then going on to 'pull-down' theory to consider what might help inform or develop insight into why people are adopting a behaviour and the potential insights that might provide ways for effectively intervening. In this way a focus on the behaviour drives the development of a theoretical perspective rather than the other way round.

Starting with an open analysis

Avoid closed analysis
Starting with our own preferred theory

↓

Examining the behaviour from the perspective of your preferred theory

↓

Select intervention options that are grounded in the theory you started with

Keeping the analysis open
Start by developing a robust understanding of the customer
eg: collecting data/intelligence on relevant behaviour and related knowledge/perceptions/attitudes/beliefs/values

↓

Draw down from the range of theories (across different disciplines) to identify ones that might offer insight & opportunities for ways to intervene

↓

Develop a 'working proposition' for how to achieve & maintain the desired behaviour

↓

Select intervention options most likely to achieve the behavioural goals

The final stages of step three should involve the development of 'working propositions' for how to achieve and or maintain the desired behaviour that is being focused on. These propositions will be based on existing and possible newly devised models of behaviour drawn from the literature but also form what is understood about the target audience and what influences the behaviour in question. Interventions can then be developed based on these propositions and tested in pilots and field trials to see if they deliver the anticipated impact on behaviour.

Principles for Designing Interventions Informed by Theory and Models of Behaviour Change. (Base on the an

amalgamation of GSR review [2] Abraham & Mitchie [3] recommendations and STELA planning model[4])

Task	Responsible Agent	Time frame	State of Completion
Identify audience/s for the intervention.			
Identify and quantify list of SMART objectives related to behaviour, attitude, beliefs, and knowledge for each audience.			
Identify relevant theory and models used before with these groups or behaviours.			
Identify key behavioural influencing factors.			
Identify further models and theory that have relevance to factors affecting the behaviours, social or economic factors being targeted.			
Identify from literature review potential intervention approaches theory and models.			
Engage target audience as active agents in agreeing the behavioural influences on the target behaviour.			
Set out and agree with target audience, and stakeholders the theoretical models, theories and or a bespoke model that will guide the intervention.			
Engage partners and stakeholders as active agents in the design, delivery and evaluation of the intervention using community engagement theory and models.			
Develop a prototype intervention based on analysis and theory using a published or bespoke design and planning model.			
Deliver and evaluate prototype intervention paying particular attention to the utility and predictive qualities of the behavioural theory and model used.			
Adapt and refine prototype and develop full implementation plan based on findings of the pilot together with stakeholder and target audience support.			

[2] Darnton A. (2008), GSR Behaviour Change Knowledge Review. Reference Report: An overview of behaviour change models and their uses, HMT Publishing Unit, London.
[3] Abraham, C and Michie S. *A taxonomy of behaviour change techniques used in interventions* in Health Psychology, 2008
[4] French J STELA planning model for social marketing programmes. 2010 available at http://stelamodel.com/

Guide to Segmentation

A key component of all successful Social Marketing interventions including those focused on pandemic events is the need for audience segmentation. Segmentation is based on the obvious recognition that people are different and that includes how they respond to information about health and other influences on their behaviour.

As resources for public health are finite ensuring that investment in interventions yield the greatest impact should be a priority for any programme. Grouping the audience into meaningful segments allows organisations to design efficient and effective strategies for communicating with total populations and specific harder to reach groups.

Segmentation

Segmentation can be a powerful tool in understanding population groups and focusing resources where they are most needed. It is a process of looking at the audience or target group and seeking to identify distinct, manageable sub-groups (segments) that may have similar needs, attitudes, beliefs or behaviours.

Those responsible for designing interventions to influence people in the commercial , not for profit and government sectors regularly segment people into groups to aid the targeting of support and influence. In policy development strategists talk about adults who are *working* and adults who are *unemployed*, *single mothers who smoke* and those who do not; and we subdivide these further by any number of social demographic characteristic including; social class, ethnicity, level of income, use of public services, and neighbourhood type etc. are all used to target interventions.

It is possible to segment populations based on quantitative or qualitative data. Some of the most useful segmentations start with looking at readily available quantitative data and then exploring the emerging segments with more in-depth qualitative research. When building segmentations it is important to draw knowledge from many fields including behavioural theory, statistics and public health science.

There are a wide range of segmentation techniques: socio-demographic, geodemographic, behavioural, epidemiological, psychographic and attitudinal, service utilization, and social network analysis, to name a few. However, there will also be a measure of judgment from practitioners who will be responsible for applying the segment definitions to create targeted programmes and interventions. In the public health arena segmentation has tended to focus on the use of demographic (age, sex, class, etc.) geodemographic (type of neighbourhood), and especially epidemiological data (mortality and morbidity). Factoring in attitudinal and *psychographic data* to provide a rounder picture of the segments is a good starting point for developing tailored interventions. 'Psychographic' variables describe the individual in terms of their overall approach to life, including personality traits, values, beliefs, and preferences. As Table 1 shows, they all draw on a pool of common factors. Not all these factors will be relevant to pandemic flu but subsets within each domain will have relevance

Table 1

Behaviour/Current Status	Demographics	Geographic	Activities and Lifestyle	Attitudinal/Psychographic
Dependency / addiction issues How engrained is the behaviour – how long has it been sustained Frequency of behaviour e.g. Regular, occasional, hardly ever, experimenting stage Occasion – e.g. social smoker, smoke after meal, never smoke at work Stage of change: e.g. contemplating change or have tried to change and relapsed Health status Are they in serious debt? Have they just experience a major life event Use of services – how often? What for?	Age / Life stage Gender Family size Income Social Class/Occupation Education Religion Ethnicity	Urban / rural Geodemographic Proximity to services Area deprivation Social Capital	How do they spend their money? Where do they socialise and what do they do What do they read, watch and listen to and what engages them most	Needs, desires, aspirations Beliefs and values Personality type Self esteem , self efficacy, locus of control Key influences in their life – parent, peers, partner, religion, and the media, role models Attitudes towards the issues in question, the service, the product, the organisation, the government, health professionals' e.g. contemplating or tried and relapsed attitudes towards services (NHS, local councils etc), customer satisfaction

Target audiences can be segmented using some of these categories into groups that share common beliefs, attitudes and behaviours. Interventions are directly tailored to specific audience segments rather than relying on 'blanket' 'spray and pray' approaches

When segmenting populations, the aim should be to define a small number of groups so that:

- All members of a particular group are as similar to each other as possible; and
- They are as different from the other groups as possible.
- It is important for social marketers to know what differentiates one group from another; but, what is more important are the similarities
  between people in a particular group. These make it possible to create clusters of people and target our interventions at priority groups.

Key attributes of a sound segmentations:[5]

- Segmentations should build on current knowledge
- Should get us a step closer to knowing our audience.
- Provide a common language for understanding peoples motivations and behaviours
- Utility/Applicability, the segments should exist in the real world rather than be just statistical constructs; the segment descriptions should make sense to the people who have to apply them; and the segmentation should add value and greater sophistication when developing and targeting interventions
- Replicability, practitioners should be able to identify or recreate the segments in their own research.
- Stability, the segmentation definitions should be fairly stable but the size of the segments may change over time as people move in and out of segments.
- The segmentation should create a focus for our time and resources
- Segmentations should not be too complicated , some of the most powerful segmentations are the simplest
- The segmentation should not be the final word but should allow room for new insight.

Most segmentations within the public health sector use *'quantitative'* (measurable) data (e.g. surveys, epidemiological data, or hospital-episode data). However, there are some good examples of *'qualitative'* segmentations (based on people's views, needs, and behaviours) which have drawn on in-depth interviews and focus groups to produce typologies of particular groups.

Although qualitative segments cannot provide accurate estimates of the size of each segment, they do provide a rich description of the various groups and types. The qualitative segments can be sized subsequently using quantitative survey research.

Segmentation starts with the citizen and how they can be helped and encouraged to behave in a healthy way instead of focusing on the actual behaviour that the public health practitioner wants them to adopt of maintain. Messages, products, or health services should

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[5] D. McVey and L. Walsh "Generating insight and building segmentations – moving beyond simple targeting" Chapter 7 in *Social Marketing and Public Health: Theory and practice.* Editors : French, Blair-Stevens, McVey and Merritt. OUP 2009

be designed or redesigned around the priority segments needs beliefs attitudes and behaviours. If executed well, this will produce more satisfied citizens and a more efficient delivery of interventions.

Segmentations do not last forever subgroups of the population are continuously developing and changing what they know, believe and feel about issues.

Segmentations that are developed need updating as media, services, and attitudes change. However, a well-constructed segmentation, which visualizes citizens with clarity and insight, should assist public health organizations and their delivery partners target better interventions and monitor results for a number of years.

Examples of segmentations applied to Pandemic Flu intervention

In the three countries, England, Italy and Hungary that SSM review as part of work programme 6 for the E-Com programme there was little evidence of segmentation beyond identifying high priority groups (Older people, Chronically Ill, Pregnancy, Children and Health Care workers. However recent research literature provides some insight into the use of segmentation generally in public health.

A recent review by Quinn et al [6] looking at Social Marketing intervention across a number of issues concluded that the least described or mentioned aspects of the Social Marketing process were pretesting and audience segmentation. Another review looking specifically at the use of Social Marketing techniques (including segmentation) in the prevention and control of communicable diseases [7] noted that segmentation is closely related to formative research and without information about the formative research process; the reviews could not discuss segmentation strategies.

A review by Mah et al (2008) [8] looking at 20 years of Social Marketing Analysis of Hand Hygiene Promotion concluded that more than half of the studies included in review described audience segmentation strategies based on formative research and but that segmentation was mainly by age and academic level, see Box 1.

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[6] Quinn GP, Ellery J, Thomas KB, Marshall R. Developing a common language for

using social marketing: an analysis of public health literature. Health Marketing

Quarterly 2010;27(4):334–353.

[7] Evidence review: social marketing for the prevention and control of communicable disease Insights into health communication www.ecdc.europa.eu: MacDonald L, Cairns G, Angus K, Stead M. Evidence review: social marketing for the prevention and control of communicable disease. Stockholm: ECDC; 2012.)

[8] Mah MW, Tam YC, Deshpande S. Social marketing analysis of 20 years of hand hygiene promotion. Infection Control and Hospital Epidemiology 2008;29(3):262–270.

Applying segmentation techniques to Pandemic Flu

Reviewing a number of countries pandemic flu interventions the evidence of planned segmentation of populations and audience is limited. There are a number of possible reasons for this:

1. The pandemic progressed so quickly from WHO phase 1 to phase 4 that there was little time to conduct any audience research or segmentation analysis to develop more sophisticated communication strategies.

2. To invest resources in separate strategies for different segments or target groups requires evidence that these targeted strategies would produce a return of the investment. Some communication experts believe evidence for such claims is not strong.

3. For pandemics which have the potential to infect all groups very quickly the case for immediate mass population approaches outweighs the argument for targeting particular segments.

These arguments are valid but research indicates that different demographic and attitudinal groups respond differently to the same message or intervention.

One of the basic tenets of Social Marketing is that tailoring interventions based on an insight into the beliefs and behaviours of specific sub groups (or segments) will be more likely to deliver the desired impact on behaviour.

This is the case whether that be encouraging people to implement preventive behaviours such as using tissues and hand gel; calling a help line for antivirals; going to the family doctor for vaccination, or staying home from work whilst infected.

BOX 1

Mah MW, Tam YC, Deshpande S. Social marketing analysis of 20 years of hand hygiene promotion

Summary of the use of Social Marketing Benchmark Criteria.

The interventions were assessed against

social marketing benchmark criteria:

• 30% of included studies included formative audience research

• 9% used social or behavioural theories

• 51% used segmentation and audience targeting

• 83% used components of the marketing mix

• 6% considered the influence of competing behaviours

• 13% cultivated relationships with the target audience

• 28% provided simple behavioural messages

A possible segmentation of the general population for pandemic flu interventions.
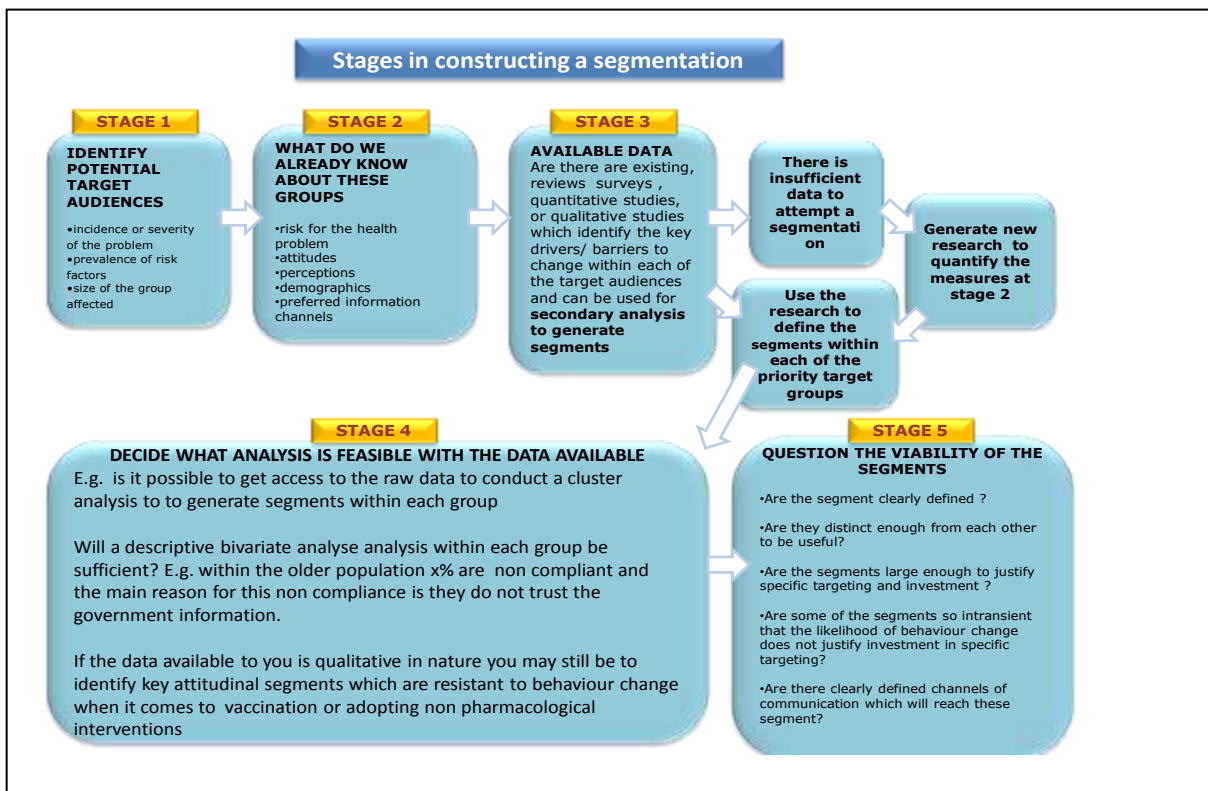
Most interventions during the pandemic flu outbreak in 2009-2010 involved a mixture of three broad stands:

- **Hand and respiratory hygiene and social distancing**
- **Antiviral use**
- **Vaccination**

There was evidence in the many of the interventions of basic demographic segmentations based on risk groups.

Stages in constructing segmentations

Below is a suggested list of five stages to build a segmentation model.

Stages in constructing a segmentation

STAGE 1

IDENTIFY POTENTIAL TARGET AUDIENCES

- incidence or severity of the problem
- prevalence of risk factors
- size of the group affected

STAGE 2

WHAT DO WE ALREADY KNOW ABOUT THESE GROUPS

- risk for the health problem
- attitudes
- perceptions
- demographics
- preferred information channels

STAGE 3

AVAILABLE DATA
Are there are existing, reviews surveys , quantitative studies, or qualitative studies which identify the key drivers/ barriers to change within each of the target audiences and can be used for **secondary analysis to generate segments**

There is insufficient data to attempt a segmentation

Generate new research to quantify the measures at stage 2

Use the research to define the segments within each of the priority target groups

STAGE 4

DECIDE WHAT ANALYSIS IS FEASIBLE WITH THE DATA AVAILABLE
E.g. is it possible to get access to the raw data to conduct a cluster analysis to to generate segments within each group

Will a descriptive bivariate analyse analysis within each group be sufficient? E.g. within the older population x% are non compliant and the main reason for this non compliance is they do not trust the government information.

If the data available to you is qualitative in nature you may still be to identify key attitudinal segments which are resistant to behaviour change when it comes to vaccination or adopting non pharmacological interventions

STAGE 5

QUESTION THE VIABILITY OF THE SEGMENTS

- Are the segment clearly defined ?
- Are they distinct enough from each other to be useful?
- Are the segments large enough to justify specific targeting and investment ?
- Are some of the segments so intransient that the likelihood of behaviour change does not justify investment in specific targeting?
- Are there clearly defined channels of communication which will reach these segment?

Stage 1: Identifying potential target audiences

The scientific evidence indicated that the impact of pandemic flu will have varying effects on certain demographic groups.

- Older groups
- People who are chronically ill
- Pregnant women
- Children (targeting parents of Children)
- Marginalised groups (Homeless , travellers, refugees, substance misusers)

Stage 2: Quantifying what we already know

Within each of these groups there will be a considerable number of people who will respond quickly to interventions to reduce their own risk of infection and limit the spread of infection from themselves to others but there will also be people who, for whatever reason , will not respond with the required behavioural change. The reasons for compliance and non-compliance will be based on attitudes, beliefs, social norms and capability of individuals to respond to messages and attain the behavioural goals.

Noncompliance - based on beliefs and attitudes

The reasons for non-compliance will vary by the behavioural change goals. For example, the reasons for non-compliance with vaccination may be very different to the reasons for non-compliance the social distancing measures. The segmentation approach will necessarily vary as a result. However, there may be considerable overlap in non-compliance factors across a number of behavioural goals. For example, possessing a belief that "I am not at risk" or "there is too much fuss being made about pandemic flu" or being someone who "takes most of their health information from non-official sources" will not only influence their propensity to take up vaccination but may also influence their compliance with hygiene and social distancing measures.

Compliance with influenza vaccination and factors affecting the compliance

As part of the EU seventh framework the TELL ME project reviewed the specific communication needs of particular groups in the area of pandemic flu. The key factors were summarised as follows:

Target group	Compliance characteristic	Positive factors associated with compliance	Negatively factors associated with compliance
Health care workers	• Compliance varied from very low (less than 10%) to around 40-50% • Compliance varied widely between and within countries • Compliance varies widely by professional category	• Self-protection • Desire to avoid infecting patients • Desire to protect family members • Perceived safety of the vaccine • Perceived efficacy of the vaccine • Perceived seriousness of disease • Perceived risk of the disease • Perceived seriousness of complications from disease • Access to vaccine • Cost of vaccine	• Fear that vaccine could cause disease
Elderly	• A trend towards increasing compliance rates among those over 65 years of age	• Number of visits to a physician during the year	• Disbelief in the efficacy and safety of the vaccine • Fear of side-effects or influenza resulting from the vaccine
Chronically ill	• Compliance is greater than for healthy people • Compliance is increasing over the years • Compliance in Europe is relatively low • A wide difference in compliance of people with different diseases	• Number of physician visits and acceptance of their advice	• Fear of side effects • Disbelief in vaccine efficacy

Pregnant women	• Compliance tends to be better with seasonal influenza vaccines than with pandemic vaccine • Compliance with seasonal influenza vaccination in the U.S. is increasing yearly	• Health care provider recommendation	• Lack of knowledge of the importance of vaccine and where to get it • Concerns for the effects of vaccine on fetal and maternal health
Pediatric population	• A big difference in compliance between different countries and over the years • Compliance of chronically ill children is greater than that for healthy children • Relatively high percentage of children getting only one dose of the vaccine	• Child's influenza vaccination in previous year • Child's receipt of all recommended immunizations • Child's uninterrupted health insurance coverage • Mother's marital	• Using a family doctor rather than a pediatrician • Parents belief that the vaccine was unneeded or that the child was getting too many shots • Parents having a hard time obtaining the vaccine

Source: D1.3 Segmentation and Specific Communication Needs of Target Groups TELL ME project pages 19-20

http://ecomeu.info/

Compliance with non-pharmacological interventions to prevent the spread of influenza

The TELL ME project also reviewed evidence on the efficacy of, and compliance with, non-pharmacological interventions to prevent the spread of influenza. The WHO recommendations on measures to be adopted during the influenza pandemic alert period have included isolation of patients and quarantine of contacts and that during the pandemic period, the focus should shift to delaying spread and reducing effects through population-based measures.

One of the key recommendations is that people with flu-like symptoms should stay at home. Depending on the severity of the pandemic, social distancing measures should be considered and non-essential domestic travel should be limited. Personal hygiene, such as hand washing and respiratory etiquette, are considered to be basic requirements. There is no clear-cut recommendation on the use of face masks.

There is little good quality scientific evidence on the efficacy or effectiveness of most non-pharmaceutical interventions to prevent the spread of influenza during pandemics. The recommendations are based on consensus among experts and include good hand hygiene and respiratory etiquette, surveillance and case reporting, and rapid viral diagnosis in all settings and during all pandemic phases. The recommendations also encourage patient and provider use of masks and other personal protective equipment as well as voluntary self-isolation of patients during all pandemic phases. The experts rejected other non-pharmaceutical interventions, including mask-use and other personal protective equipment for the general public, school and workplace closures early in an epidemic. Mandatory travel restrictions were rejected as likely to be ineffective, infeasible, or unacceptable to the public.

Factors that affect compliance with vaccination may also be applicable to non pharmacological measures. They include:

- Desire for self-protection
- Desire to avoid infecting patients
- Desire to avoid infecting family members
- Perceived seriousness of the disease
- Perceived risk of the disease
- Perceived seriousness of complications from the disease.

Stage 3: Assessing Available data

Using Existing data

Based on the available review data, which explores the knowledge, attitudes and beliefs of priority groups, it is possible to create a broad set of categories (or segments) of people who are more or less likely to respond to behaviour change messages. In the absence of any other data this will provide useful information about where resources should be targeted. However, if quantitative data is available, applying a more systematic approach will improve the accuracy of the segment definitions, the estimated size of each segment and hence the effectiveness of the targeting of planned interventions. There may be existing sources of

data in a country on the knowledge, attitudes, beliefs and practices that are relevant to pandemic flu. If this is the case, this data can be re-analyzed to generate segments. There are many approaches to analysing data to generate segments. It is important to have a plan of analysis which will meet the objectives for the segmentation.

For example, if a public health team wish to identify distinct segments within a subset of a population e.g. older people, one approach would be to select this group from the data set and define segments within this group. For example older people who are resistant to vaccinations or who do not feel at risk or who are unable to attend vaccination clinics compared to those that do get vaccinated. Alternatively it is possible to decide to look at the whole adult population and identify a set of key characteristics of those who are not vaccinated which in turn will define the particular segments.

The more information you have on respondent's knowledge, attitudes, beliefs and behaviours, the more detailed segment definitions you will be able to construct. However, using too many variables to define segments can overcomplicate the definitions and result in the segments having little use for those designing interventions and campaigns.

 Only use variables which clearly have a strong influence on behavioural intentions or actual behaviour e.g. a sense of personal susceptibility, a belief in the severity of the disease, fear of side effects, trust in government information or access to vaccines and antiviral. How to select variables is explained later in Stage 4.

What data is available on European attitudes and behaviour in relation to pandemic flu?

The Directorate-General for Health and Consumers commissioned a survey that examines public opinion about influenza and pandemic H1N1 2009. The Flash Eurobarometer survey "FL287 – Influenza H1N1" This survey covered the following issues:

- The intention to get vaccinated against seasonal influenza this year
- Awareness of pandemic H1N1 influenza (swine flu)
- Worries and beliefs about pandemic H1N1 2009
- Level of information about pandemic H1N1 2009
- Trust in sources of information about pandemic H1N1 2009
- Pandemic H1N1 2009 in the media
- Measures against pandemic H1N1 2009
- Opinions about the vaccination against H1N1 influenza

The survey's fieldwork was carried out between the 26th and 30th November 2009. Over 28,000 randomly selected citizens aged 15 years and over were interviewed across the 27 EU Member States, as well as in Norway, Switzerland and Iceland. The survey was conducted by telephone, with WebCATI (web-based computer assisted telephone interviewing). To correct for sampling disparities, a post-stratification weighting of the results was implemented, based on socio-demographic variables.

The data provides a useful and unique) cross country comparison. The Summary report is available at http://ec.europa.eu/public_opinion/flash/fl_287_sum_en.pdf and provides a top
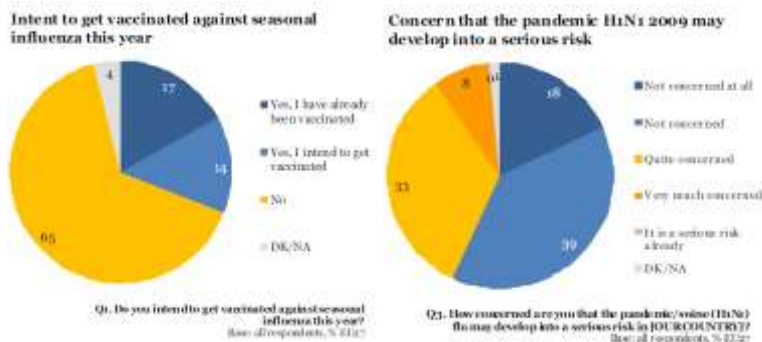
line analysis for whole of the EU. Datasets are also available by specific countries with approximately 1000 people interviewed in each member state. Looking at the top line findings on the key questions is a good place to start to determine which variables to include in the segmentation.

The questions were chosen because they were deemed important measures to assess the population's opinions and behaviours but also to assess the extent of the barrier to infection control and vaccination which have been documented in other public health research
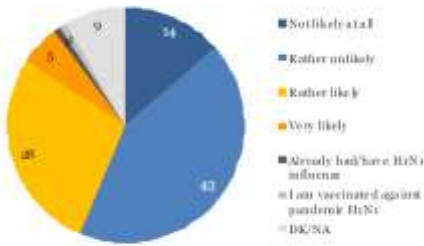
The measure below can be summarised into 4 categories:

- Knowledge and beliefs about the pandemic, infection control and vaccination
- Risk and susceptibility
- Trust in government and other information sources
- Behaviour / behavioural intentions (hygiene and vaccination)

Looking at the spread of responses within each question indicates that most questions work in differentiating respondents. For example, on the issue of "concern" there are reasonable sample sizes of people who were *concerned* (approx. 40%) compared to those who were not *concerned* (approx 60%).Hence this variable should yield sufficient numbers in each category for analysis. However, you should note that this figure is a European average. When looking at individual country data the profile of responses may be very different. If you find that say 10% of the population say "yes" to a question and 90% say "no" then the response to this question is approaching saturation and is unlikely to be useful in a segmentation analysis.

ECOM

Likelihood of personally catching influenza H1N1

- Not likely at all
- Rather unlikely
- Rather likely
- Very likely
- Already had/have H1N1 influenza
- I am vaccinated against pandemic H1N1
- DK/NA

Q4. How likely do you think it is that you, personally, will catch pandemic (H1N1) flu?
Base: all respondents, % EU27

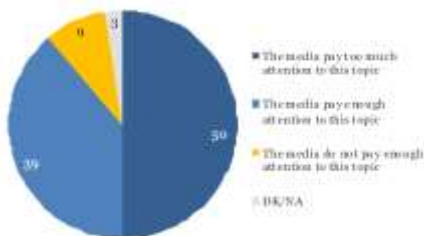## Trust in information sources for the pandemic H1N1 2009

■ Trust completely ■ Trust mostly ■ Trust not much ■ Do not trust at all ▪ DK/NA
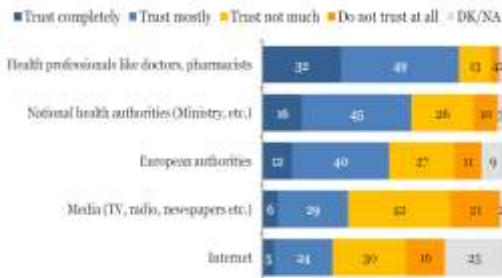
Q10. How much do you trust each of the following sources to inform you about the pandemic (H1N1) flu?
Base: all respondents, % EU27

What can people do to protect themselves against the pandemic influenza H1N1?
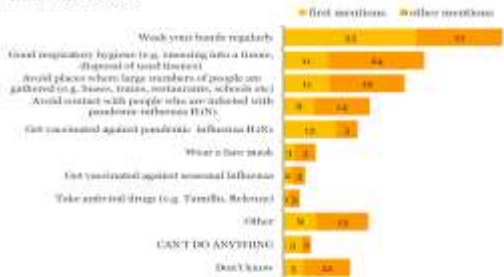
■ first mentions ■ other mentions

Q7. In general, what can people do to protect themselves against the pandemic H1N1 flu?
Base: all respondents, % EU27

Pandemic H1N1 2009 in the media

- The media pay too much attention to this topic
- The media pay enough attention to this topic
- The media do not pay enough attention to this topic
- DK/NA

Q11. In your opinion, do the media in [OUR COUNTRY] pay too much, enough, or not enough attention to the pandemic (H1N1) flu?
Base: all respondents, % EU27

Prevention: **Wash your hands regularly**

■ first mentions ■ other mentions
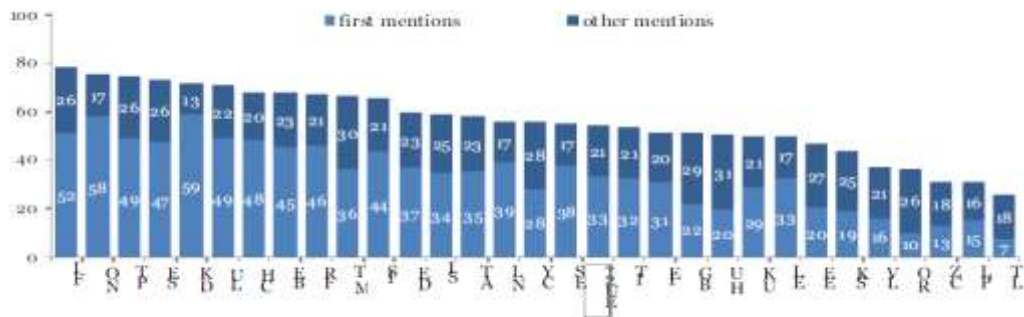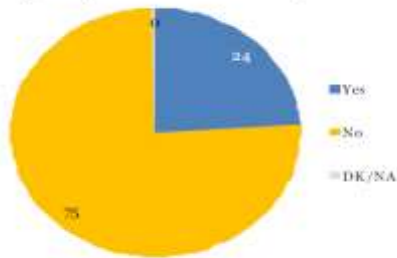

Q7. In general, what can people do to protect themselves against the pandemic H1N1 flu?
Base: all respondents, % by country

ECOM

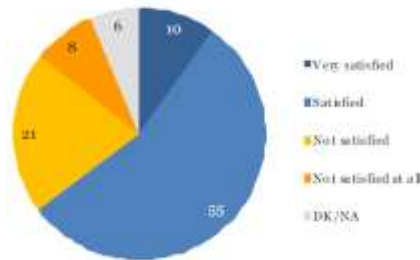## Behavioural changes to protect against pandemic H1N1 2009


- Yes — 24
- No — 75
- DK/NA — 0

Q8. Have you changed your behaviour to protect yourself against pandemic (H1N1) flu?
Base: all respondents, % EU 27

Satisfaction with taken preventive measures against pandemic H1N1 2009

- Very satisfied — 10
- Satisfied — 55
- Not satisfied — 21
- Not satisfied at all — 8
- DK/NA — 6

Q12. Based on what you know, how satisfied are you with the preventive measures that authorities in [OUR COUNTRY] have taken so far against pandemic (H1N1) flu?
Base: all respondents, % EU 27

Seasonal influenza vaccination provide protection against the H1N1 influenza

- Yes — 24
- No — 60
- DK/NA — 16
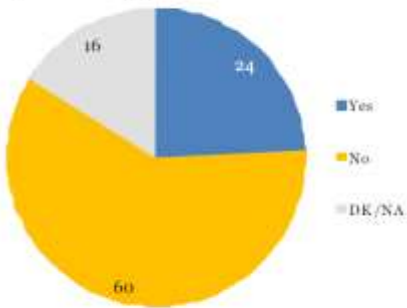
Q14. Do you think that the seasonal flu vaccination will provide protection against the H1N1 flu?
Base: all respondents, % EU 27

Likelihood of getting vaccinated against the pandemic H1N1 2009

- Very likely — 17
- Likely — 22
- Not likely — 23
- Not likely at all — 31
- You have already received this vaccination — 1
- DK/NA — 5
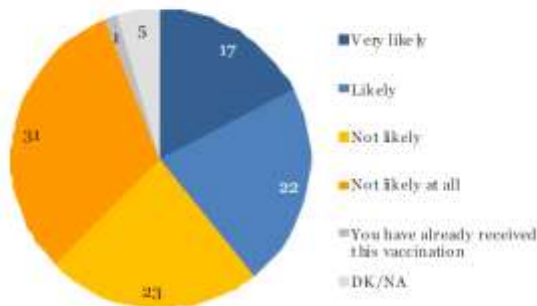
Q16. If the vaccine were available to you, how likely would you be to get vaccinated against the pandemic (H1N1) flu?
Base: all respondents, % EU27

Will pandemic H1N1 2009 vaccine be effective and safe?

- Yes — 45
- No — 30
- DK/NA — 25
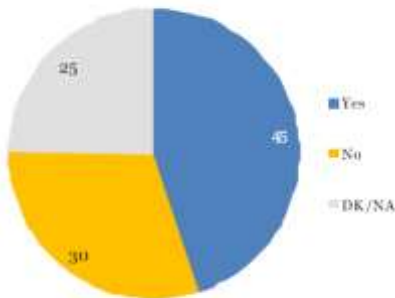
Q18. Do you believe the pandemic (H1N1) flu vaccine will be effective and safe or not?
Base: all respondents, % EU 27

Source of information about the H1N1 influenza vaccine
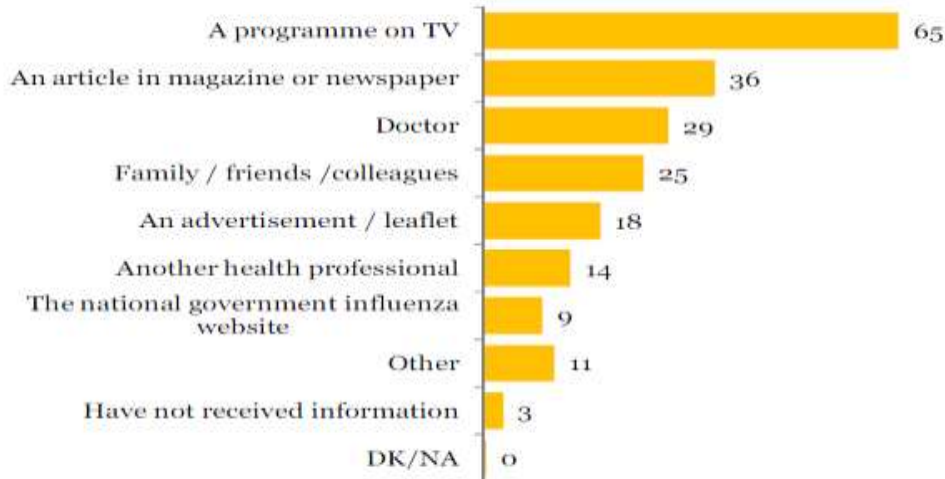
Q15. From whom or where have you received information about the H1N1 vaccine?
Base: all respondents, % EU27

Source : **An article in magazine or newspaper**
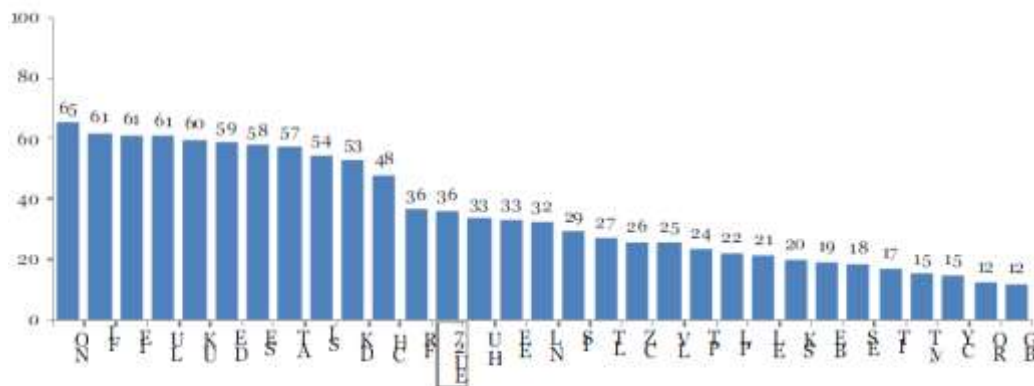
Q15. From whom or where have you received information about the H1N1 vaccine?
Base: all respondents, % by country

Stage 4: Deciding what analysis is feasible with the available data.

The Eurobarometer is a general population dataset so in addition to the variables described above there will be a number of demographic variables, age, gender, social class and other socio economic variables.

Analysis - Exploring the data

Some of the analysis steps described employ basic statistical techniques. If you require help with interpreting the output from such analysis you should ask a statistician who will be able to interpret the tests of association and correlation.

Step One - Eyeball the data

Analyse the pandemic flu questions by key demographics and look for variations, particularly variations by the key target groups e.g. the older populations and those who are chronically ill. For example, you may discover that greater proportions of older people feel greater susceptibility and acknowledge the seriousness of the disease but also feel that seasonal vaccinations will protect them against the flu.

Clearly this group will need to be made aware that seasonal vaccine does not protect against pandemic flu. However, there may be a smaller but significant group of older people who do not feel at risk, who do trust health professionals and have no intention of getting vaccinated. This group will need a very different intervention to move them to a stage where you can persuade them to get vaccinated. Just by looking at simple bivariate relationships between attitudes, patterns and distinct groupings begin to emerge.

Step Two - Construct a correlation matrix

Look for significant relationships between certain attitudes. For example, are people who believe that the vaccine is unsafe, also less likely to trust government and health professionals? And are they less concerned about the pandemic? The easiest way to examine the relationships between different attitudes and the relationship between attitudes and demographics is to generate a correlation matrix which includes all these variables.The matrix will give an immediate sense of which attitudes are most strongly correlated and which attitudes vary by age and sex and social grade - or whatever other demographics variables you have in the data set which you believe will be useful. The Eurobarometer is a general population survey.

The proportion of health care workers (an important target group for pandemic influenza interventions) within a general population sample will be small and may not permit any further analysis. Data on health care workers attitudes which will permit segmentation analysis will have to be gleaned from other sources but the same process of analysis described in this section of the guide will apply.

Having explored the relationships in the correlation matrix you will have identified which attitudes are significantly correlated with each other and which attitudes are more closely correlated with intentions to change behaviour.

CORRELATION MATRIX - The statistical correlation analysis will populate each cell		Knowledge and beliefs			Trust			Risk and susceptibility		Intentions and behaviour change			Demographics and state of health
		What can you do to protect yourself against pandemic flu	Seasonal influenza vaccine provide protection	Will the vaccine be effective and safe	Trust in the information sources for pandemic flu	Media treatment of pandemic flu	Satisfaction with the preventative measures taken	Likelihood of personally catching pandemic flu	Concern that pandemic flu may develop into a serious risk	Intention to get vaccinated against seasonal flu	Likelihood of getting vaccinated against pandemic flu	Have you changed your behaviour to protect against pandemic flu	Age, Gender, Social Grade, chronic illness, access to media etc
Knowledge and beliefs	What can you do to protect yourself against pandemic flu	1											
	Seasonal influenza vaccine provide protection		1										
	Will the vaccine be effective and safe			1									
Trust	Trust in the information sources for pandemic flu				1								
	Media treatment of pandemic flu					1							
	Satisfaction with the preventative measures taken						1						
Risk and susceptibility	Likelihood of personally catching pandemic flu							1					
	Concern that pandemic flu may develop into a serious risk								1				
Intentions and behaviour change	Intention to get vaccinated against seasonal flu									1			
	Likelihood of getting vaccinated against pandemic flu										1		
	Have you changed your behaviour to protect against pandemic flu											1	
Demographics and state of health	Age, Gender, Social Grade, chronic illness, access to media etc												

Step Three - Simple Statistical Modeling

In addition to exploring the bivariate relationships between variables, a useful added step is to build a simple *logistical regression model.* The output variable (the "dependent" variable) should be a behaviour variable or a behavioural intention i.e. intention to get vaccinated or to adopt behaviour changes to minimise the chance of infection. The input variables (the "independent" variables) should be selected demographics, attitudes and belief statements that have a statistically significant correlation with the behavioural /behavioural intentions. The correlation matrix will provide information on which variables to include in the model. The logistic model will provide information on the *relative impact* on behaviour and behavioural intentions of each of the demographic, attitudes and beliefs put into the model.

In addition a *factor analysis* could be performed on the attitude and belief questions to reduce the set of statement to a manageable set of domains e.g. "trust in - and satisfaction with - government response ", "no sense of personal risk or susceptibility ".

Step Four - Cluster analysis

Based on the findings from steps 1 to 4 you should select the variables to include in the segmentation analysis. The most common statistical programme for a segmentation analysis is a cluster analysis. *Cluster analysis or clustering* is the task of grouping a set of respondents in such a way that respondents in the same group (called cluster) are more similar (in some sense or another) to each other than to those in other groups. The resulting "clusters" are the segments.

There are several approaches to this final stage. For example, you can select the attitude, belief and demographic variables which have a significant impact on behaviour / behavioural intentions or select the demographics, attitudes, beliefs and behaviour variables and include all of these in the clustering programme.

There are a number of conditions that have to be set prior to running a cluster programme. e.g. should it be centroid based, distribution – based, or density based[9]. Do you want to specify the number of clusters (segments) generated in advance, in which case you should apply a K- means algorithm[10]. If you do not have sufficient statistical training enlist the help of a statistician who can help with this stage of the analysis and advise what the best approach would be in preparing the data, executing the cluster programme and interpreting the outputs.

With cluster analysis it is best to test several approaches, examine the cluster (segments) that are generated and make a decision on which approach will yield the most useful segmentation. Whatever programme or approach you employ always keep in mind that the final cluster groups have to be useable. For example, a good test is to ask the following two questions:

- Are the segments, which are a selection of variables describing particular groups, easily interpreted and recognisable populations to you, the stakeholders, the campaigners or health workers who will interact with them?

- Are there too many segments?

There should not be too many segments generated. Some segmentations generate 10 and sometimes 20 different segments. For a single issue intervention such as pandemic flu this is too many segments to deal with effectively in planning an intervention. A maximum of 5 segments per target group under study will usefully provide enough differentiation between segments whilst maintaining a reasonable segment size for targeting. Sometimes the analysis process will not yield useable segments. Some of the segments may be so small that they do not justify specific targeting or the clusters that emerge from the analysis cannot be clearly described and do not make intuitive sense. Changing the parameters of the cluster analysis programme can help remedy these problems.

A hypothetical segmentation solution

To our knowledge no country has conducted a segmentation analysis of the Euro barometer surveys. In the absence of any example we will now set out a hypothetical segmentation solution in relation to pandemic events. let us begin by defining the universe for a segmentation. You could focus on one of the key target groups i.e. older people or you could look at the total adult population and see how that segments. For this hypothetical example we will look at the whole adult population from the Euro barometer population for the country in question. Steps 1 to 3 are performed and a set of variable/ domains are selected for input in the cluster programme.

Step 4 is performed and several cluster solutions are generated. The most intuitive and useable segment solution is selected.

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[9] Definitions of each of these properties can be found at http://en.wikipedia.org/wiki/Cluster_analysis

[10] K- means clusters are explaining at http://en.wikipedia.org/wiki/Cluster_analysis

The Hypothetical Outputs - Naming the segments

The cluster analysis output will list the segments (clusters) generated by the programme and will describe how each of the input variables (demographics, attitudes, belief, behaviours) load on that cluster. So, for example, **Segment 1** scores lower than average on a sense of personal risk, lower on trust in government, lower on intention but higher than average on knowledge. **Segment 2** however, scores higher than average on knowledge, a sense of personal risk, trust and intentions to change.

These are *hypothetical segments* but the analysis process described above will result in a number of segments each of which load more strongly on certain input factors such as knowledge and beliefs, risks and susceptibility, trust in institutions and doctors and any other factors you believe are important in predicting behaviour and behavioural intentions.Looking at how each of the factors load for each segment will help define the overall description or segment name.The hypothetical cluster analysis has allocated each respondent to one of four segments so analysis can be performed to look at the demographic profile of each segment- average age, gender split, social grade, access to media, what they read and anything else collected as part of the original Eurobarometer survey.The segment descriptions will help with formulating the right intervention approaches required for each segment.For example, looking at hypothetical Segment 2 - "*Informed Early Responders ".* This segment equates to 40% of the general population. They will respond to campaigns to change behaviour including vaccination. They need to be made aware that there is a pandemic coming, what do and where to get vaccinated if required. They do not need any targeted interventions to address the barriers to engagement with the issue. They do not require a lot of persuading to get vaccinated or follow hygiene recommendations.

However, looking at hypothetical ***Segment 1 - "The Older Deniers"***. This group are older (55+) and probably more vulnerable to infection but they do not see themselves at risk. They are aware of the government advice about how to protect them but they think the whole pandemic has been exaggerated and are less likely to trust the authorities and doctors, although they generally trust doctors more than government. These general attitudes result in them taking very few steps to prevent infection whether it is hygiene measures or vaccination. This group clearly needs some more targeted interventions that go beyond the general population information campaign messages. The exact nature of the interventions and messages that will be effective with this segment will require further exploration in a small number of focus groups. This will help you understand more about what drives these beliefs and attitudes and what is required to persuade and encourage this group to take action.

Finding the people to interview

Using a cluster analysis programme it is possible to create an ***allocation algorithm*** based on responses to key questions in the Euro barometer questionnaire which will allocate people to each of the 4 segments. The degree of accuracy in allocating people based will vary depending on how many questions you include. The higher the number of questions the greater the degree of accuracy. Accuracy levels of over 70% can be achieved with a few as 6 questions.

SEGMENT 1
Older Deniers
(12% of the general population)

Older people 55+
Not currently ill , and more likely to be male (3: 1 male: female). No discernible social grade differences

Knowledge and beliefs
Aware of what you can do to protect your self but do not see it as a serious risk. They don't believe seasonal flu vaccination will give protection against pandemic flu and are more likely to think the pandemic vaccine is infective or unsafe

Risk and susceptibility
Do not feel at risk of catching pandemic flu.
Do not think there is a serious risk and tend to believe that the media pay too much attention to it.

Trust
They are less likely to trust infrmation from the National Authorities and more likely to trust information from doctor – but are still less likely to trust doctors than other segments

Behaviour / behavioural intentions
They are least likely to get vaccinated and will do very little to protect themselves

SEGMENT 2
Informed Early Responders
(40% of the general populations)

All ages some ill, some not.
Marginally more likely to be women (4: 5 male: female).
No discernible social grade differences, more likley to have dependent children

Knowledge and beliefs
Aware of what you can do to protect yourself and tend to see it as a serious risk. They don't believe seasonal flu vaccination will give protection against pandemic flu and are also more likely to think that the pandemic vaccine is effective or unsafe

Risk and susceptibility
Do feel some risk of catching pandemic flu – especially if they are older or pregnant
They do think there is a serious risk and tend to believe that the media pay enough attention to it.

Trust
They tend to trust the information from the National Authorities and from doctors and HCW and so far age satisfied with the measures taken by the authorities

Behaviour / behavioural intentions
They are the most likely to say they have made behaviour changes to protect themselves are most likely to get vaccinated against pandemic flue if the medical advice recommends it for them

Alternatively you can use a reduced version of the Euro barometer questionnaire which includes the key questions on knowledge and beliefs, risk susceptibility, trust, behaviour and behavioural intentions and set a high threshold for the responses to ensure you select people that very clearly fit within the segments of interest. Using such the algorithm or the standard questionnaire you will be able to recruit segments types to focus groups. Respondent recruited will be asked the questions and the algorithm will determine their segment type.

The segments which require your attention e.g. *the older deniers* can be interviewed in depth or in focus groups to understand the drivers of the resistance to vaccination , lack of trust in government and explore the type of social marketing "exchanges" that should be included in government approaches and / or local interventions to motivate a change in behaviour.

SEGMENT 3

Informed- but don't want/trust vaccination

(30% of the general populations)

All ages some ill, some not.
No gender differences. No discernible social grade differences. Some with dependent children , some without

Knowledge and beliefs
Aware of what you can do to protect yourself and tend to see it as a serious risk. They don't believe seasonal flu vaccination will give protection against pandemic flu and are also more likely to think that the pandemic vaccine is infective or unsafe

Risk and susceptibility
Do feel some risk of catching pandemic flu – especially if they are older or pregnant
They do think there is a serious risk and tend to believe that the media pay too much attention to it.

Trust
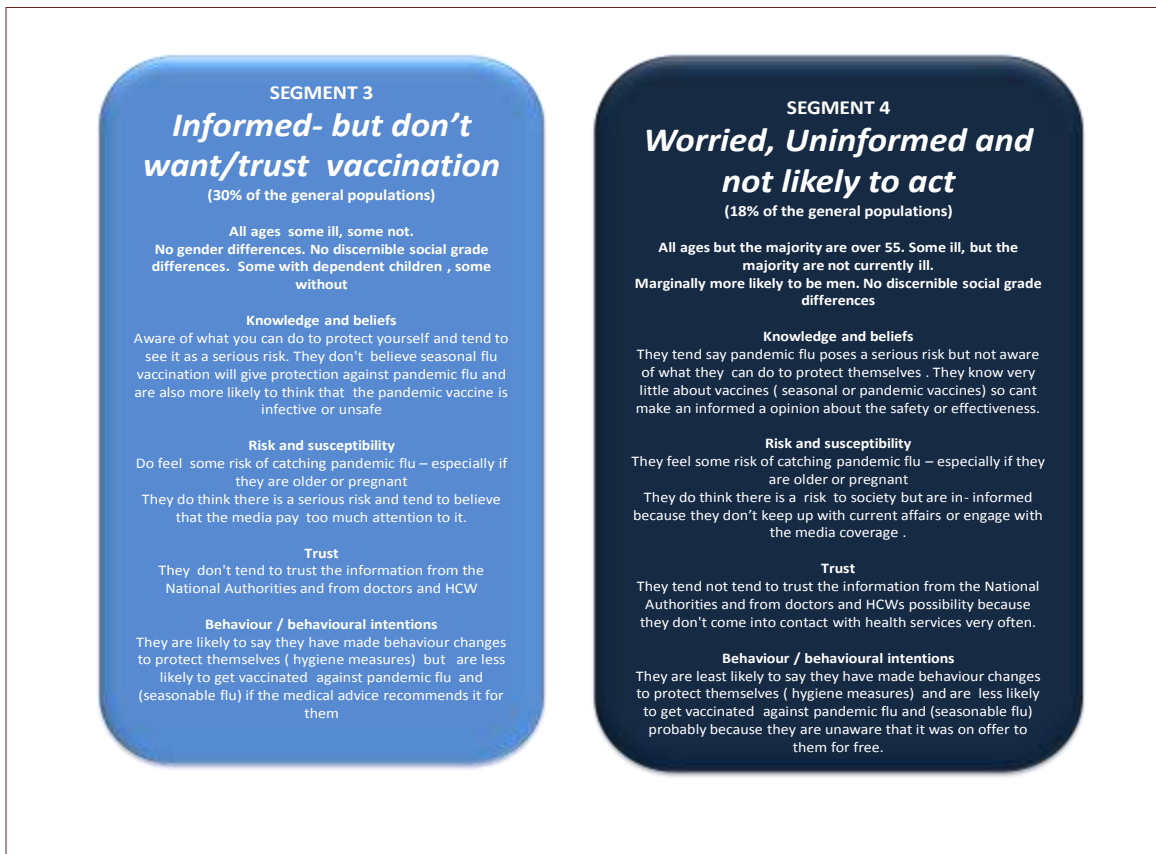They don't tend to trust the information from the National Authorities and from doctors and HCW

Behaviour / behavioural intentions
They are likely to say they have made behaviour changes to protect themselves (hygiene measures) but are less likely to get vaccinated against pandemic flu and (seasonable flu) if the medical advice recommends it for them

SEGMENT 4

Worried, Uninformed and not likely to act

(18% of the general populations)

All ages but the majority are over 55. Some ill, but the majority are not currently ill.
Marginally more likely to be men. No discernible social grade differences

Knowledge and beliefs
They tend say pandemic flu poses a serious risk but not aware of what they can do to protect themselves . They know very little about vaccines (seasonal or pandemic vaccines) so cant make an informed a opinion about the safety or effectiveness.

Risk and susceptibility
They feel some risk of catching pandemic flu – especially if they are older or pregnant
They do think there is a risk to society but are in- informed because they don't keep up with current affairs or engage with the media coverage .

Trust
They tend not tend to trust the information from the National Authorities and from doctors and HCWs possibility because they don't come into contact with health services very often.

Behaviour / behavioural intentions
They are least likely to say they have made behaviour changes to protect themselves (hygiene measures) and are less likely to get vaccinated against pandemic flu and (seasonable flu) probably because they are unaware that it was on offer to them for free.

As the outbreak develop how does this affect the segmentation

How do populations respond to an evolving pandemic develop? A report by Strategic Social Marketing for the E-Com programme assessed communication approaches in the context of an evolving pandemic[11] .

The diagram below taken from WHO and UNICEF guidance[12] indicates the need for a shifting tone of communication during different phases of an Outbreak. Depending on the severity of the outbreak there would also need to be a change in the behavioural goals of a programme.

A review completed as part of the wider E-Com programme has reinforced the need for a flexible approach to communication over the phases of an outbreak. The review [13] found

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[11] E-Com@Eu Programme Work Programme 3: Report on Behavioural Analysis, *From Communication to Behavioural Influence, an Overview of Approaches and Issues:* Jeff French , Strategic Social Marketing 2012

[12] Behavioral interventions for reducing the transmission and impact of influenza A (H1N1) Virus Framework for Communication Strategies WHO /UNICEF 2009

[13] Bults M, Beaujean D, Richardus J H, Voeten H. Perceptions and Behavioural Responses of the General Public during the 2009 Influenza A (H1N1) Pandemic: a systematic review (In Press) 2012.

that public perceptions and behaviours evolved during the course of the 2009 pandemic. In most countries, perceived severity and anxiety declined, but perceived vulnerability increased. High levels of perceived self-efficacy and intention to take preventive measures were observed. Improved hygienic practice and social distancing was practiced most commonly, but vaccination acceptance remained low in most countries. Marked regional differences were also noted.

A review by Bish and Michie[14] has also highlighted that demographic and attitudinal factors can have a big influence on the adoption of protective behaviour during a pandemic. Being older, female and more educated, or non-white, is associated with a higher chance of adopting the behaviours. "There is evidence that greater levels of perceived susceptibility to and perceived severity of the diseases and greater belief in the effectiveness of recommended behaviours to protect against the disease are important predictors of behaviour.

There is also evidence that greater levels of state anxiety (i.e. anxiety felt at that moment), and greater trust in authorities are associated with an increased chance of behaviour being carried out".

These findings point to the need to adapt behavioural influencing and communication programmes for specific groups of individuals, such as men, younger people, and the less well educated.

The need to focus on perceptions of risk in communications as susceptibility is a key factor in decisions to act. In this respect a certain level of perceived susceptibility is required to get people to take action and therefore interventions aimed at increasing this sense of risk appear to be well founded.

However, ethically, interventions designed to emphasise perceptions of risk should also be combined as Bish and Michie say with "advice as to how the perceived threat can be lessened; for example, by emphasising that risk can be reduced by carrying out the recommended protective actions and providing information about the efficacy of such measures in reducing risk"

Emotional Epidemiology

Based on analysis of the pandemic in Hungary, researchers described the "Emotional Epidemiology" of pandemic flu vaccination which details the unfolding public emotional reaction to events and news stories [15]

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[14] Bish and Michie (2010) Demographic and Attitudinal Determinants of Protective Behaviours during a Pandemic: a review. *British Journal of Health Psychology.* DOI:10 1348/135910710X485826

[15] Ofri D. The Emotional Epidemiology of H1N1 Influenza Vaccination. The source article (10.1056/NEJMp0911047) was published on November 25, 2009, at NEJM.org.

News	Emotions	Reactions
A new influenza virus with pandemic potential	Immediate fear of the unknown	When will there be a vaccine?
The novel disease establishes itself within society	Emotional tolerance is created. H1N1 infection waxed and waned over the summer	Patients grew less anxious
News about school outbreaks in autumn	Expectation from my patients that this swine flu problem should have been solved already	Patients instead grew suspicious
The new vaccine is available	"It's not tested" "Everyone knows there are problems with the vaccine." "I'm not putting that in my body."	Reluctance, mistrust, opposition

Looking at these different but complimentary perspectives is necessary to develop sets of communications guidance with specific objectives related to each identifiable target group at each stage of an outbreak. These are valuable perspectives on how the developing pandemic affects the psychology and behaviour of populations.

The segments you define at the beginning of the pandemic will be subject to interventions which may result in them becoming more or less likely to change their behaviour to protect themselves and others. The value of the primary segmentation is that you will have a greater insight into why people are not engaged at the beginning of the outbreak and a much better understanding (from the quantitative and qualitative research) of how each of the segments change as the pandemic moves through the phases. This understanding will not only help with managing a current event but also provide useful understanding about probable reactions in subsequent events.

Conclusion

Segmentations which rely solely on demographic factors such as age, gender or region can add value to intervention targeting but do not harness the full potential that more attitudinal informed segmentations can offer in terms of understanding resistant groups and prioritizing audience effort.

Effective Social Marketing requires reliable insight into the behaviour of target audiences to help shape both the interventions and evaluation. Segmentations which go beyond basic

demographic variables and encompass attitudinal drivers as well as physical, knowledge and emotional barriers to change contribute to the general body of insight and should help to generate a greater return on investment in terms of influencing the behaviour of targeted populations and subgroups.

This guide has provided a brief overview of the main segmentation approaches and stages and has also offered hypothetical example of a possible pandemic segmentation to illustrate the process of generating useable segments.

Guide to constructing a customer journey map

Step 1 : Confirm the journey and customer – identify customer segments

The starting point for the journey is always the customer, and the initial step is to decide which customer(s) to consider. Because everyone is an individual, in an ideal world, we would design and target communications and interventions at an individual level. But in the real world, we have to take a broader approach and target groups.

The important point when targeting groups is to understand the key characteristics that a group shares. We need to identify the motivations that are common to group members that can be influenced to bring about the desired behaviour.

Segmentation of the customer base makes it possible to choose where to focus the work for example the focus could be on:

- Who has the greatest need (minority groups, young people, people with chronic respiratory conditions)

- Where is the current experience least satisfactory, based on evidence from research and evaluation studies. This is likely to vary by place, but may include those who failed to take up recommended behaviours

- Where the mapping is likely to have most impact – for example in large cities or among those who travel abroad, or among the most socially connected groups where there is greatest risk of infection transmission (for instance parents with young children)

Step 2: Construct the systems map

Mapping the system involves creating a graphic representation of all the steps, actions, interactions and decision points of a process, in order to understand it and identify opportunities for improvement. In order to construct a map of how the journey *ought* to operate, ask service providers and policy makers to identify the start and end points of the journey, and the key steps or stages, including the key touch points. These include moments when the service seeks to engage with members of the target audience. They may include communications touch points, physical touch points (clinics and hospital services), online and telephone touch points and face to face interactions. An example of a systems map, derived from the case studies conducted for this project might include the following goals and process or systems map.

Core system goals	Goal 1 Provide actionable information to prevent spread of infection	Goal 2 Minimise number of people with flu symptoms swamping primary care and hospital services	Goal 3 Achieve high rates of vaccine uptake among identified priority groups, when vaccine becomes available

Process or systems map for pandemic influenza planning
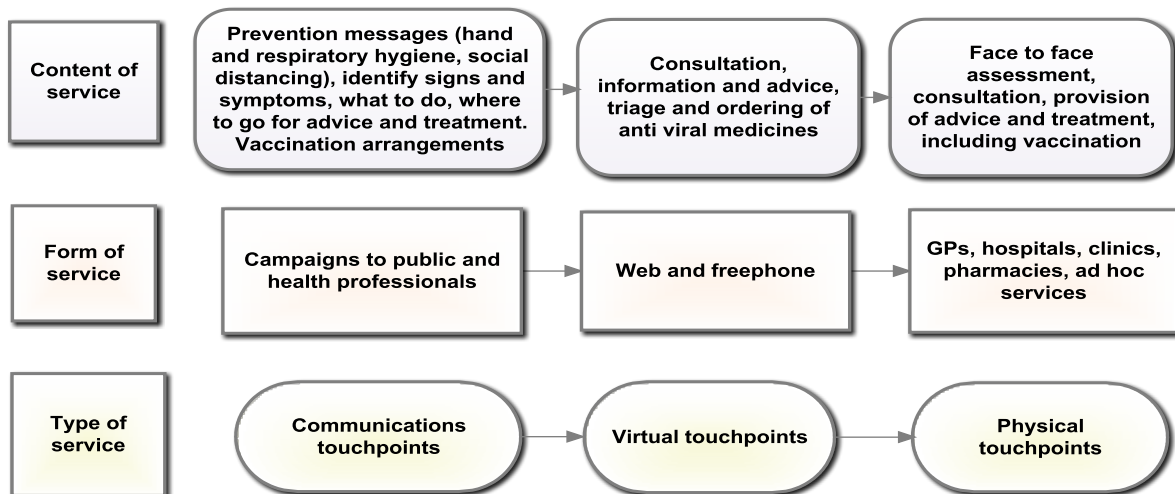
Step 3: Walking in the customer's shoes

Customer experience mapping is a qualitative research technique. It tracks the main steps in a customer's experience and records how customers think, feel and act at each step. There are a variety of ways to gather information about customers and their journeys.

- Recruiting service users to recall – or to anticipate - the journey in focus groups or in individual interviews
- Recruiting service users and knowledgeable service providers and asking them to 'walk through' parts of the journey in real time

The key with any research is to start with clear objectives and the development of relevant questions.

The aim of the research is to identify the following
- Key journey steps
- Actions, feelings, thoughts and reactions
- Touch points – where customers interact with communications and/or services
- Moments of truth– points where customers stop and evaluate

Checklist: the customer experience

Preparation	Running	Capture and output
Who? • Service users • Frontline staff • Policy and strategy • Service managers • People with a vested interest **How many?** • 8-10 people	**What to bring** • Clear description of and evidence supporting the segments chosen • Customer profiles and pen portraits • Relevant research • Existing customer satisfaction measures • Inputs from mapping events	**What to capture** • Plan to capture as much as possible • After – edit, tidy up • Simplify without losing details • Look for output that is visual and arresting with pictures and diagrams • Check back with customers or staff who took part in the mapping events – to validate outputs •
Where? • A creative place that is relevant to the journey	**How to run** • Plan an agenda that is realistic • If covering more than one journey or customer group – be realistic •	

Example questions

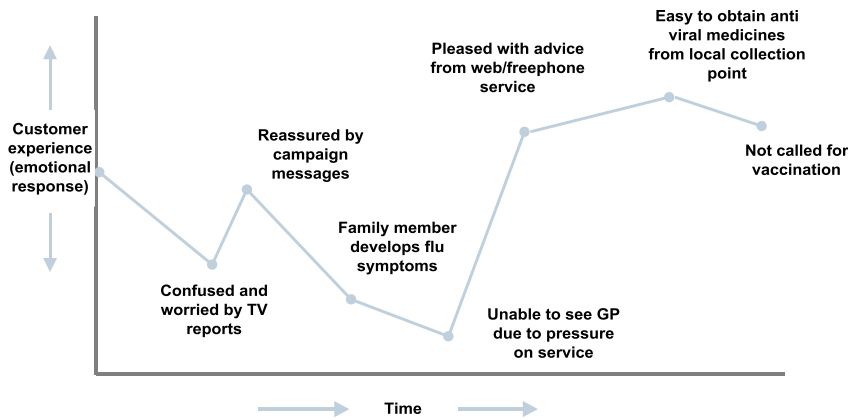| What are the key journey steps?	Learning about the pandemic, prevention, what to do if symptoms suspected and vaccination programme	Prevention behaviours	Contacting web or phone based service	Contacting GP or hospital	Vaccination programme
Actions/ thoughts and feelings at each step	Emotional impact – fear, anxiety, reassurance? What impact did emotional response have in relation to adopting behaviours? Any questions not addressed by official messages?	Are they achievable - consistent? Are others: peers, role models etc - doing these things? Barriers and facilitators to behaviour change?	What was the experience like? Was the service easy to use? Any concerns re confidentiality? Were prevention messages reinforced as well as treatment, advice and information?	Was it clear to service user that there were alternatives? Why did they use these services?	Was it clear who was prioritised? Were risks and benefits clearly explained? Was it clear how to obtain vaccine? Reasons for being/not being vaccinated?
How did they feel at different steps?	Anxious, reassured, personally affected?	Too difficult/ not worth the effort? Or important to follow guidance?	Was this a positive experience or negative? Why? How could it be improved?	Was this a positive experience or negative? Why? How could it be improved?	Was this a positive experience or negative? Why? How could it be improved?

Step 4: Identify key journey steps and draw the map

Having collected the evidence, find a means of identifying the important points so that it is easier to see where changes are needed. This step involves arranging the information by chronological order. Identify between 6-10 key steps. Identify channels people use at each step. Include actions, feelings, thoughts and reactions – taking the customers' point of view for each step, use emotive words, in everyday language

Identify the touch points – for each step identify physical (buildings) human (face to face or telephone or web) and communications
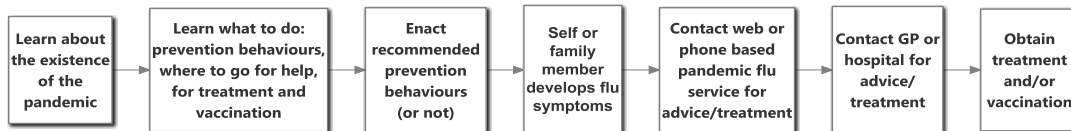
Moments of truth – look at the whole journey, identify moments of truth – key points in the journey where customers pause and evaluate the experience or make a crucial decision.

Customer experience map for pandemic influenza planning
(example)

Customer experience (emotional response)

Easy to obtain anti viral medicines from local collection point

Pleased with advice from web/freephone service

Reassured by campaign messages

Not called for vaccination

Confused and worried by TV reports

Family member develops flu symptoms

Unable to see GP due to pressure on service

Time

Key steps on the journey

| Learn about the existence of the pandemic | Learn what to do: prevention behaviours, where to go for help, for treatment and vaccination | Enact recommended prevention behaviours (or not) | Self or family member develops flu symptoms | Contact web or phone based pandemic flu service for advice/treatment | Contact GP or hospital for advice/ treatment | Obtain treatment and/or vaccination |

Possible lessons from customer journey mapping

Campaign messages do not lead to behaviour changes - review message content, emotional content and tone

Anti-vaccination campaign dominant on social media. Develop comms strategy to engage on social media

Web and phone based services cope well with demand. Raise profile of service for future outbreaks

Certain 'types' of people continue to use physical services despite messages to use web and freephone. Research reasons and consider options

Step 5: Taking action and measuring success

The aim of customer journey mapping is to use the information to improve the service. Once the research is completed, it is possible to identify and implement solutions that improve the service users' experience. They fall into the following areas

- Improving process or service design – for example cutting out unnecessary steps or designing new services to meet unmet needs
- Communications planning – to provide clearer or more targeted information
- Staff training – more training or support to key members of staff

In normal circumstances, evaluating the impact of the changes should be done at some point in time when it is reasonable for the changes to have taken effect. With pandemic influenza, true evaluation is only possible following a future outbreak. However, an analysis of the changes is possible through testing of the system.
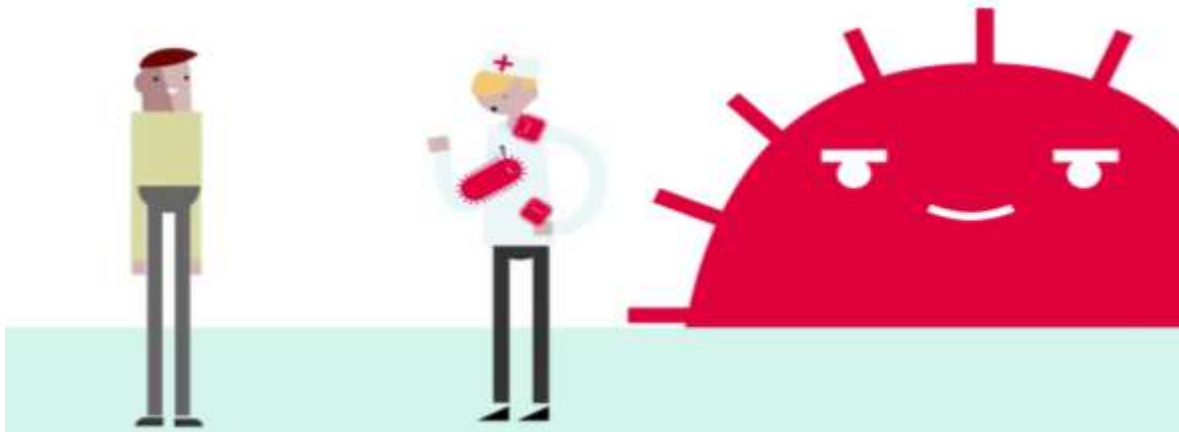
- The kind of questions to be asked of an evaluation will depend on where the customer journey mapping has been applied. The following are generic areas where system testing may be considered

Complexity: is the path through the system clear to customers? Are there points where they are unclear where to go next? Are they having to do the same thing more than once? Are they clear where responsibility lies at each step of the process? Is poor design causing delays?

Time taken: how long does the whole process take now? How long does each step take? Are people satisfied with the overall timespan and with timespan for individual steps? Where do delays occur?

Accessibility: where and when are people coming into this system? Are they coming at the right points? Once in the system, is signposting clear? Does the customer see consistent branding? Are you offering appropriate channels?

Guide to Social Marketing Planning

STELa
Scope, Test, Enact, Learn & act

Scoping Stage and scoping report:

1.0   The rationale:

- Sets out why action is needed on the identified social issue, the target audience and why they have been selected. Sets the action in the relevant policy context and within the overall strategic objectives of the project sponsor /s.

2.0   Situation Analysis

- SWOT: Organizational Strengths & Weaknesses and Environmental Opportunities & Threats

- Competition analysis/ Force Field analysis: List and assign weight to factors influencing adoption of the behavior including positive enabling factors and barriers to change.

- Literature review , what we know about how to tackle the issue

- Environmental scan of programs focusing on similar efforts: activities & lessons learned

- Asset mapping: recording of all social assets including: social networks, community assets, stakeholder analysis

ECOM

3.0   Target Audience Profile

- Size of target audience

- Primary audience (first priority, secondary audiences and tertiary audiences (These can often be intermediaries)

- Data analysis including : service up take data, demographics, geographics, relevant behaviors (including risk),

- Target audience insight, developed form qualitative and quantitative target audience research and psychographics.

4.0   Intervention Proposition

- Set out how and why the exchange in relation to the behavior change will be positioned with the target audience, how the benefits be maximized and costs reduced.

- In the case of non-rational choice situations set out how the choice environment will be structured, or what , policy or service transformation be introduced

5.0   Initial Marketing Objectives

- Cognitive objectives : measuring knowing

- Affective objectives: measuring beliefs and attitudes

- Psychomotor :measuring behavior

NOTE: OBJECTIVES SHOULD BE: **SMART: Specific, Measurable, Achievable, Relevant, Time bound**

Testing stage and report:

6.0   Marketing intervention Mix Strategies

- Which combination of the five intervention types will be used: 1 Inform, 2   Educate, 3 Support, 4 Control, 5 Design and how the 4 P's of marketing will be applied:

- Also set out what 'Form' of intervention wil be used:

    - Hug: High cognitive choice with a positive reward

    - Nudge: Low cognitive engagement with a positive reward

    - Shove Low cognitive engagement with a penalty

    - Smack: High cognitive engagement with a penalty

It can also be useful to think about: Product: the actual benefit people get form adopting the behaviour and also the physical objects or services offered to assist adoption. Price: Costs that will be associated with adopting the behavior and how they will be reduced and what Incentives and Disincentives will be used. Place, ensuring convenient access, opportunities to engage and attractiveness. Promotion, how the desired behavior will be promoted and through which channels.

6.2   Pre testing and piloting

- Methods used to test the interventions & timetable and plan for the pilot

6.3   Report on the impact of the pilot programme

- Reporting on impact, outcome, return on investment and efficiency

6.4   Full business plan setting out

- Final SMART objectives for the programme

- Recommended intervention and marketing mix

- Anticipated impact over designated time frame

- Resources required from main sponsors , partners and stakeholders

- How the budget will be applied

- How stakeholder and partners will be engaged

- Programme management and governance.

Enact

10.0   Plan for Implementation the programme including

- Programme time frame and key mile stones

- Recommended intervention mix and marketing mix

- Resources allocation to elements of the intervention and marketing mix

- Stakeholder and partner management plan

- Programme management and reporting plan,

- Evaluation and monitoring plan

Learn and Act

11.00 Evaluate and report

- Report to sponsors, stakeholders and partners
- Report to target audiences
- Report to professional audiences
- Record learning and share findings
- Review and build in learning to next wave of implementation

Social Marketing plan Template

For a full version of this guide see:

European Centre for Disease Control (ECDC) Technical Guide to Social Marketing (2014). French J, Apfel. http://ecdc.europa.eu/en/publications/Publications/social-marketing-guide-public-health.pdf

Scoping Stage and scoping report:

The rationale:

Why action is needed

(Problem statement)

Target audience selection (Why selected)

Need / Problem to be addressed

Seriousness

Social, economic health, wellbeing drivers

Policy driver

Ability to intervene

Numbers involved

Situation Analysis

- SWOT: Organizational Strengths & Weaknesses and Environmental Opportunities & Threats

Strengths in dealing with the issues,

Weaknesses, in dealing with this challenge

Opportunities:

Threats, issues that may make the situation worse)

Competition / Force Field analysis

(List possible factors, individual, organisations that may be promoting the problem behaviour or not supporting the positive behaviour you want to encourage, and then set out possible strategies for reducing this influence)

Competitor   **Possible action to reduce influence**

Factors influencing the behaviour:

Barriers

Enabling factors

(Give a weighting of 1 low – 5 high for each)

Literature review and field experience.

Summary of what is known from the literature about effective interventions).

Asset mapping

(List all current resources that could be brought to bear on the behaviour including organisations, individual's physical assets, services, budget, research capacity etc.)

Target Audience Profile

Size of target audience

Primary audience

(The behaviour you wish to influence)

Secondary audience

(People who directly influence the primary target audience behaviour)

Tertiary audience

(People who indecently influence the primary of secondary audience behaviour)

ECOM

Summary of key available data

(Demographics, service use, uptake, risk taking etc.)

Target audience insight

(Derived from qualitative and quantitative research about beliefs, attitudes and knowledge)

Primary abidance

Secondary audience

Tertiary audience

Intervention Proposition

> **How the exchange will be positioned with the target audiences,**
> (How the benefits will be set out and how the costs will be reduced)
>
>
> **Benefits** (How they will be reduced or increased)
>
>
>
> **Costs** (How they will be reduced or increased)

> **Non rational choosing**
>
> (In the case of non-rational choice situations set out how the choice environment will be structured, or what, policy or service transformation be introduced)

Initial Marketing Objectives

> ## List your objectives
>
> **Cognitive objectives:**
>
>
> **Affective objectives:**
>
>
> **Psychomotor objectives:**

NOTE: OBJECTIVES SHOULD BE: **SMART: Specific, Measurable, Achievable, Relevant, Time bound**

Testing stage and report:

Marketing intervention Mix Strategies

Set out which combination of the five intervention types will be used and which of the four forms of intervention will be used (Nudge, Hug, Smack, and Shove):

Inform (Nudge, Hug, Smack, Shove):

Educate (Nudge, Hug, Smack, Shove):

Support (Nudge, Hug, Smack, Shove):

Design (Nudge, Hug, Smack, Shove):

Control (Nudge, Hug, Smack, Shove):

Pre testing and piloting

Methods that will be used to test the interventions

(Include timetable and plan for the pilot)

Report on the impact of the pilot programme

> **How the pilot programme will report on impact, outcome, return on investment and efficiency.**

Full business plan setting out

Final SMART objectives for the programme

1

2

3

4

Etc.:

Recommended intervention and marketing mix

1

2

3

4

Etc.**:**

Anticipated impact over designated time frame

Measurable impact　　　　　　　　　**Date Achieved**

1

2

3

4

Etc.:

Resources required from main sponsors, partners and stakeholders

1

2

3

4

How the budget will be applied

Summary:

Intervention	Time frame	Budget

How stakeholder and partners will be engaged

Programme management and governance arraignments

Enact

Plan for Implementation the programme including

Final intervention mix and marketing mix:

Resources allocation to elements of the intervention and marketing mix:

Stakeholder and partner management plan:

Programme management and reporting plan:

Rick management plan:

Evaluation and monitoring plan:

ECOM

Learn and Act

Evaluate and report

How you will report to sponsors, stakeholders and partners to target audiences

How you will report to professional audiences
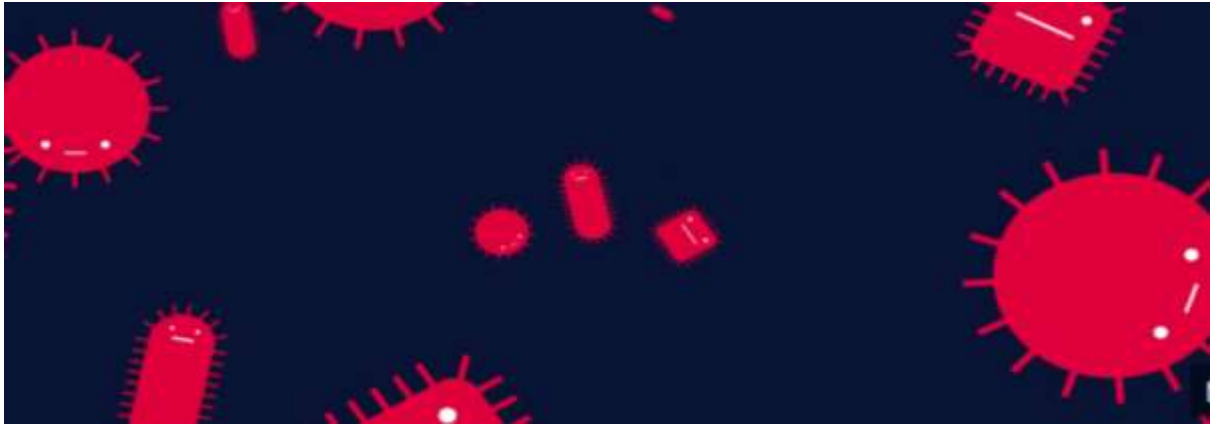

How you will record learning and share findings

How you will review and build in learning to next wave of implementation

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Additional notes notes

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