

A guide to tailoring health programmes

Using behavioural and cultural insights to tailor health policies, services and communications to the needs and circumstances of people and communities



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PDF



World Health
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European Region

Abstract

Some of the most persistent public health challenges are dependent on human behaviour. These include, among many others, overuse of antibiotics, use of tobacco and alcohol, suboptimal uptake of vaccination and cancer screening, lack of pandemic or sexual protective behaviours, and low adherence to treatment plans for diabetes and cardiovascular disease. These challenges place a weighty burden on health systems and on the health and well-being of individuals. They call for evidence-based action that draws on an understanding of these health behaviours and the cultural context in which they take place, and on engaging with those affected.

Using evidence, models and methods from behavioural and cultural sciences allows to tailor health-related services, policies and communication, thereby improving their outcomes. This guide offers an approach to do so, the Tailoring Health Programmes (THP) approach, and is aimed at public health units and experts who would like to apply behavioural and cultural insights (BCI) to health. The approach comprises four phases, each involving several steps, as well as a theoretical model and framework. An accompanying tool book offers inspirational ideas and exercises that complement the advice given in this guide. The THP approach can be applied to any health behaviour in any population group.

Keywords

HEALTH BEHAVIOURS
BEHAVIOURAL INSIGHTS
CULTURAL CONTEXT
HEALTH POLICIES
HEALTH SERVICES
HEALTH COMMUNICATION

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The origin of the Tailoring Health Programmes approach

This guide to Tailoring Health Programmes (THP) was developed by the Behavioural and Cultural Insights (BCI) Unit of the WHO Regional Office for Europe. It builds on the Tailoring Immunization Programmes (TIP) approach originally developed in 2012-13 for vaccination behaviours as well as subsequent versions adapted for antimicrobial resistance (TAP) and flu vaccination (TIP FLU).

A second TIP version was published in 2019, followed by a second TAP version in 2021. These second version documents were grounded in evidence and country experience from 12 countries within and outside the WHO European Region in the period 2013–2019 and an external evaluation conducted in 2018. Building on the lessons learned in this process, a generic version has been developed which can be applied to any health behaviour in any context.

Acknowledgements

Warm thanks go to the many people who have led the TIP, TAP and TIP FLU projects in countries and been instrumental in shaping the further development of the THP approach. Many people have contributed to the development and review of this document and previous versions, and deserve warm thanks for their time and contributions.

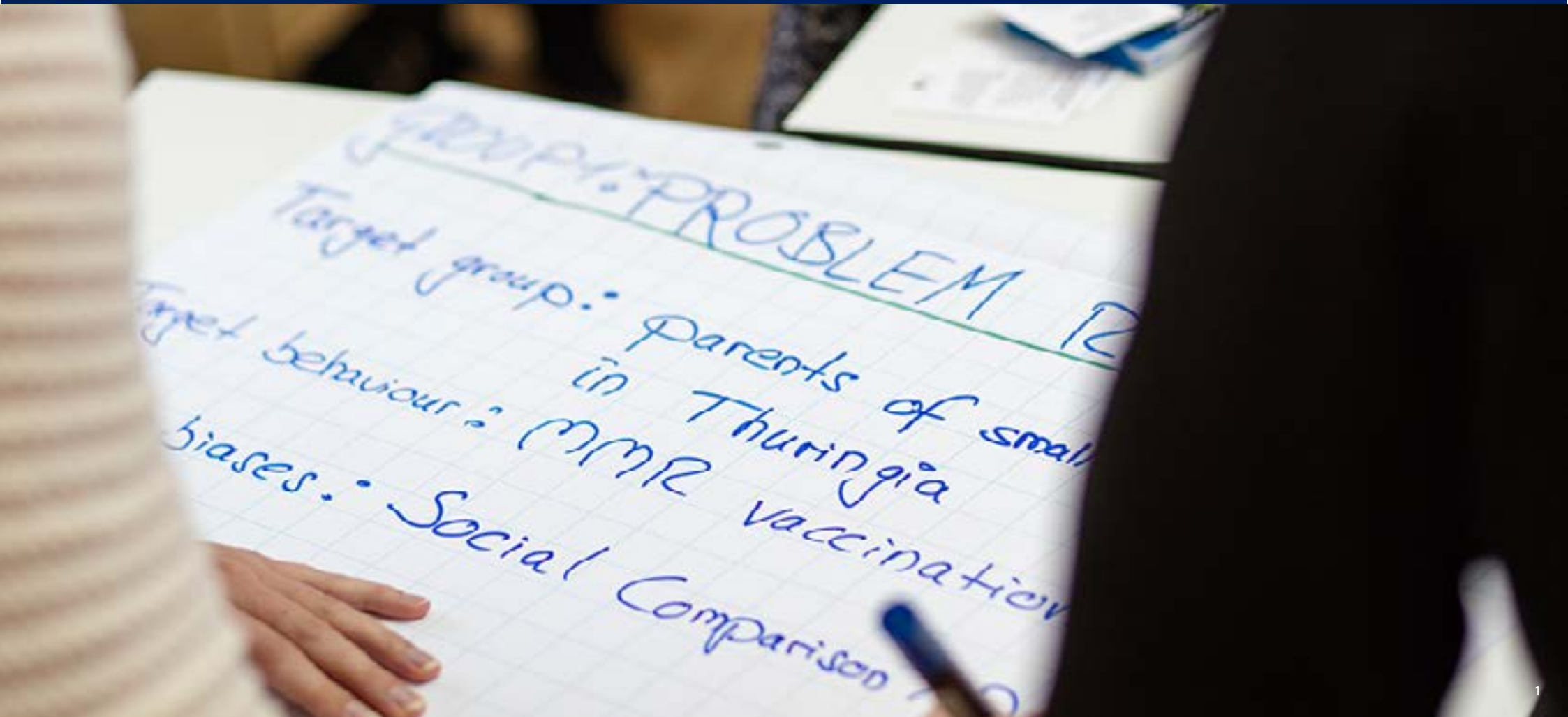
These include, but are not limited to Katrine Bach Habersaat, Robb Butler, Tiina Likki, Josefine Skou Jakobsen, Nils Fietje, Anastasia Koylyu, Pernille Jorgensen, Siff Malue Nielsen and Danilo Lo Fo Wong (WHO Regional Office for Europe) and Cath Jackson, Martha Scherzer, Marie Louise Wright, Anja Schreijer and Nathalie Likhite (WHO consultants).

Abbreviations

BCI	Behavioural and cultural insights
COM	Capability, Opportunity, Motivation
COM-B	Capability, Opportunity, Motivation – Behaviour
M&E	Monitoring and evaluation
PPG	Patient Participation Groups
THP	Tailoring Health Programmes

SECTION 1

Background



Introduction

Exploring the factors that affect health behaviours and using these insights to tailor interventions to the needs and circumstances of people and communities can contribute to better health and reduced inequity.

Some of the most persistent public health challenges of our time are dependent on human behaviour. These include – to name but a few – overuse of antibiotics, use of tobacco and alcohol, suboptimal uptake of vaccination or cancer screening, lack of pandemic or sexual protective behaviours, and low adherence to treatment plans for diabetes or cardiovascular disease.

These challenges call for evidence-based action that draws on an understanding of the health behaviours concerned and the cultural context in which they occur, and that engages with those affected.

Behavioural and cultural insights

Applying evidence, methods and models from behavioural and cultural sciences can help to address health challenges that involve human behaviour (1). The term behavioural and cultural insights (BCI) was coined by WHO Regional Office for Europe framing a comprehensive approach to health behaviours in which both individual and contextual factors affecting these behaviours are acknowledged and addressed. This approach is grounded in the notion that the responsibility for health behaviours lies with individuals, governments and health systems alike.

Two key elements of BCI are insights and evaluation:

- **Insights** are derived by exploring a given health behaviour, the people who engage (or do not engage) in this behaviour, and what affects them; they can be gained from published literature and studies conducted locally and from experts and

people with lived experience. Health behaviours are affected by many and very different factors, so evidence and methods from disciplines as diverse as psychology, sociology, behavioural economics, anthropology, political science and cultural studies can be drawn upon. Insights are used to tailor health policies, services and communication to the needs and circumstances of people and communities.

- **Evaluation** is conducted before broader rollout of an intervention to document its impact and to identify and address any possible negative unintended effects, as well as after wider implementation to document its long-term impact.

MORE BACKGROUND ON BCI

[European regional action framework for behavioural and cultural insights for health, 2022–2027](#). Copenhagen: WHO Regional Office for Europe; 2022.

[Case examples of applying behavioural and cultural insights \(BCI\) to health-related policies, services and communication processes](#). Copenhagen: WHO Regional Office for Europe; 2022.

The Tailoring Health Programmes approach

The Tailoring Health Programmes (THP) approach can be used to support the application of BCI for health. It can help develop new health-related policies, services and communication, or to improve existing ones.

The THP approach was originally developed for specific health programmes (vaccination and antimicrobial resistance). It has been continuously used and refined over 10 years in multiple countries (2–18), has undergone an external evaluation (19), and is now broadened for use in any health programme with the current guide.

At the core of the THP approach are a **process** of four phases, each with several steps, as well as a **theoretical model** and theory of change. These are described in detail in this guide. An accompanying [tool book](#) offers a rich collection of complementary inspiration boxes and exercises.

Who is this guide for?

The guide can be used by public health units and experts who would like to apply BCI for any health behaviour in any population group. The approach should be applied in an integrated manner alongside medical, epidemiological and health systems-related data and considerations.

Users may find it helpful to draw on other guidance documents in the process. A list of valuable resources, literature and tools is given in [Inspiration box 1](#) of the tool book.

Principles of the THP approach

The THP approach for applying BCI to health is based on eight underpinning principles (20).

- **Tailored** Acknowledging that the same measures will not be right for all, BCI work should support the tailoring of health-related policy, services and communication processes to meet different cultural, geographical, socioeconomic and health literacy-related needs and circumstances.
- **People-centred** Health policies, services and communication should be shaped by and respond to the needs, perspectives and conditions of the citizens, patients, health workers, caregivers, relatives and others involved and affected.
- **Equity-focused** BCI work should be designed to improve outcomes for everyone and all communities, with special concern for health inequities and those experiencing disadvantage, applying approaches that protect and promote equity, ethics, gender equality and human rights.
- **Participatory** BCI work should seek to empower and engage relevant people and communities, including through listening and co-design, thereby drawing on a range of experiences, expertise and perspectives and ensuring ownership and sustainability.
- **Evidence-based** BCI work should be informed by local and global evidence related to the psychological, cultural, social and structural influences health behaviour in any given context.

- **Multisectoral** BCI work should be integrated with biomedical and health systems approaches and data and should build on data and work from across sectors, such as those relating to social, cultural and educational matters, health literacy, employment, migration and housing.
- **Action-focused** BCI work should be actionable, relevant and applicable, to inform and improve health-related policies, services and communication.
- **Evaluation-informed** BCI work should be tested and evaluated to provide empirical evidence and inform improvements, scale-up and replication, using research-tested methods.

Theoretical model and framework

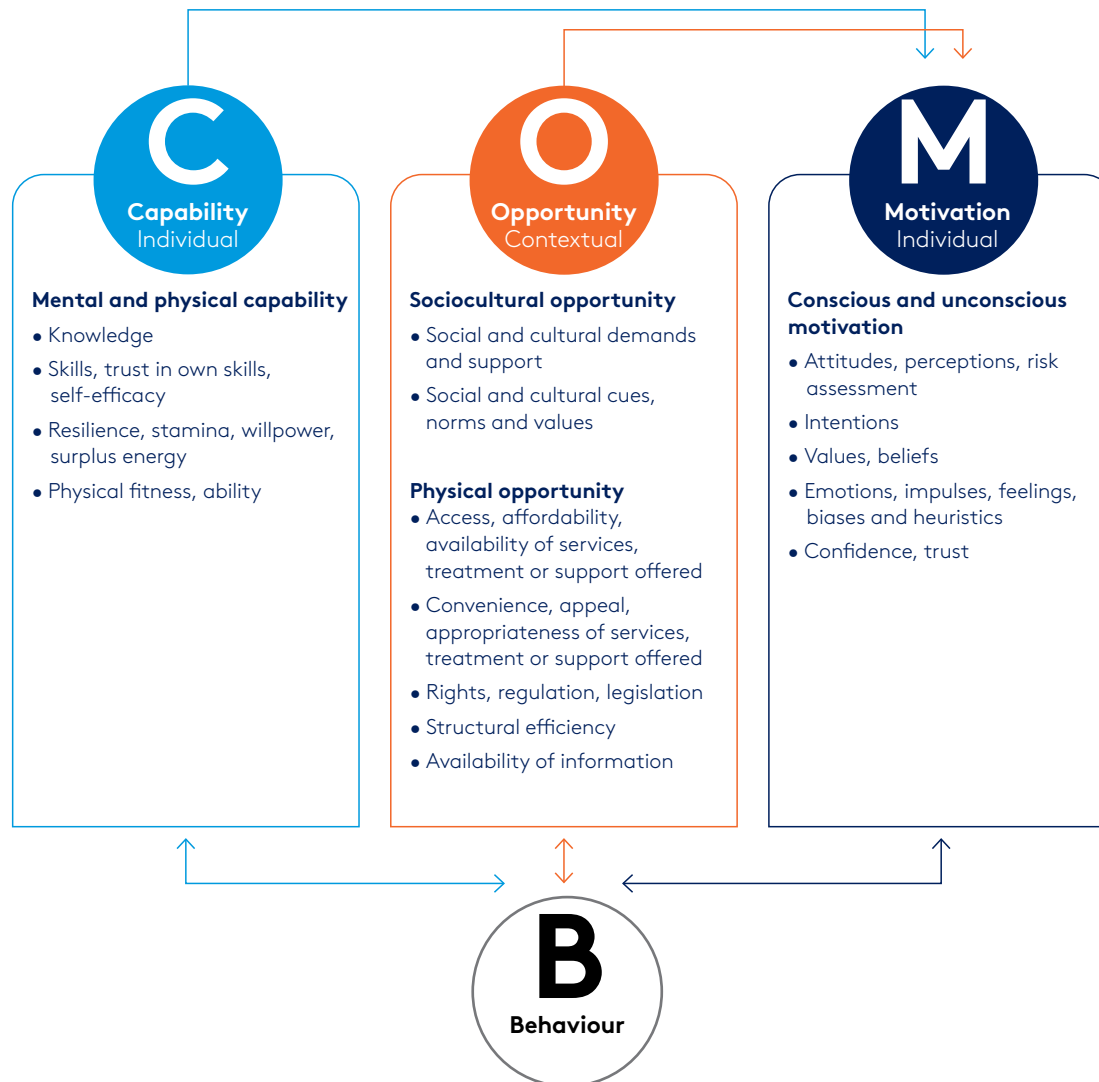
The theoretical model used in the THP approach is based on the COM-B model, which draws on 19 different frameworks of behaviour change (21). The model has been adapted to health and simplified to fit the THP approach (Fig. 1) (22).

The COM-B model was chosen because it acknowledges that behaviours are affected by a broad range of individual and contextual issues. Using the model helps to ensure that no barriers or drivers of behaviour are missed or overlooked. At the same time, the model offers a fairly simple system for structuring these many factors, which has proved useful for collecting and synthesizing data, as well as analysing them.

At the centre of the adapted COM-B model, there are three overall factors – capability, opportunity and motivation (COM) – that need to be in place for any health behaviour (B) to occur. Capability and motivation are individual factors; opportunity is a contextual factor and is split into two: sociocultural and physical. The factors interact, and motivation is affected by opportunity and capability. The dimensions under the three factors could act as either drivers of or barriers to health behaviours ([Inspiration box 9](#)).

In addition, the Behaviour Change Wheel, which is a framework for translating research into interventions (21), has been used as inspiration for developing the steps described in this guide and the exercises included in the [tool book](#).

Fig. 1. The COM-B model adapted to fit the THP approach (21,22)



Key concepts used in the guide

Health topic is the overall topic in focus. For example, the THP approach may be applied to topics such as alcohol, tobacco, hypertension, diabetes, HIV, tuberculosis, road safety and many other.

Health behaviour is any behaviour related to the health topic that affects people's health and well-being, in their daily lives and in their uptake of health services. Examples of such behaviours include individuals smoking, drinking alcohol and attending vaccination or cancer screening; patients adhering to treatment or attending check-ups; and health workers prescribing medications or communicating with patients appropriately.

- **Target behaviour** is the specific behaviour targeted in an intervention. Within a health topic, several health behaviours may be identified and addressed. For example, for hypertension, behaviours may relate to individuals at risk attending blood pressure screening prior to diagnosis; patients attending check-ups, changing lifestyle behaviours or taking medications appropriately; and physicians offering appropriate services and following up with their patients. For a THP project, it is important to define exactly which target behaviours are addressed for which target group.

Barriers and drivers are the factors that affect the uptake of the target behaviour in a negative or positive way. Barriers and drivers can relate to the individual (for example, to knowledge or perceptions) or to the context (for example, to social norms and

cultural context, or to health systems structures and legislation). Addressing the barriers and harnessing the drivers can make a health behaviour possible or more accessible, convenient, appropriate or attractive to the people affected.

People affected are individuals and groups who are affected by the health topic. It includes those who engage in the target behaviour and those who have an influence on its uptake. Depending on the situation, this may include people at risk of a particular disease; people receiving health services or medication, or caregivers of such people; a community targeted for intervention; health workers or staff at health facilities; and social workers.

- **Target group** is the specific population group whose behaviour is targeted in an intervention – for example, patients, caregivers or health workers. Often these groups are further defined by demographics (geography, age, gender, income, education), cultural traits (ethnicity, nationality, religion), professional group (doctor, nurse, social worker) or other.

Stakeholders are people with lived experience, expertise, insights or influence with respect to all of the above concepts. Stakeholders may include representatives of the people affected, interest groups, civil society and private entities, experts, representatives of national/subnational public health administration and planning, decision-makers, and many more.

SECTION 2

The THP process

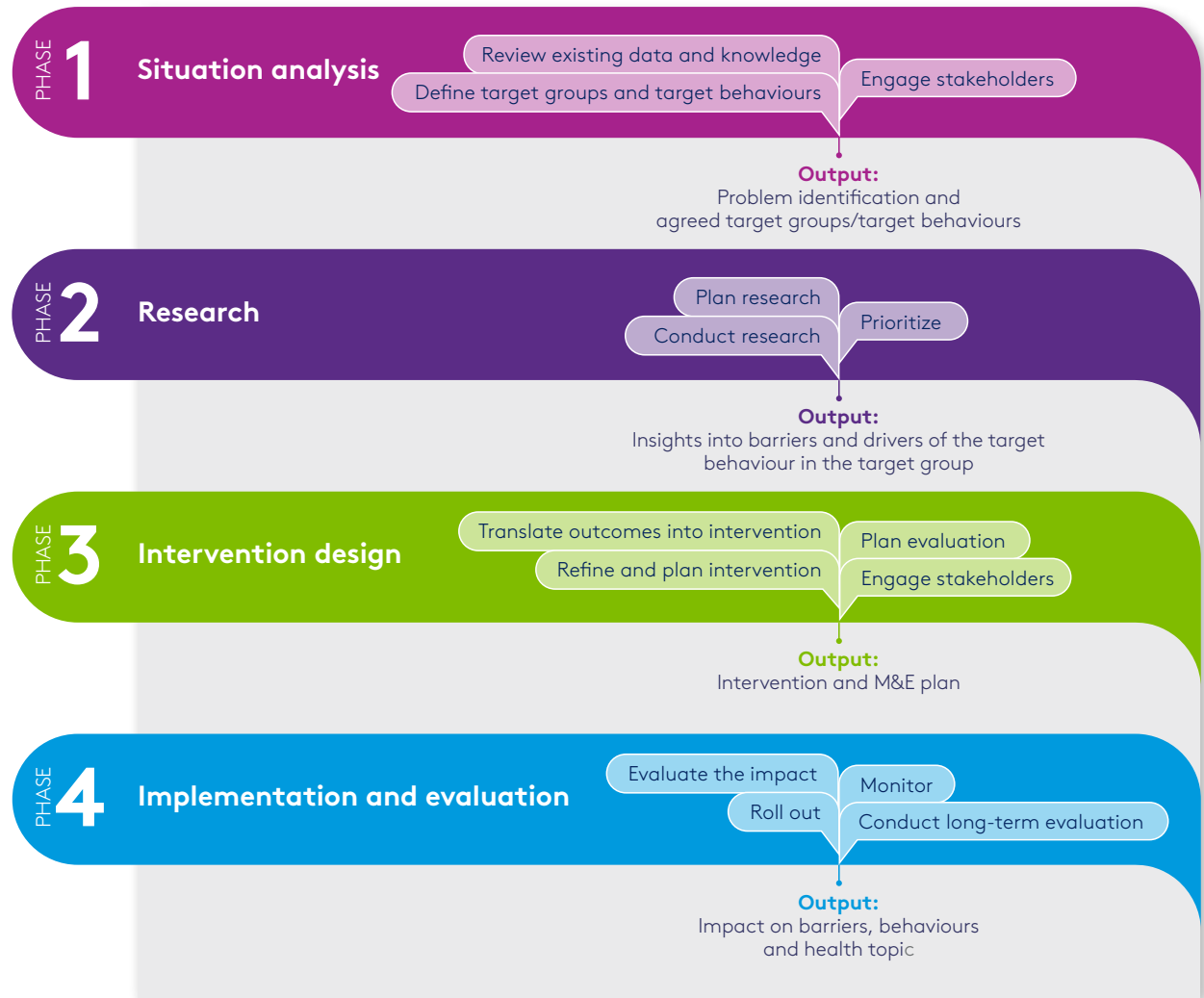


Phases and steps

The THP evolves over four phases with underlying steps. Each of the phases and steps is discussed in detail in the subsequent sections of this guide, and there are corresponding exercises and inspiration boxes in the [tool book](#).

The four phases of the THP approach each involves several steps (Fig. 2). While the steps are presented in this guide in a certain sequence, they are deliberately not numbered, as they may not take place in the same sequence each time and there may be overlap between them. The THP process is iterative, and those implementing it may jump back and forth between the steps in one phase before proceeding to the next.

Fig. 2. Phases and steps of the THP process



Theory of change

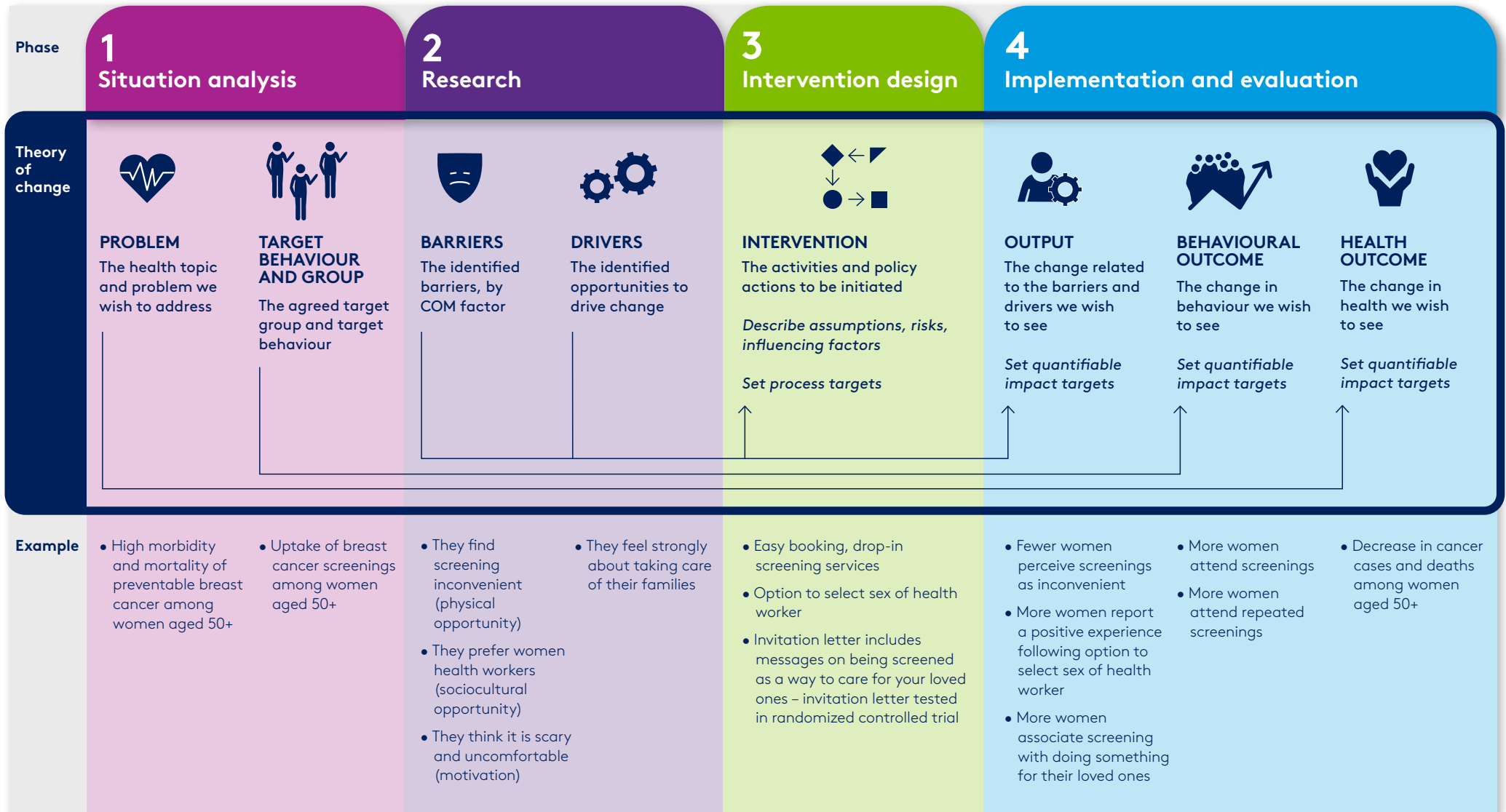
A theory of change shows how a desired change is expected to happen. In the THP approach, the theory of change is linked with the THP phases.

The phases and steps of a THP project together evolve over the course of the project into an evidence-informed theory of change. The theory of change explains how and why change will occur by describing and illustrating the process, including all the key elements from problem to solution and the connections between them (Fig. 3).

The theory of change thereby provides a clear and shared rationale of how and why a certain intervention will be effective and allows the theory to be tested. In the last phase of the THP project it is used for planning the monitoring and evaluation the intervention.



Fig. 3. Phases and steps of a THP project and the resulting theory of change, including example text



Planning a THP project



Considerations for planning

For a THP process to be successful, implementers must ensure that there are political/management will and support, funding available for all phases, and human resources available to lead and carry out the process for all phases. Particular consideration should be given to time, stakeholders, organization and funding.

Time needed to conduct a THP project

The time needed to conduct a THP project depends on the project and the human and financial resources available. All phases can be carried out rapidly (for example, in an emergency) if dedicated human and financial resources are allocated, or they may stretch over several months.

Stakeholders

Being participatory is a principle of the THP approach. Identifying relevant stakeholders and deciding how best to engage them depends on the context. Some will be actively engaged in the THP Core Group; others will be consulted via workshops or research interviews; others still will just need to be kept informed. [Inspiration box 2](#) in the THP tool book provides some ideas on which stakeholders to consult and engage.

Organization

A THP process may be organized by a THP Core Group, which engages other stakeholders at different stages in the process. A project lead within this group may be appointed to lead the project. A suggested model for organizing a THP project and engaging stakeholders is presented in Fig. 4

Budget

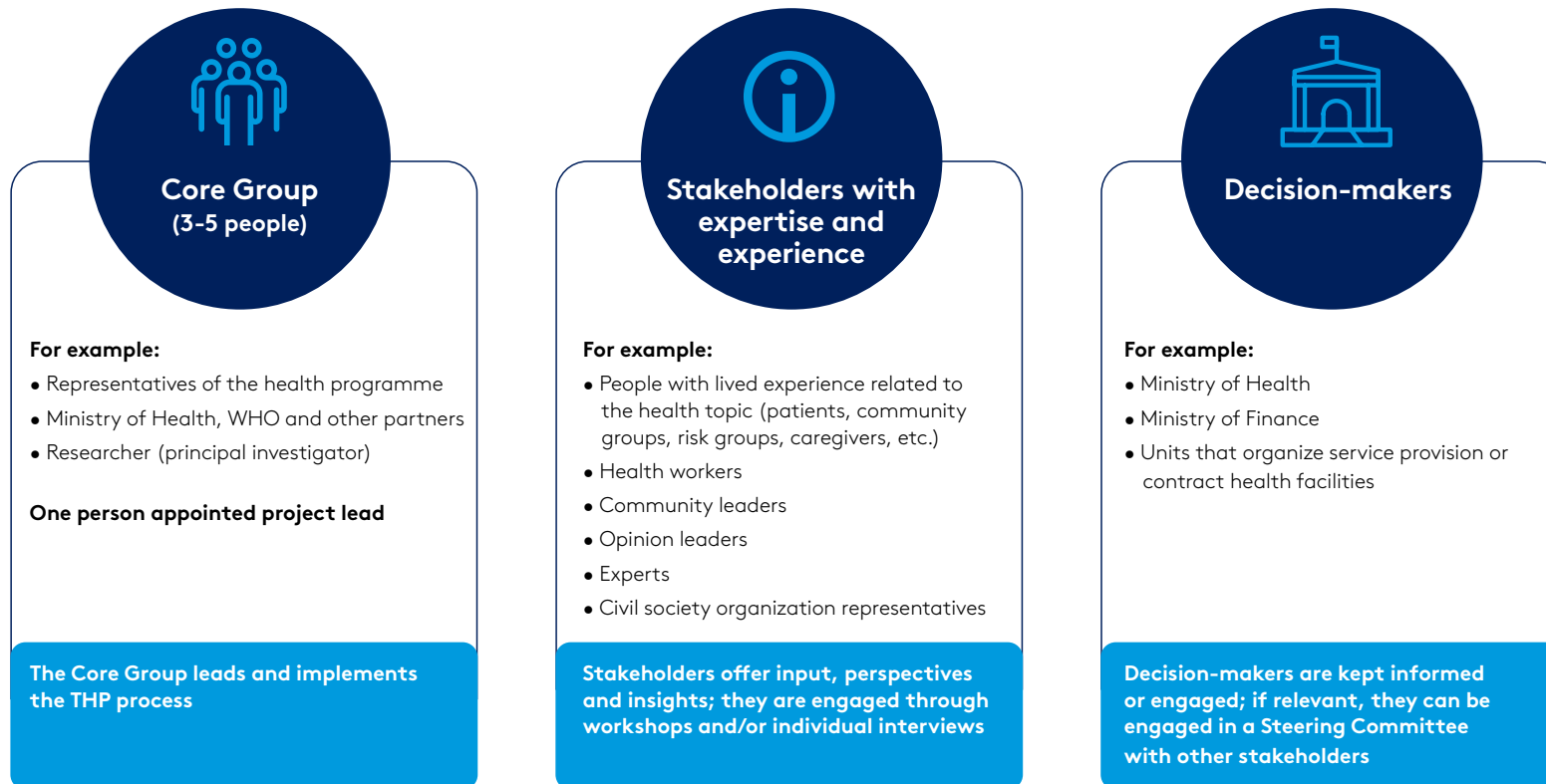
Costs may relate to the THP project itself and to the long-term sustainability of the intervention developed through this process ([Inspiration box 3](#)). When assessing whether the necessary financial resources are available, the THP Core Group needs to consider the cost of the following overall budget lines:

- stakeholder engagement, e.g. workshops
- Core Group engagement and meetings
- situation analysis
- literature review
- research study/studies
- evaluation
- ongoing and future implementation of the intervention.

The THP progress report as a tool

The ongoing development and progress of the THP process should be documented through a progress report, summarizing decisions, actions and conclusions for each phase ([Inspiration box 4](#)). The progress report is a working document that develops as the THP project progresses.

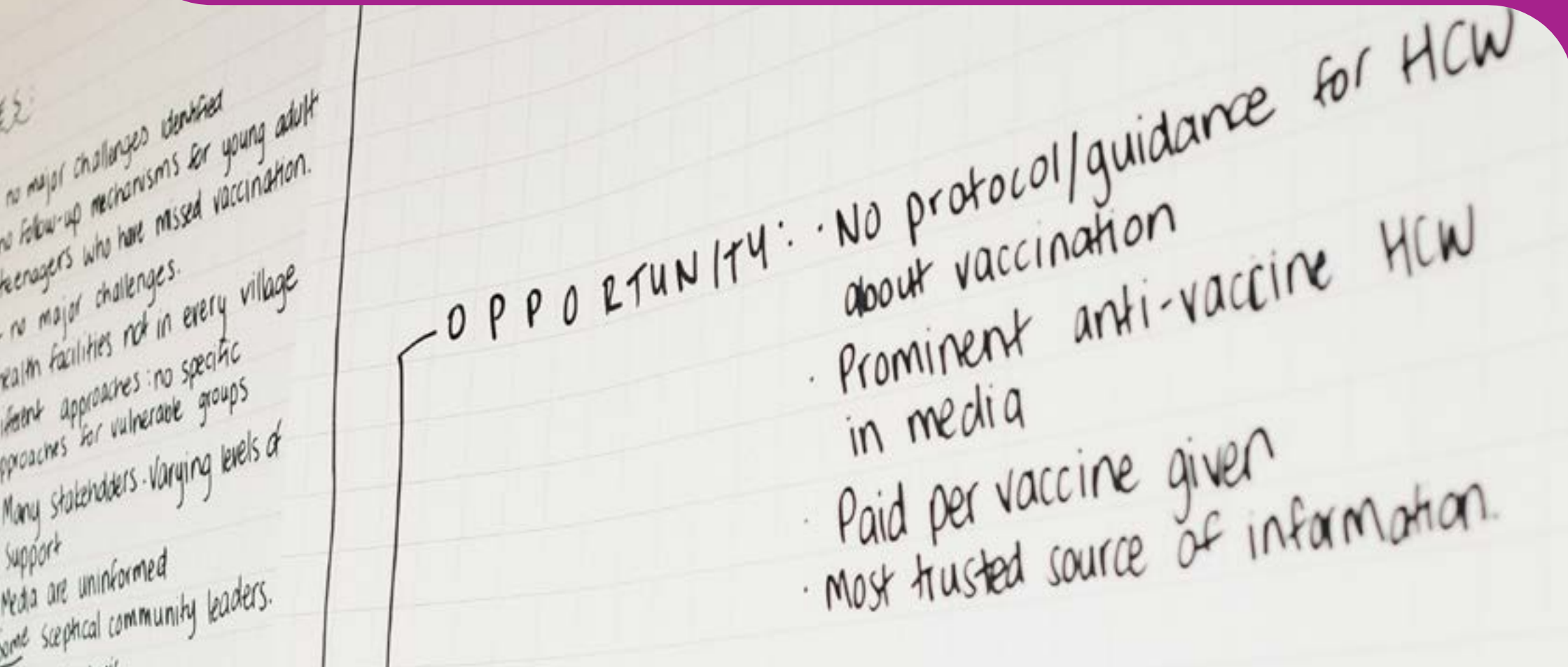
Fig. 4. Suggested roles for different kinds of stakeholders



PHASE

1

Situation analysis



PHASE 1 Situation analysis

Review existing data and knowledge

The objective of this step is to explore existing data and knowledge.

Gathering, analysing and synthesizing available data, insights and knowledge in a situation analysis report help the THP Core Group to make decisions that are evidence-informed.

A wide range of information sources can be explored, including disease surveillance data, population health data, lifestyle data, health service utilization data, equity analyses, evaluation reports for previous interventions, among others ([Inspiration box 5](#)).

The analysis of these data may reveal relevant geographical and sociodemographic patterns and insights related to specific population groups and health behaviours.

Being equity-focused is a principle of the THP approach, and special consideration should be given to social determinants such as income, education and ethnicity. Marginalized and underserved populations might be offered the same services as the majority population but have difficulties accessing or utilizing them.

Relevant literature may also be reviewed and synthesized in a (rapid) literature review to explore evidence on public health, behavioural science, the cultural context or other factors related to the health topic ([Inspiration box 6](#)).

OUTPUTS OF THIS STEP

- ✓ a situation analysis report with data summarized by the COM factors
- ✓ possibly a rapid literature review report with data summarized by the COM factors
- ✓ a situation analysis summary as a PowerPoint presentation, e.g. for use at a stakeholder workshop
- ✓ updated progress report



TOOLS AND GUIDANCE IN THE THP TOOL BOOK

[Inspiration box 5](#) offers guidance on the contents and data sources for a situation analysis

[Inspiration box 6](#) offers guidance on conducting a rapid literature review

PHASE 1 Situation analysis

Define target groups and target behaviours

The objectives of this step are to identify and further explore target groups and target behaviours and possible barriers and drivers, as well as to prioritize between these.

An initial mapping can be helpful to create an overview of relevant target groups, target behaviours, and possible barriers and drivers based on the situation analysis, previous reports, relevant literature and feedback from stakeholders (*Inspiration boxes 7-9; Exercise 1*). At this stage, both knowledge and assumptions are included, with a clear indication of what is currently only assumed.

A decision can then be made on which target group and target behaviour to prioritize, using impact, likelihood of change and spillover effects as the main criteria (*Exercise 2*).

Once one (or a few) target groups and target behaviours have been agreed, it is useful to go back and specify the target group in more detail, and to specify more clearly what the target behaviour consists of, and when and where it takes place (revisiting *Inspiration boxes 7 and 8*).

To provide inspiration and help in gaining a better understanding of target groups, at any point in this process the journey technique can be used to imagine the experiences and perspectives of an individual such as a patient or health worker (*Exercise 3*). This can be done to identify relevant target groups and target behaviours and/or to explore in more depth the experience, interaction, and barriers and drivers related to the target behaviour for a target group.

OUTPUTS OF THIS STEP

- ✓ a decision on target group and target behaviour
- ✓ an overview of possible barriers and drivers of the target behaviour in the target group (to be further explored in PHASE 2)
- ✓ an overview of knowledge gaps to be explored in research
- ✓ updated progress report



TOOLS AND GUIDANCE IN THE THP TOOL BOOK

Inspiration box 7 offers guidance on defining possible target groups

Inspiration box 8 offers guidance to identify behaviours related to the health topic

Inspiration box 9 introduces considerations for each of the COM factors and explains how they relate to barriers and drivers

Exercise 1 offers guidance on forming an initial overview of target groups, target behaviours, and barriers and drivers

Exercise 2 proposes a process for deciding on priority target groups and target behaviours

Exercise 3 proposes a process for imagining the experiences and perspectives of a person by using the journey technique

PHASE 1 Situation analysis

Engage stakeholders

The objectives of this step are to utilize stakeholders' expertise and experience to inform prioritization and planning, as well as to strengthen their ownership and support of the THP process.

Stakeholders may be engaged at any point during PHASE 1. Engaging stakeholders has several benefits. For instance, it helps to promote critical reflexivity, creates real-world and locally grounded knowledge, and may lead to ownership, buy-in and longer-term positive social change.

Stakeholders can be engaged in many ways ([Inspiration box 10](#)). Choosing which way to use depends on the social, political and cultural context, and may include individual meetings or a stakeholder workshop with group work (for example, using

Exercises 1, 2 and/or 3) and plenary discussion.

Presentations may cover:

- the health topic, challenges and goals (based on situation analysis)
- the THP approach and goals
- relevant evidence, for example from studies or reports with relevant conclusions.

Stakeholders may be divided into smaller groups, each of which discusses barriers and drivers for one target group and behaviour. Conclusions can be summarized in the THP progress report.

OUTPUTS OF THIS STEP

- ✓ stakeholder input and feedback
- ✓ updated progress report



TOOLS AND GUIDANCE IN THE THP TOOL BOOK

[Inspiration box 2](#) suggests stakeholders to engage
[Inspiration box 10](#) offers ideas on how to engage stakeholders
[Exercises 1, 2 and 3](#) can be used in a stakeholder workshop

PHASE

2 Research



PHASE 2 Research

Plan research

The objectives of this step are to agree on a focus for research and to develop a research protocol.

Building on PHASE 1 and the discussions concerning target groups and target behaviours, the THP Core Group can now agree on a set of research questions and develop a research protocol. The COM-B model (Fig. 1) can be used to inform the development of research questions and to structure the findings.

To develop the protocol, it is worth considering what is currently known, assumed and not known about the barriers and drivers of the target behaviour in the target group. In addition, consideration should be given to which study methods may be most appropriate to explore this question, how data will be collected and analysed, and which participants should be included (sampling) and how they will be recruited. It is also important to consider the timeline and budget for the research study, the roles and responsibilities within

the study team, and where ethical approval should be sought (*Inspiration boxes 11–13*).

As an alternative outcome of this step, the THP Core Group may have found that several relevant research studies to explore barriers and drivers have already been conducted; if so, they can go straight to PHASE 3.

OUTPUTS OF THIS STEP

- ✓ research protocol, time plan and budget
- ✓ ethical approval
- ✓ updated progress report

**TOOLS AND GUIDANCE IN THE THP TOOL BOOK**

Inspiration box 11 presents an overview of the different types of research study that may be conducted
Inspiration box 12 outlines the contents of a research protocol
Inspiration box 13 offers guidance on obtaining ethical approval

PHASE 2 Research

Conduct research

The objective of this step is to obtain insights into barriers and drivers of the target behaviour in the target group.

Research studies are carried out as determined in the research protocol. One study may focus on several target behaviours for one target group, or it focus on one behaviour for several different target groups.

The research study should aim to identify barriers and drivers of the target behaviour in the target group. For each target group and target behaviour, the barriers and drivers should be structured by capability, sociocultural opportunity, physical opportunity and motivation.

If relevant, the different target groups and target behaviours that were explored in the research study can be compared, and differences can be described.

OUTPUTS OF THIS STEP

- ✓ research report
- ✓ updated progress report including a summary of research findings by target group, with barriers and drivers structured by the COM factors



TOOLS AND GUIDANCE IN THE THP TOOL BOOK

Inspiration box 11 presents an overview of the different types of research study that may be conducted
Inspiration box 12 outlines the contents of a research protocol
Inspiration box 13 offers guidance on obtaining ethical approval

PHASE 2 Research

Prioritize target groups and target behaviours

The objective of this step is to make a final decision on which target groups and target behaviours to prioritize.

If the research phase identified several different subgroups among the target groups that need to be approached in different ways, it may be necessary to conduct an additional prioritizing exercise.

This can be done by developing an overview of the target groups (with each subgroup considered a target group in itself) and their barriers and drivers of the target behaviours, structured by the COM factors; and then discussing and agreeing on the most relevant target groups and target behaviours to focus on in the intervention (revisiting [Exercise 2](#)).

To help decide the journey technique may be repeated, now including the insights from the research ([Exercise 3](#)). This can help to revisit and explore in more depth the experience, interaction, and barriers and drivers related to each target behaviour for each target group.

OUTPUTS OF THIS STEP

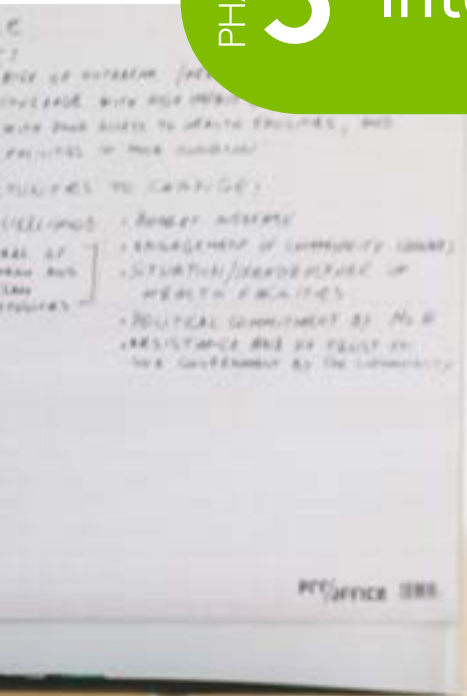
- ✓ a final decision on prioritization of target groups and target behaviours for the intervention
- ✓ updated progress report



TOOLS AND GUIDANCE IN THE THP TOOL BOOK

[Exercise 2](#) describes a process for making a final decision on priority target groups and target behaviours
[Exercise 3](#) proposes a process for imagining the experiences and perspectives of a person by using the journey technique

PHASE 3 Intervention design



PHASE 3 Intervention design

Translate outcomes into an intervention

The objective of this step, based on the outcomes of PHASES 1 and 2, is to identify an intervention with underlying activities.

Four exercises can be used to translate the outcomes of PHASES 1 and 2 into an intervention ([Exercises 4–7](#)). These exercises involve agreeing, for each target group and each target behaviour, priority barriers to address; the appropriate intervention type to address these barriers; and activities within this intervention. Each step in this process builds on the previous one ([Inspiration box 14](#)).

Barriers

It is necessary, first, to select the barriers that are most important to address for the target group ([Exercise 4](#)). Criteria for this include: which barrier has the most important impact on the behaviour; which barrier can realistically be changed; and which is most urgent to address. These barriers should then be linked to the COM factors, defining them in relation to capability, sociocultural opportunity, physical opportunity or motivation.

Intervention types

Intervention types that are appropriate to address these barriers can now be identified ([Exercise 5](#)). Specific intervention types are linked to COM factors by the Behaviour Change Wheel.

Activities

Once an intervention type has been agreed, brainstorming can identify a list of possible activities within this intervention ([Exercise 6](#)). These activities can be prioritized, using the criteria of feasibility (are they affordable, practicable and acceptable) and impact (are they effective, cost-effective and equity-focused?) ([Exercise 7](#)).

If several target groups and target behaviours have been agreed, these four exercises should be repeated for each of them.

OUTPUTS OF THIS STEP

- ✓ an overview of the relationship between the health topic, target group and target behaviour and the goal, COM factors, intervention types and activities
- ✓ a PowerPoint presentation for stakeholder workshop showing:
 - introduction to the THP project
 - outcomes of PHASES 1 and 2: results of the situation analysis, stakeholder input, research study findings
 - suggested intervention, linked with the outcomes of PHASES 1 and 2 (what, for whom and why)
 - a rough budget estimate for the intervention
 - topics to discuss with stakeholders
- ✓ updated progress report



TOOLS AND GUIDANCE IN THE THP TOOL BOOK

[Exercise 4](#) provides guidance on selecting barriers to target

[Exercise 5](#) provides guidance on identifying potential intervention types for the selected barriers

[Exercise 6](#) provides guidance on identifying possible activities within the intervention

[Exercise 7](#) provides guidance on prioritizing and further developing activities

[Inspiration box 14](#) shows example text for outcomes of Exercises 4–7

PHASE 3 Intervention design

Refine and plan the intervention

The objectives of this step are to take into account some overall considerations for the intervention and to develop a detailed project plan.

As part of refining and planning the intervention, some overall issues should be considered:

- **Lessons learned** Consulting experts and other countries that have implemented similar interventions and reviewing published evaluations of similar interventions can be used to refine the intervention ([Inspiration box 6](#)).
- **Psychological effects** Exploring whether various psychological biases may influence the motivation of the people affected can be used as a starting point for designing an intervention or to refine activities and messages ([Inspiration box 15](#)).
- **Policy action** Exploring whether different types of policy action are necessary for or can support the

implementation of the intervention can help to decide if such actions should be added to the intervention ([Inspiration box 16](#)).

- **Equity and diversity sensitivity** Revisiting and exploring possible issues relating to equity and diversity and cultural sensitivity can help to refine how communities are engaged and address such issues in the way the intervention is planned ([Inspiration box 17](#)).
- **Sustainability** Discussing the long-term sustainability of the intervention, including the human and financial resources available, supporting structures and political will, can help to refine activities and manage ambitions ([Inspiration box 18](#)).

All the activities that are decided on should be described in a project plan. A good project plan can help to ensure funding and successful implementation. The plan should include details on activities, policy actions, community engagement, budget, timeline, roles and responsibilities ([Inspiration box 19](#)).

OUTPUTS OF THIS STEP

- ✓ a detailed project plan for the intervention
- ✓ updated progress report



TOOLS AND GUIDANCE IN THE THP TOOL BOOK

- [Inspiration box 6](#) gives advice on conducting a literature review
- [Inspiration box 15](#) provides an overview of unconscious psychological effects
- [Inspiration box 16](#) gives guidance on policy action
- [Inspiration box 17](#) gives guidance on equity and diversity sensitivity
- [Inspiration box 18](#) offers considerations on sustainability
- [Inspiration box 19](#) explains how to construct a project plan

PHASE 3 Intervention design

Plan evaluation

The objectives of this step are to develop a theory of change and to prepare a monitoring and evaluation (M&E) framework for the intervention.

The theory of change describes the logic behind the intervention and describes all the elements that it comprises: problem identification, target group and target behaviour identification, barrier and driver identification, the intervention itself, intended outputs, behavioural outcome and health outcome (*Inspiration box 20*). It also includes influencing factors and underlying assumptions and risks. The theory of change is a helpful first step in developing an M&E framework as it provides an overview of what needs to be monitored and evaluated.

Monitoring and evaluation are two different concepts that together can help to define what has been done in an intervention and the effect that it has had.

- **Monitoring** involves tracking the progress of the intervention implementation through periodic data collection.

- **Evaluation** is a systematic inquiry to determine the effectiveness of the intervention.

M&E constitutes an ongoing process that should provide continuous feedback into project planning and implementation. It requires thoughtful consideration, planning and resources, but early efforts will yield long-term benefits.

The core of the M&E framework is a set of targets and indicators, an overview of baseline data, and guidance on data collection and analysis. It may also include considerations related to equity, cost-effectiveness and external influencing (confounding) factors (*Inspiration box 21*).

The M&E framework relates both to the implementation of the intervention, its quality, acceptability and use (process monitoring); and to the intermediate and long-term impact of the intervention (impact evaluation) (*Inspiration boxes 22 and 23*).

The M&E framework is developed before the intervention is piloted and describes data collection actions:

- before any intervention implementation (to create a baseline)
- during a pilot phase (to measure and assess the effects and acceptability of the intervention, to explore the reasons for its successes or shortcomings, and to highlight opportunities to adjust, improve and scale it up)
- after rollout (to document longer-term impact).

OUTPUTS OF THIS STEP

- ✓ a theory of change
- ✓ a detailed M&E framework to be added to the project plan
- ✓ updated progress report



TOOLS AND GUIDANCE IN THE THP TOOL BOOK

Inspiration box 20 provides guidance on developing a theory of change
Inspiration box 21 introduces the key concepts of monitoring and evaluation
Inspiration box 22 introduces process monitoring and evaluation
Inspiration box 23 introduces impact evaluation

PHASE 3 Intervention design

Engage stakeholders

The objectives of this step are to utilize stakeholders' expertise and experience to refine the intervention, and to strengthen their ownership and support of the planned intervention.

Stakeholders may be engaged at any stage during PHASE 3. Early engagement allows a greater level of co-creation of the intervention.

Stakeholders can be engaged in many ways ([Inspiration box 10](#)). Choosing which way one to use depends on the social, political and cultural context, and may include individual meetings or a stakeholder workshop with group work (for example, using [Exercise 7](#)) and plenary discussion.

The considerations presented above (lessons learned; psychological effects; policy action; equity and diversity sensitivity; and sustainability – see PHASE 3, STEP Design, refine and plan an intervention) can also be discussed with stakeholders.

It is also suggested that managers and decision-makers should be approached, as appropriate and feasible, so that the proposed intervention can be presented to them and their support obtained. Advocacy and engagement with key stakeholders should be implemented at all stages in the process from this stage onwards.

OUTPUTS OF THIS STEP

- ✓ input from stakeholders
- ✓ refined intervention based on feedback from stakeholders
- ✓ updated progress report



TOOLS AND GUIDANCE IN THE THP TOOL BOOK

[Inspiration box 2](#) provides an overview of suggested stakeholders
[Inspiration box 10](#) offers ideas on how to engage stakeholders
[Exercise 7](#) can be used in a stakeholder workshop

PHASE

4 Implementation and evaluation



PHASE 4 Implementation and evaluation

Evaluate the impact

The objectives of this step are to pilot test the intervention and evaluate its impact, as specified in the M&E framework.

The process of designing an intervention ideally involves an element of evaluating it on a smaller scale before broader rollout, to determine its impact as well as evaluate the process of implementing the intervention in specific contexts and with specific target groups.

This evaluation may involve experiments, trials or mixed methods approaches to evaluating the intervention.

The piloting and evaluation of an intervention are guided by the theory of change ([Inspiration box 20](#)) and the M&E framework developed in PHASE 3 ([Inspiration boxes 21-23](#)).

This process may even be seen as a way of gaining additional insights into barriers and drivers of the target behaviour in the target group, which can help to inform other efforts.

The evaluation should be used to adjust and refine the intervention before broader roll-out. If no impact can be shown, it may be necessary to return to PHASE 3 to develop a new intervention.

OUTPUTS OF THIS STEP

- ✓ final project plan and theory of change, adjusted on the basis of pilot and evaluation



TOOLS AND GUIDANCE IN THE THP TOOL BOOK

- [Inspiration box 20](#) provides guidance on developing a theory of change
- [Inspiration box 21](#) introduces the key concepts of monitoring and evaluation
- [Inspiration box 22](#) introduces process monitoring and evaluation
- [Inspiration box 23](#) introduces impact evaluation

PHASE 4 Implementation and evaluation

Roll out

The objective of this step is to roll out successful elements of the intervention more broadly.

How activities are rolled out depends on the success of the intervention so far and on the recommendations following the evaluation. Using the conclusions and recommendations from the evaluation, a stakeholder workshop may be considered at this stage as an opportunity to discuss the rollout of the intervention.

Scale-up and replication

In the longer term, consideration should be given to scaling up the intervention, which involves broadening it to include additional target groups or additional geographical areas. This may involve replication, where the impact of the intervention is evaluated in a different target group or geographical area to assess whether the findings from the pilot evaluation are replicated.

Tailoring the intervention

A successful intervention may also be tailored to address other health behaviours or health topics with the same or another target group. As the intervention was based on insights relating to a specific target group, a specific health topic and a specific health behaviour, PHASES 1-3 of the THP process should be revisited to ensure that tailoring is appropriate to the new circumstances.

OUTPUTS OF THIS STEP

- ✓ project plan for rollout finalized
- ✓ final project plan implemented

PHASE 4 Implementation and evaluation

Monitor

The objective of this step is to obtain evidence on the extent to which the intervention is being implemented and on its quality, following broader rollout.

Monitoring the process allows to evaluate, understand and document the implementation of an intervention. The data may relate to the quantity, extent, quality, acceptability and use of activities ([Inspiration box 22](#)). Monitoring and evaluating the process is additional to evaluating the impact of an intervention, not a substitute for it.

Many different types of data can be relevant to monitor the implementation of the intervention, including from registers, from activity reporting and from surveys with those affected by the intervention.

The M&E framework includes a description of what data are collected and how, in order to monitor the process. Guided by this, monitoring can be done regularly throughout the implementation process ([Inspiration box 21](#)).

OUTPUTS OF THIS STEP

- ✓ regular analysis of the data collected
- ✓ conclusions regarding the implementation of the intervention
- ✓ recommendations for improving the intervention



TOOLS AND GUIDANCE IN THE THP TOOL BOOK

[Inspiration box 21](#) introduces the key concepts of monitoring
[Inspiration box 22](#) introduces process monitoring

PHASE 4 Implementation and evaluation

Conduct long-term evaluation

The objective of this step is to understand the effects of the intervention in the longer term, for whom it has an effect, why and in which context.

The evaluation, which aims to assess whether targets have been reached, is guided by the theory of change ([Inspiration box 20](#)) and the M&E framework ([Inspiration boxes 21–23](#)). To do so, data are collected and analysed to measure progress on both process and impact indicators. Data collection methods can be quantitative or qualitative, and different methods may be used to supplement each other. A range of frameworks exist for evaluating health interventions (23–30).

When evaluating the impact of the intervention, it is recommended to consider the **outputs** (any changes related to the barriers and drivers identified), the **behavioural outcome** (any change in target behaviours) and the **health outcome** (any change related to the health topic ([Inspiration box 23](#))).

Consideration should be given to documenting any possible impact on health equity in the evaluation. It may also be considered whether an economic evaluation to document the intervention's cost-effectiveness should be carried out; this could help to secure long-term funding to sustain the intervention. Lastly, the broader unintentional effects of the intervention can also be explored – for example, positive or negative effects on the well-being, trust or feeling of social cohesion among people affected by the intervention (23) ([Inspiration box 21](#)).

OUTPUTS OF THIS STEP

- ✓ an analysis of the data collected
- ✓ conclusions on the impact, effectiveness and cost-effectiveness of the intervention
- ✓ recommendations on opportunities for continuation and scale-up



TOOLS AND GUIDANCE IN THE THP TOOL BOOK

[Inspiration box 20](#) provides guidance on developing a theory of change
[Inspiration box 21](#) introduces the key concepts of monitoring and evaluation
[Inspiration box 22](#) introduces process monitoring and evaluation
[Inspiration box 23](#) introduces impact evaluation

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Tool book



INSPIRATION BOX 1

Resources, literature and tools



Planning a THP project

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INSPIRATION BOX 2

Suggested stakeholders to consult and engage



Planning a THP project

PHASE 1

Engage stakeholders

PHASE 3

Engage stakeholders

Relevant stakeholders include those with expertise and lived experience in a wide range of areas, including the health topic, health behaviours, target groups, and health systems and services. Some suggestions are included in Table 2.1.

Table 2.1. Potential stakeholders and their areas of expertise

Area of expertise	Potential stakeholders
Health programme	<ul style="list-style-type: none"> • health ministry • institute of public health • departments responsible for the health topic, health promotion, health equality, health data, evaluation, behavioural and cultural insights, etc. • district and municipal health authorities • national health institutes/institutions • centres for specific diseases or disease areas • experts within the health topic
Health service provision	<ul style="list-style-type: none"> • health and care workers: doctors, nurses, social workers • medical faculties • professional associations
People and communities affected	<ul style="list-style-type: none"> • people with lived experience • representatives of patients, caregivers, risk groups • community representatives and leaders • interest organizations, e.g. related to specific diseases • nongovernmental organizations • community organizations or groups • community charity organizations • local health workers • experts with specific knowledge of the community
Research methods and approaches	<ul style="list-style-type: none"> • researchers • research institute (private or university-based) • staff in health ministry or institute of public health
Other potentially relevant areas	<ul style="list-style-type: none"> • ministries responsible for education, poverty, children, social affairs • national institutions or institutes involved in education, poverty, children, social affairs, etc. • international organizations and partners

INSPIRATION BOX 3

Costs related to a THP process



USE FOR Planning a THP project

The budget for a THP process may include a variety of line items as shown in Table 3.1.

Table 3.1. Line items typically appearing in a THP budget

Item	Costs
THP Core Group fees	Potentially fees for 3–5 people for a period of one year or more
THP Core Group meetings (5–10 meetings with 3–5 people)	Venue, catering Transport Translation Printing documents
Stakeholder workshops (2–3 workshops with 10–30 people)	Venue, catering Transport Translation Printing documents
Research (one or more studies)	Fees for researcher(s) (research company or institution) Costs related to implementation of studies, such as: <ul style="list-style-type: none"> • protocol writing • submission to ethical review • training of data collectors and analysers, if necessary • data collection (surveys, focus groups, in-depth interviews, observations) • participant fees • data analysis • report writing and layout • writing paper for peer review
Implementation of the intervention – activities, evaluation and scale-up	Costs related to piloting of intervention, including: <ul style="list-style-type: none"> • development of activities (e.g. new policy, new health services, new guidelines, new training curricula) • implementation (small-scale) • evaluation (e.g. randomized controlled trials, observations, interviews, data analysis) Costs related to rollout of activities, including: <ul style="list-style-type: none"> • running costs • monitoring • evaluation
Advocacy	Printing, distribution of materials Dissemination of results Open access fees for journals Meetings, webinars, other

INSPIRATION BOX 4

Suggested contents of a THP progress report



Planning a THP project
All steps of the THP project
(update after each step)

The progress report documents every step of the project. Suggested contents are outlined below. It is a working document that develops as the THP project progresses. This means all elements before PHASE 1 are added at the initiation of the project, while subsequent elements are added as the project unfolds.

- Background
- Brief overview of THP approach (e.g. theoretical model and framework, phases and steps, Core Group members, key stakeholders)
- Health topic and problem, including key data
- Timeline
- Budget
- PHASE 1: Situation analysis
 - Review of existing data, studies and literature
 - Consultation with stakeholders
 - Identified target behaviour and target group
 - Planning research
- PHASE 2: Research
 - Studies conducted: aims, target group, research questions, methods
 - Research findings
 - Final decisions/refinement re target behaviour and target group
- PHASE 3: Intervention design
 - Agreed intervention and how it links with the findings of PHASES 1 and 2
 - Design and planning the intervention
 - Consultation with stakeholders
 - Planning the monitoring and evaluation framework
- PHASE 4: Implementation, evaluation, adjustment, scale-up
 - Implementation of planned activities and policy actions
 - Monitoring of pilot
 - Evaluation of pilot
 - Adjustment of activities and policy actions
 - Scale-up
 - Monitoring following rollout
 - Long-term evaluation
- References

INSPIRATION BOX 5

Contents and sources of data for a situation analysis



PHASE 1

Review existing data and knowledge

Synthesizing available data in a situation analysis report supports evidence-informed decision-making. This box proposes possible sources of data and contents of a situation analysis report and offers some considerations how data can be structured in the report.

Suggested sources of information

The following data and information sources (among many others) can be reviewed:

- previous surveys or studies conducted locally and related to health, to the health topic or to a relevant population group;
- relevant mortality and morbidity data, disease surveillance and outbreak data;
- health service utilization data;
- data on the use of medicines and vaccines;
- population health data;
- lifestyle data;
- the Global Health Observatory;
- multiple Indicator Cluster Surveys;
- demographic and health surveys;
- strategies and action plans related to the health area or relevant population groups;
- equity analyses;
- legislation related to the health area and relevant population groups;
- reports and evaluations of previous initiatives conducted;
- reports, recommendations and assessments from national and international organizations related to the health area or relevant population groups;
- media coverage related to relevant population groups and health behaviours;
- peer-reviewed publications.

Proposed contents of a situation analysis

The scope of the situation analysis depends on the health topic, the health behaviour and the context. The following topics may be considered.

Background related to the health topic

- Introduction to diagnoses and treatments
- Relevant definitions related to the health topic
- Data on morbidity and mortality related to the health topic; broader implications on health and well-being; economic implications, including national and global data

People affected

- Identified challenges as regards behaviours related to the health topic
- Population groups affected, including current health behaviours and current engagement with the health system
- Social, religious, cultural dynamics among population groups affected
- Evidence on affected population groups' perceptions, well-being, health literacy, knowledge, skills and trust
- Evidence on health workers' perceptions, well-being, health literacy, knowledge, skills and trust

Equity

- Access and utilization of services, care and support related to the health topic in different population groups
- Socioeconomic, cultural, demographic, linguistic or other factors that may create inequity

Legislation and regulation

- Relevant rules and regulations related to the health topic
- Identified challenges as regards legislation related to the health topic

Health system

- Health system governance related to the health topic, including roles and responsibilities across national and subnational levels and various (health) institutions
- Services, support mechanisms, care and management related to the health topic (provided by whom, where and how often), as well as human resources and financing mechanisms for these
- Identified challenges as regards health systems or services related to the health topic

Interventions

- Insights from published literature on relevant interventions and evaluations (see also [Inspiration box 6](#))
- Evaluations and lessons learned from previous projects in the country

- Evaluations and lessons learned from successful interventions in other areas of health, or in other countries, which may be tailored and replicated

Stakeholders

- Overview of stakeholders who should be consulted (see also [Inspiration box 2](#))
- Existing coalitions and collaborations

Data synthesis and presentation

It is recommended that the data and insights are presented under the headings outlined above, and then summarized in a structure determined by the COM factors:

- **Capability:** evidence related to knowledge and skills among the people affected
- **Sociocultural opportunity:** evidence related to social and cultural dynamics, norms and support among the people affected
- **Physical opportunity:** evidence related to the health system, legislation, structures and health service provision
- **Motivation:** evidence related to perceptions, beliefs, trust and emotions among the people affected.

For each COM factor, the data and insights may be substructured by different target groups.

For each of the four factors, note if there are knowledge gaps, or if the data and insights included are based on assumptions and may need to be explored in a study.

INSPIRATION BOX 6

Rapid literature review



USE FOR

PHASE 1

Review existing data and knowledge

PHASE 2

Refine and plan the intervention

A rapid review is a form of evidence synthesis that allows outcomes and insights from literature to be summarized and described with respect to the health behaviour itself, identified barriers and drivers of the health behaviour, successful and less successful interventions and lessons learned.

To identify relevant published literature, a range of databases are searched using agreed search words related to the health behaviour. Databases may include PubMed, CINAHL, PsycINFO, GACD, Cochrane Library and Embase, among others. Some limits to the search may be agreed – for example, related to date, language, type of study design or geography.

Unpublished (grey) literature may also be included, such as reports from the Ministry of Health, WHO or other partners. To explore cultural contexts in greater depth, the literature review may include a review of historical research and even local newspapers and literary and other cultural outputs.

Identified articles are screened for relevance by one or two reviewers. Upon screening of the articles, common themes can be identified, structured according to the focus of the review (research questions) and to the factors in the COM-B model:

- capability (individual), such as knowledge and skills
- sociocultural opportunity (contextual), such as social norms and dynamics and the cultural context
- physical opportunity (contextual), such as systems, structures and service provision
- motivation (individual), such as psychological factors and biases.

Study design types, population subgroups, intervention types and target behaviours may also be used to structure themes. Useful tools in this process may include EndNote (for citation) and NVivo (for thematic coding).

If extra quality assurance and rigour are required, risk-of-bias assessments and peer review of the findings can be conducted.

A narrative summary report with key findings can then be prepared, including considerations on how the findings are relevant to the context and recommendations. For interventions, effect sizes may be mentioned to indicate how great an impact certain interventions can be expected to have. Summary tables presenting all relevant articles can be prepared for an overview. A PowerPoint presentation with key findings and recommendations may also be prepared.

FURTHER GUIDANCE

For more guidance on rapid literature reviews, see: [Rapid reviews to strengthen health policy and systems: a practical guide](#). Geneva: World Health Organization; 2017.

Garrity C, Gartlehner G, Nussbaumer-Streit B, King VJ, Hamel C, Kamel C, Affengruber L, Stevens A. [Cochrane Rapid Reviews Methods Group offers evidence-informed guidance to conduct rapid reviews](#). J Clin Epidemiol; 2021.

INSPIRATION BOX 7

Identifying relevant target groups



PHASE 1

Define target groups and target behaviours

PHASE 2

Prioritize target groups and target behaviours

Identifying relevant target groups involves considering the following questions.

- Who may need to change their health behaviour? People in risk groups, patients, caregivers, health workers, social workers, peers, influencers, others?
- Who are the particular at-risk groups related to the health topic?
- How can they be grouped?
For example, according to:
 - disease status (diagnosed, undiagnosed, different diagnoses);
 - lifestyle behaviours (different groups of users, long-term use, short-term use);
 - individual factors (age, gender);
 - socioeconomic factors (social group, income, education, employment, family size);
 - geography (subnational entity, rural/urban, country size, population density, climate);
 - community/cultural factors (appropriate and self-identified categories of cultural, religious, political, community, lifestyle affiliation);
 - professional group (family doctors, specialists, nurses, social workers).

Using the journey technique ([Exercise 3](#)) may help to identify and group relevant target groups.

INSPIRATION BOX 8

Identifying behaviours related to the target group



PHASE 1

Define target groups and target behaviours

PHASE 2

Prioritize target groups and target behaviours

Once the possible target groups have been identified, relevant behaviours related to the health topic can be mapped. The following considerations can be taken into account.

Be specific and detailed

Be as specific as possible and break down overall behaviours into specific behaviours. For example, for antimicrobial resistance, behaviours may relate to:

- prescribing (health workers, veterinarians)
- sale (pharmacists)
- use (patients).

Each of these behaviours may be broken down into specific behaviours. For a patient's use of antibiotics, there are several specific behaviours:

- taking the antibiotics as prescribed;
- always using antibiotics for treatment, and never as a preventive measure;
- always buying antibiotics with a prescription, and never over the counter without prescription;
- only using antibiotics for own use, and never sharing them with family or friends;
- trusting a doctor's diagnosis and treatment, and not putting pressure on them to prescribe antibiotics.

Consider and define what needs to happen in relation to the health behaviour: it may need to be initiated or stopped; its frequency may need to be reduced or increased; or its duration, intensity or form may need to change.

Focus on behaviours

Distinguish between outcomes and behaviours, and include only behaviours. For example, in the case of prescribing antibiotics, examples may be:

- behaviour: communicating with the patient in an appropriate and respectful way;
- outcome: increased trust;
- behaviour: reducing inappropriate prescribing;
- outcome: reduction in drug resistance.

Using the journey technique ([Exercise 3](#)) may help to identify relevant target behaviours.

INSPIRATION BOX 9

Using the COM-B model to explore possible barriers and drivers



PHASE 1

Define target groups and target behaviours

The COM-B model can be used to identify possible barriers and drivers related to the health topic. Below is an overview of considerations related to each factor.

Capability

Capability relates to the mental and physical ability and capability of an individual to engage in the health behaviour. Key factors relate to the person's knowledge and skills and their personal resilience, stamina, willpower and surplus energy. Their self-perceived ability and skills also play an important role, as do their physical fitness and ability to engage in the health behaviour.

Issues that may be explored:

- Do people in the target group have the necessary knowledge of the health topic and risk factors?
- Do they have the necessary knowledge related to the health services provided and support opportunities available?
- Are they physically able to engage in the health behaviour?
- Do they have the willpower and surplus energy required for the health behaviour?
- Do they understand the language in which information is provided (literacy)?
- Do they understand risk as numbers, percentages or probabilities (numeracy)?
- Are they able to plan for the health behaviour to take place?
- Are they confident in their own ability to plan and engage in the behaviour?
- How (un)familiar is the health service they are being offered?

Sociocultural opportunity

Sociocultural opportunity relates to the context in which the health behaviour takes place. Key factors relate to cultural traditions and cues, norms, values and beliefs, social demands, and social support. The social dimension can relate to the family or wider community or to the social support provided in the health system, for example by a health worker.

Issues that may be explored:

- Are people in the target group part of a community with particular positions or beliefs (e.g. religious, online, philosophical) related to health?
- Do their community leaders (religious, political, social) support the health behaviour?
- Do their family, friends and workplace provide the support they need to engage in the health behaviour?
- Do health workers provide the support they need to engage in the health behaviour?
- Do they feel that their community is respected by health workers and the health system?
- What is the level of social acceptance of the health behaviour? Is it a social norm and expectation?
- What are the cultural practices related to the health behaviour? Do historical factors play a role in the health behaviour?
- Do their peers engage in the health behaviour? Do they think that their peers do so?

Physical opportunity

Physical opportunity relates to the structural, legislative and health systems-related context in which the health behaviour takes place. Key factors relate to access, affordability and availability of services, treatment, support and information in the health system; also important are the convenience, appeal and appropriateness of these services and the structural efficiency of the way in which they are delivered. The legislative framework, including rights, regulation and legislation, is also an important factor.

Issues that may be explored:

- What is the experience of people in the target group of how easy and safe it is to travel to service locations?
- What is their experience of the direct and indirect costs involved?
- Are health services and support available at convenient times and easy to book?
- How do they feel about the comfort level in health facilities? (e.g. What are the waiting areas like? Are they child-friendly? Are there breastfeeding facilities?)
- Are health services delivered in a nondiscriminatory, gender-equal way?
- What rights do they have according to national laws? And what duties and responsibilities?
- Do they have free and equal access to health services? What is required (e.g. identity card, address in approved area) and does everybody have access to these?

- Do they have to sign a consent form? Are they comfortable with this?
- Are effective call and reminder systems in place? Are they implemented properly?
- Are health workers properly trained?
- Is relevant accessible and trustworthy information available to them?
- Has the official information about the health topic been tested for understanding and user-friendliness?
- Are there competing physical opportunities at play (leading to a scarcity of time or other resource)?

Motivation

Motivation is a broad category (broader than the everyday use of the word) related to both conscious and unconscious factors that affect an individual's mental impetus to engage in the health behaviour. Key factors relate to the individual's attitudes, perceptions, intentions and risk assessment with respect to the health topic and behaviours, and to their underlying values and beliefs. Unconscious factors such as emotions, impulses, feelings, biases and heuristics also play a role, as do their levels of confidence, trust, etc.

Issues that may be explored:

- Do people in the target group believe that the health behaviour is associated with any risk?
- How do they perceive sickness and health, and a healthy lifestyle?

- Does the health behaviour represent a positive value for them?
- Do their attitudes and values about disease and prevention align with the health behaviour?
- Is alternative medicine in line with their values and worldview?
- Which beliefs (e.g. religious or lifestyle-related) influence their intentions and behaviours?
- Have they made a decision (is it their intention) to engage in the health behaviour?
- Do they trust health workers? Health authorities? Science, scientists and scientific medicine?
- Which emotions influence their health behaviours? (e.g. fear, concerns)
- Are any of their behaviours habitual? (Do they occur without intention and conscious attention?)
- Are there any identified biases or heuristics that may affect their perceptions or behaviours ([Inspiration box 15](#))?

INSPIRATION BOX 10

Stakeholder engagement



USE FOR
All phases of the THP project

Stakeholder engagement is an organization's effort to understand and involve stakeholders and their experiences, perceptions and concerns in its activities and decision-making processes. Stakeholders include people with lived experience, expertise or other engagement in the health topic ([Inspiration box 2](#)).

Choosing which method to use will depend on the social, political and cultural contexts within which the THP project is being carried out. Examples of different methods include the following.

- **Stakeholder workshops** can bring together people with different experiences and expertise in a one- or two-day event during which a mix of presentations and plenary and group work exercises take place. Diversity among participants can create good dynamics and discussion. However, it may be relevant to take power relations into account, for example in considering who works together in groups.
- **Patient participation groups (PPGs)** can be established as a mechanism for patients to advise and inform health authorities about their experiences and needs related to health services. PPGs involve gathering a group of representative patients, carers and health-care professionals in structured consultations to discuss a health intervention or project in order to improve it. PPG members can also serve as ambassadors and help to promote an intervention. A PPG would typically meet at regular intervals throughout the lifetime of a project, allowing the research team to receive feedback in relation to project challenges, milestones or critical decisions. Existing PPGs can be engaged in a THP project, or a dedicated PPG can be established for the project (1).
- **Knowledge dialogues** are used when there is a need to explore and overcome differences in culturally rooted opinions, beliefs and customs that exist between the health system and health providers on the one side and those who benefit from or would like to access health services on the other. The dialogues involve communication and exchange between certain groups or individuals and health workers. The objective is, among others, to improve access to health services and build intercultural health, with an emphasis on solving previously raised problems and their causes, establishing mutual understanding, and creating solid links. Knowledge dialogues can range from a single workshop to a longer journey that involves participatory planning and extends over several meetings scheduled over the course of several months. Critical to a knowledge dialogue is the role of the dialogue facilitator, who should be a member of the stakeholder community and versed in the local culture (2).

- **Body maps** can be defined as life-size human body images that can be created using drawing, painting or other art-based techniques to visually represent aspects of people's lives, their bodies and the world they live in. For instance, participants could be divided into groups of two, with each participant taking turns to trace the outline of their body onto a piece of paper and then mapping their feelings or responses in the form of drawings onto parts of their body outline. Body mapping may be useful to examine and appreciate how emotions, cultural norms or practices relate to (specific parts of) physical bodies, or are embodied; and to explore topics that people find difficult to express verbally. Body mapping can also be used as a research methodology (3).

References*

1. Patient participation groups: a guide to setting up and developing your PPG. Harrow: The Patients Association; 2021. <https://www.patients-association.org.uk/Handlers/Download.ashx?IDMF=3a099b36-93af-4582-a267-d4806ddb1f8>.
2. The knowledge dialogues methodology. Washington (DC): Pan American Health Organization; 2022. (<https://www.paho.org/en/documents/knowledge-dialogues-methodology>).
3. Skop M. The art of body mapping: a methodological guide for social work researchers. *Aotearoa New Zealand Social Work*. 2016;28(4). doi: 10.11157/anzswj-vol28iss4id295.

* All references were accessed 6 January 2023.

Initial overview of target groups, target behaviours, and barriers and drivers



USE FOR

PHASE 1

Define target groups and target behaviours
Engage stakeholders

The objectives of this exercise are:

- to map the evidence and assumptions that exist with respect to possible target groups and target behaviours in these groups;
- to map the evidence and assumptions that exist with respect to barriers and drivers experienced by the target groups in relation to the target behaviours.

This exercise is recommended for a stakeholder workshop or for the THP Core Group alone.

The exercise can be repeated in greater detail and with more evidence after the research study has been completed.

Steps of the exercise

1. Map relevant target groups and target behaviours

- List the population groups in the country which you believe or know have adverse behaviours in relation to the health topic ([Inspiration box 7](#)). Unless you have already defined a specific target group, you are advised to use overall categories. For example, you may use “patients” and “health workers”, and leave details on which kinds of patients or health workers for a later stage. Discuss using the situation analysis and the following inspiration questions:
 - Which groups have a high disease burden and low well-being that are related to the health behaviour?
 - Which groups have a direct or indirect influence on these behaviours?
- For each group, consider relevant target behaviours ([Inspiration box 8](#)).
 - For example, for smoking, you may wish to focus on smoking initiation, excessive smoking, social smoking, passive smoking or other behaviours. There may also be indirect behaviours that should be taken into account, such as selling tobacco, encouraging others to smoke or creating social spaces for smokers.
- Prepare a chart with the target group in the middle and the relevant behaviours around them.
- Take notes for the research phase by identifying where you need to know more:
 - Are your answers assumptions or evidence-based facts?
 - Do you know enough? Do you have knowledge gaps?

If you have limited time, this part of the exercise can be done in advance of a stakeholder workshop. In this case, you present a list of target groups and target behaviours and discuss it with the stakeholders.

EXERCISE →

2. Map potential barriers and drivers of the health behaviour in the identified population groups

- Use the situation analysis, your own experience and knowledge, previous reports, relevant literature and feedback from stakeholders to discuss and map possible barriers and drivers experienced by the target groups in relation to the target behaviours.
- Map the identified barriers/drivers using the COM factors ([Inspiration box 9](#)):
 - capability factors
 - sociocultural opportunity
 - physical opportunity
 - motivation factors.
- Prepare one map per population group/behaviour (Fig. 1.1 and Fig. 1.2).
- Make sure that all three COM factors are thoroughly explored for each population group/behaviour.
- If no or limited information exists for a certain COM factor, note that down as well.

If this exercise is done by a bigger group of people in a stakeholder workshop, the stakeholders can work in small groups, each group working on one population group/behaviour.

Fig. 1.1 Mapping of potential barriers and drivers of a health behaviour in an identified population group

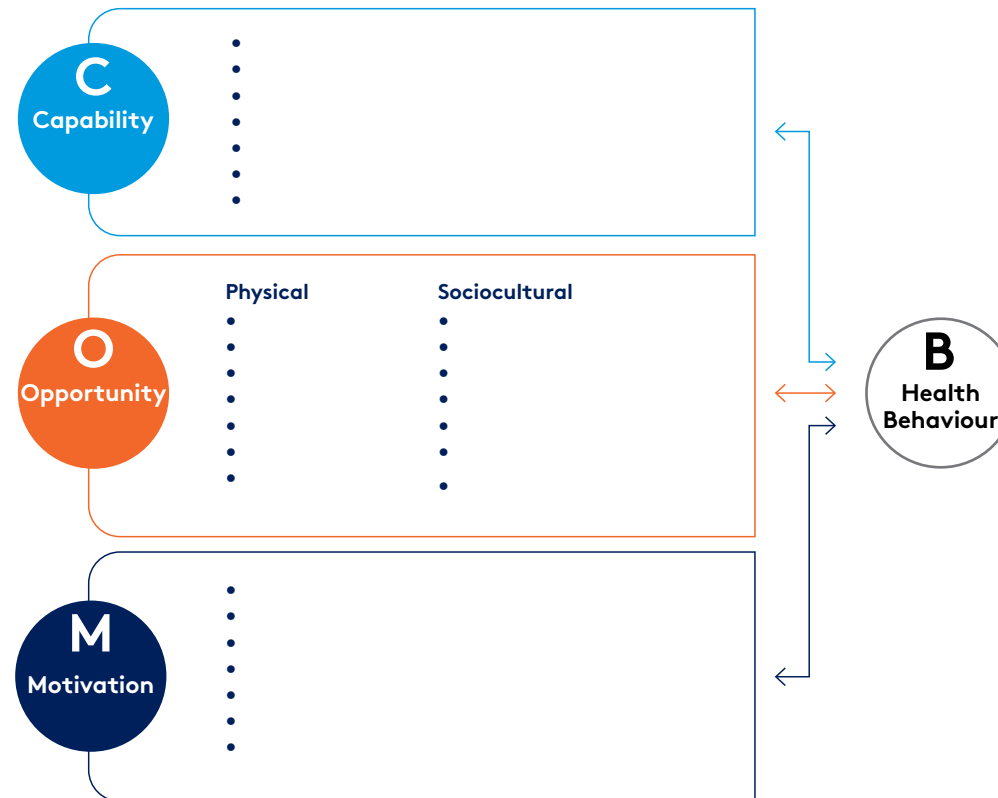
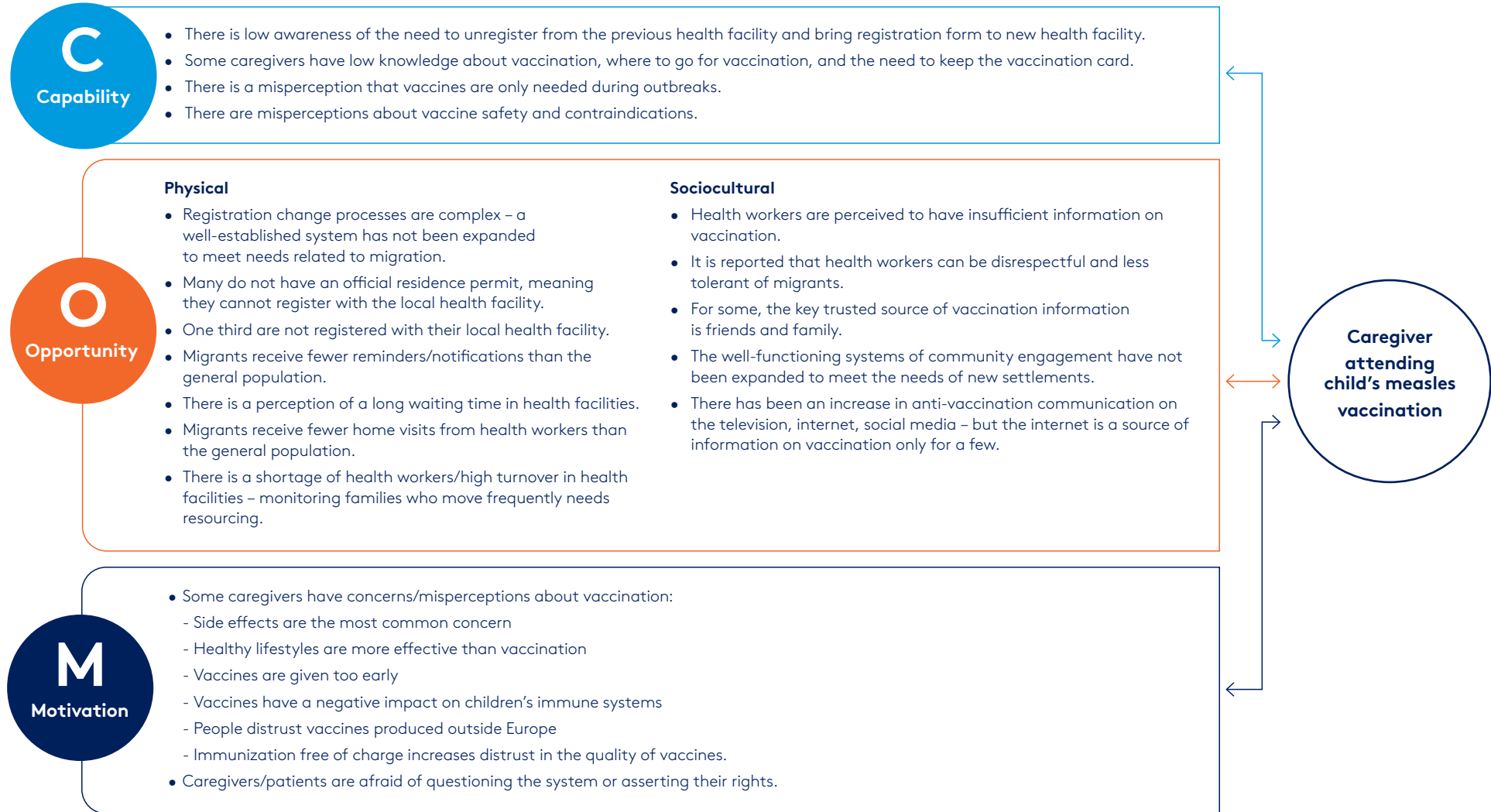


Fig. 1.2. Example of mapping of barriers and drivers (vaccination among migrant population)



EXERCISE 2

Prioritizing target groups and target behaviours



PHASE 1

Define target groups and target behaviours
Engage stakeholders

PHASE 2

Prioritize target groups and target behaviours

The objectives of this exercise are:

- to prioritize key target groups;
- to prioritize target behaviours found in these groups.

This exercise can be repeated after the research study has been completed, when target groups and target behaviours have been more clearly defined and more evidence is available to help make a final decision.

Steps of the exercise

1. List the population groups/behaviours identified as relevant in PHASE 1.

2. Discuss and agree which population groups/behaviours should be prioritized.

- Use Table 2.1 and apply the following criteria.

• Impact

- How much of an impact could addressing this target group/behaviour have on health outcomes within the health area?
- How much of an impact could addressing this target group/behaviour have on equity and health access in your country?

• Likelihood of change

- How likely is it that this behaviour in this group can be changed?
- Are there opportunities to focus on subgroups within the target group where change is more likely?
- Are there any particular obstacles to consider?

• Spillover effects/impact

- Could targeting this group/behaviour with activities have a positive impact on other health issues for the target group?
- Could targeting this group/behaviour have a positive impact, indirectly, on other target groups?

- Use colour-coding (red = low, amber = medium, green = high) or score them (1 = low, 5 = high) to do your rating.
- If the target groups, target behaviours or health topic are sensitive, consider also possible negative effects or risks associated with addressing the target groups/behaviours. If necessary, reconsider your scoring with this in mind before making a final decision about target groups/behaviours.
- You may want to work in small groups to do the exercise and then come together to discuss your ratings and agree which target groups/behaviours to select. Select a maximum of two.
- Table 2.1 can be completed on the basis of stakeholder discussions and expert opinions, and the data can be presented in the situation analysis.

Table 2.1. Template for selecting your target group/behaviour(s)

Target group/ behaviour	Impact	Opportunities to change	Spillover	Possible negative effects or risks

Selected target groups and target behaviours

EXERCISE 2

The journey technique



USE FOR

PHASE 1

Define target groups and target behaviours

Engage stakeholders

PHASE 2

Prioritize target groups and target behaviours

The objectives of this exercise are:

to imagine the experiences and perspectives of an individual, for example, a patient or a health worker with respect to a health topic and behaviour, and thereby:

- to identify relevant target groups and target behaviours; and/or
- to explore in greater depth the experience, interaction, and barriers and drivers related to the target behaviour.

Steps of the exercise

The journey technique involves preparing a timeline and illustration of events and people involved in the health behaviour from the perspective of the individual person (for example, patient, health worker). This may be different for each target behaviour and each target group.

1. Imagine you are the target group

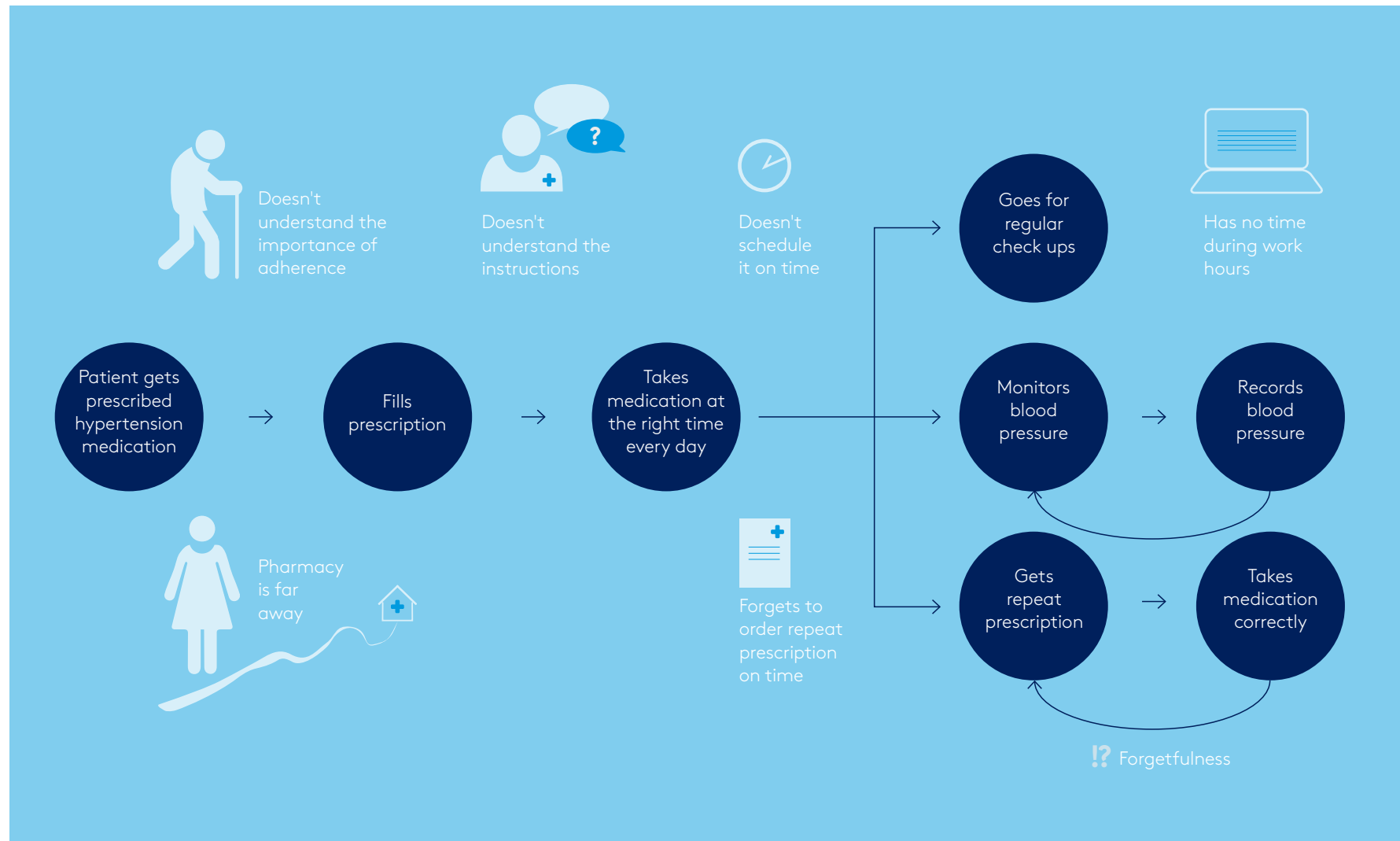
- Put yourself in the shoes of a target group and imagine following them from the time they start thinking about the behaviour until after they have engaged in the behaviour.
- Consider, for example:
 - Do they look for information or talk to their peers? If so, who?
 - Do they plan the behaviour – for example, by booking an appointment, taking time off work, or making a plan for when and where they will engage in the behaviour?
 - Do they travel to a venue to conduct the behaviour? If so, how long does it take, and is there a cost involved?
 - What happens when they engage in the behaviour? Who is involved, how many steps are needed, what do they and others need to do?
 - What happens afterwards, immediately and in the longer term? Must the behaviour be repeated, and if so, how often?

2. Note down what influences the process

- For each step in the journey, write down possible influences, emotions that may be associated with the behaviour, and missed opportunities where the health system (or other structures) might have supported the process. Include as much detail as possible. Discuss the barriers and drivers at each step of the journey using the COM factors:
 - capability (individual knowledge and skills);
 - sociocultural opportunity (social dynamics, norms and cultural context);
 - physical opportunity (structural and environmental context, service provision);
 - motivation (individual conscious and unconscious influences and biases, perceptions, trust).

By the end of the exercise, you will have a step-by-step description of how the behaviour may take place and what happens before and after the behaviour is performed. An example of what such a journey might look like is shown in Fig. 2.1.

Fig. 2.1. Example of a patient journey related to hypertension medication



INSPIRATION BOX 11

Types of research study



PHASE 2
Plan research

Information can be collected using either a qualitative or a quantitative study design (Table 11.1), or a combination of both (mixed methods). The choice between these options depends on the type of information needed to answer your research question and on the type of research data that already exists on the topic. Both qualitative and quantitative research methods have their strengths and limitations (Table 11.2).

Table 11.1. Types of research

Qualitative	Quantitative
<ul style="list-style-type: none"> • Focus group discussions • Individual in-depth interviews • Observational studies <p>Qualitative element in quantitative research: - Open-ended questions in surveys</p>	<ul style="list-style-type: none"> • Telephone surveys • Face-to-face surveys • Self-administered questionnaires (online or paper) • Population or patient data analysis • Arts-based data collection • Social listening, sentiment analysis <p>Quantitative element in qualitative research: - Observation grid data from observational studies</p>

Table 11.2. Strengths and limitations of qualitative and quantitative research

Qualitative	Quantitative
Strengths	
<ul style="list-style-type: none"> • Rigorous methods • Can provide in-depth understanding of people's concerns, needs and personal experiences, and how and why they behave in certain ways • Valuable for describing complex relations • Data generated can be rich in detail • Useful for generating hypotheses to be tested in quantitative studies • Through careful sampling and reaching data saturation, confidence in findings can be achieved 	<ul style="list-style-type: none"> • Rigorous methods • Useful for examining the frequency of a behaviour and the factors that influence it • Can test hypotheses and assess cause-and-effect relationships • Can produce generalizable findings if the study is well designed and the sample is representative of the target population • Can provide a comparison of baseline and endline data to assess effect of interventions
Limitations	
<ul style="list-style-type: none"> • Difficult to generalize results to a wider population • The time required for data collection, analysis and interpretation can be lengthy 	<ul style="list-style-type: none"> • Not suitable to uncover complexity of people's experience, perceptions and knowledge • Requires larger number of participants

Qualitative research

Qualitative research is conducted to gain an understanding of a target group's knowledge, perceptions, beliefs, attitudes and experiences. It can provide rich, in-depth information on the barriers and drivers of health behaviours. For example, qualitative research methods can be used to explore the reasons why people adopt specific behaviours and can provide insights into what the target group knows and does not know, their fears and worries, hopes and desires, as well as more complex issues, such as their access to a health service. Popular qualitative research methods are focus group discussions, individual in-depth interviews and observational studies. These methods require careful sampling and trained and experienced moderators, and interviews must be continued until data saturation is achieved (the point in the data collection process where no new information is obtained).

Individual in-depth interviews

In an individual in-depth interview, a moderator has a one-on-one conversation with a single person, usually face to face but sometimes over the telephone or in an online meeting. Individual interviews are particularly useful when the participant has special knowledge or a unique point of view; when the topic is sensitive and the participant may not feel comfortable speaking openly in a group; when individual circumstances are important; or when it is difficult to bring a larger group together.

Focus group discussions

A focus group discussion is a moderated conversation with a group of people from the same target group. Focus group discussions are especially useful for

identifying social norms and dynamics and can reveal both agreement and differences of opinion about a relevant topic. Focus groups require careful moderation, as participants may be less likely to share views about sensitive topics in the presence of others, and power dynamics between people of different rank or personality may influence the outcome. About 5–12 participants are usually involved in a focus group discussion.

Observational studies

In observational research, a researcher watches and records people in a natural setting. Observational studies are particularly relevant when researchers want to gain insights into topics where self-reported answers might be less reliable or into behaviours that people may be less aware of and therefore less able to describe in interviews or focus groups.

It can be relevant to observe people individually, and how they interact. Observation is usually done by trained observers who take notes about events and interactions. An observation grid allows to obtain quantitative data on whether or not specific behaviours or actions are taken. Participants themselves can also make observations by taking photos or recording videos of certain situations in their everyday context that relate to the research question.

Observational data are often combined with interviews in which the participant is asked to discuss their observed behaviour. Observation enriches data collected in interviews and overcomes potential limitations of poor recall and the desire of interviewees to present themselves well. In a THP process, observations might take place in a health facility.

To limit the influence of the observer on the behaviours of those observed, observation is best conducted over an extended period of time. Training observers and developing clear guidelines for recording observations are crucial.

Arts-based data collection methods

Arts-based data collection methods represent a wide umbrella category under which there are many artforms, genres and practices, including visual, audiovisual, multimedia and performative arts, creative writing, storytelling, etc. Arts-based data collection methods can support the perspectives, needs and interests of research participants in their own, familiar cultural contexts, rather than exposing them to a research methodology that might feel alien. Using arts-based methods may also improve opportunities for engaging with stakeholders and disseminating research findings.

A well-known example of an arts-based research method is a technique called photovoice. Photovoice allows participants to document and reflect on experiences they consider to be relevant to a research question using photos. Photovoice deprioritizes the spoken and written word, which can help to level participants and may allow greater creativity in their responses. Visual images can also be a communication tool, challenging stereotypes and providing a platform for emotionally engaged reflection.

Quantitative research

Quantitative research is based on structured collection and analysis of numerical data, rather than textual data as in qualitative studies. Quantitative methods can provide information on the frequency of certain behaviours, beliefs and knowledge. If data are collected from a representative sample, it is possible to generalize the results to a larger population. Quantitative research is appropriate when the nature of barriers or drivers of a health behaviour are clearly defined and measurable; when it is desirable to understand which barriers or drivers are most common (and if these vary in different population groups); and when data need to be compared over time (that is, in a longitudinal study).

Surveys

Surveys are a common quantitative method for gathering data on knowledge, perceptions, and other barriers and drivers of health behaviours. They present a relatively easy way of collecting information from a large number of people in a short time. Data are collected through standardized questionnaires with predefined, usually closed-ended, questions. Questionnaires can be administered face to face or by telephone, or survey participants can be invited to complete the questions on paper or electronically. Self-completed written or Internet/email-based questionnaires are cheaper than surveys administered face to face or by telephone. It is important that questionnaires are pretested to identify any problems that may lead to biased answers.

Survey design is a specific field of expertise, and the appropriate knowledge and skills should be brought to the task. Questions must be asked precisely to

ensure clarity for the participant and accuracy of interpretation for the researchers. This is especially true when asking questions related to perceptions or psychological constructs, rather than demographics or specific self-reported behaviours. Where possible, it is recommended that variables and scales that have been tested for reliability and validity are used; this requires that it is confirmed that questions:

- actually measure what we think they do (construct validity); and
- predict the behaviour of those who answered (predictive validity).

Statistical expertise is also helpful when designing a survey. Since it is not practical to collect information from the whole population of interest, surveys are usually conducted among a sample of the population. Sample size can be calculated based on statistical requirements as well as on cost and resources available. A representative sample of the target population allows results to be generalized to the population of interest. Sampling can be done using random, systematic methods (probability sampling). Other approaches to sampling include purposive, convenience and snowball samples. However, these nonprobability methods are prone to bias.

Population or patient data analysis

If the situation analysis and already available data do not provide the detailed or disaggregated data that are needed on the target behaviours, a study may be conducted to explore patient data through medical records (electronic or not) or other registries or data sources. While the data may not allow disaggregation by income, education or ethnicity, an analysis of behaviours (such as cancer screening

attendance or vaccination) by age, gender, local area or other sociodemographic factors may provide an indication of which particular groups or areas need to be targeted. Medical records may also be explored to examine patterns between diagnosis, follow-up and treatment adherence. For example, analysis may be carried out to determine who comes back for repeated services (screenings, vaccination) and who only attends once. Such analysis can be used to identify relevant target groups to focus on, to understand behavioural patterns, and to establish a baseline to monitor longer-term impact.

Social listening, sentiment analysis

Social listening is a methodology for collecting information from online and offline conversations on a particular topic and synthesizing key points and trends into actionable insights. In an environment with high social media usage, there are a variety of paid-for and free tools for collecting online conversation trends, such as WHO Early AI-supported Response (EARS), Meltwater and Google Analytics, among others. Sentiment analysis is a particular approach to measuring reactions to social media posts that can help to quickly interpret trending perspectives. Offline social listening collects information about rumours and conversations through structured tools such as a rumour log shared among communities, traditional media monitoring, and telephone hotline records, such as frequently asked question logs.

Mixed methods

If resources are available, it is advantageous to conduct both qualitative and quantitative research. The combination of different methods (triangulation) means that both breadth of information (through quantitative methods) and depth of information (through qualitative methods) are captured, which increases confidence in the research findings. Qualitative and quantitative research can be carried out at the same time or in sequence. Examples of sequential studies include using qualitative interview data to inform the development of a quantitative survey questionnaire, or using qualitative interviews to further explore interesting or unexpected findings from a quantitative survey.

Another consideration in research design is whether to collect data at one time point with a unique set of participants (cross-sectional) or to follow the same participants over time (longitudinal).

FURTHER GUIDANCE

Further guidance on research methods appropriate for behavioural and cultural insights (BCI) for health may be found in the following resources.

[A field guide to qualitative research for new vaccine introduction: step-by-step instructions to help immunization programmes understand their target audiences before communicating about the introduction of a new vaccine](#). Copenhagen: WHO Regional Office for Europe; 2018.

[Barrier Identification Tool](#). London: Behavioural Insights Team; 2020.

[Behaviour change: guides for national and local government and partners](#). London: Public Health England; 2020.

[Ethics resources](#) [online hub]. Applied Behavioral Science Association; 2021.

[Explore: Four simple ways to map and unpack behaviour](#). United Kingdom: The Behavioural Insights Team; 2022.

Lobe B, Morgan D, Hoffman KA [Qualitative Data Collection in an Era of Social Distancing](#). International Journal of Qualitative Methods; 2020.

[Participatory health research with migrants: a country implementation guide](#). Copenhagen: WHO Regional Office for Europe; 2022.

[Online tools for behaviour change](#) [online hub]. London: UCL Centre for Behaviour Change

[Rapid qualitative research to increase COVID-19 vaccination uptake: a research and intervention tool](#). Copenhagen: WHO Regional Office for Europe; 2022.

Seppälä T, Sarantou M, Miettinen S, editors. [Arts-based methods for decolonising participatory research](#). Abingdon: Taylor & Francis; 2021 Paris: OECD Publishing; 2019.

Tsang S, Royse CF, Terkawi AS. [Guidelines for developing, translating, and validating a questionnaire in perioperative and pain medicine](#). Saudi J Anaesth. 2017;11(Suppl 1):S80–S89. doi: 10.4103/sja.SJA_203_17.

INSPIRATION BOX 12

Contents of a research protocol



PHASE 2 Plan research

The research protocol is an essential part of a research project. It is a detailed description of how the research will be conducted and should be used as a handbook for the research team to ensure adherence to the methods chosen. It is also the document that can be submitted for ethical approval.

The following sections can be included in a research protocol for a quantitative, qualitative or mixed methods study. The detail in each section will vary depending on the type of research and the requirements of the individual ethical review committee.

- General information – title of research project; version and date of protocol; name and contact details of funder, sponsor and lead researcher.
- Background and rationale – a statement of the problem that is the basis for the THP process; existing knowledge and gaps in knowledge; reasons for doing the research.
- Research questions, aims and objectives – the overall questions or aims of the research, and the specific objectives achieved by addressing them.
- Study design – the overall study design, for example a longitudinal, qualitative, face-to-face interview study; the theoretical model that underpins the study (e.g. adapted COM-B).
- Study setting, participants and recruitment – where the study will be conducted; where and how research participants will be recruited; sampling, inclusion and exclusion criteria; how participants will be informed about the study; how informed consent will be obtained (participant information sheet and consent form to be included as appendices).
- Data collection – the content of the data collection tools (e.g. interview topic guide, postal questionnaire); how the tools will be developed or if existing validated tools will be used; pilot testing; final administration (data collection tools to be included as appendices).
- Data analysis – the planned quantitative (statistical) or qualitative analysis; for a mixed methods study, a description of how the quantitative and qualitative data will be synthesized.
- Data management – where the data will be stored and protected; who will see the data; how the data will be transferred; how confidentiality will be ensured; how national regulations on data management will be met.
- Ethical considerations and ethical and other approvals – which ethics committee will review the research; other necessary approvals.
- Processes to ensure anonymity and confidentiality.
- Considerations on how participants benefit from participation and possible risks; possible incentives to be offered to participants; expenses to be reimbursed.
- Details on all stakeholders involved in the study and their CVs and roles.
- Dissemination – how results will be shared, e.g. reports; papers that will be produced, including a short summary for participants.
- Timeline – clear deadlines for each step of the research project.
- References.
- Appendices (participant information sheet, consent form, data collection tools).

INSPIRATION BOX 13

Ethical approval



USE FOR

PHASE 2
Plan research

Depending on the rules and standards of the country in which the research takes place and on the nature of the study, ethical approval should be sought from an independent ethical committee prior to starting data collection.

Ethical approval is initiated to ensure that the rights of any individual taking part, as well as their dignity, safety and well-being, are considered above all else. It is usually required for publishing study findings in a peer-reviewed journal.

Research should be conducted according to the standards outlined in two key documents:

- the **Declaration of Helsinki (1)**, developed by the World Medical Association as a statement of ethical principles to provide guidance on medical research involving human subjects
- the **EU General Data Protection Regulation (GDPR) 2016/679 (2)**, which aims to regulate the processing of personal data and the free movement of such data.

The content of an application for ethical approval depends on the requirements of the individual ethical committee. In some cases, the research protocol ([Inspiration box 12](#)) must be submitted to external experts for peer review before being submitted to an ethical committee.

References*

1. [WMA declaration of Helsinki – ethical principles for medical research involving human subjects](#). Helsinki: World Medical Association; 1964
2. [Regulation \(EU\) 2016/679 of the European Parliament and of the Council of 27 April 2016 on the protection of natural persons with regard to the processing of personal data and on the free movement of such data, and repealing Directive 95/46/EC \(General Data Protection Regulation\)](#). Brussels; 2016

* All references were accessed 6 January 2023.

INSPIRATION BOX 14

Overview of Exercises 4–7



PHASE 3

Translate outcomes into an intervention

Exercises 4–7, described in detail below, involve discussing and selecting priority barriers and linking them to COM factors; selecting intervention types that can address these barriers; selecting activities for the chosen intervention; and prioritizing and refining them further. It is advised to read through all the exercises and obtain an overview before engaging in them.

The outcomes of the exercises can be summarized as shown in Table 14.1; examples are given in Tables 14.2 and 14.3

Table 14.1. Template for creating an overview of outcomes of Exercises 4–7

Problem identification			
Target group			
Target behaviour			
	Selected barriers to address (Exercise 4)	Selected intervention types (Exercise 5)	Selected activities (Exercises 6 and 7)
Barriers related to capability*			
Barriers related to sociocultural opportunity*			
Barriers related to physical opportunity*			
Barriers related to motivation*			

*If no barrier is selected related to this COM factor, leave cells on this row blank.

Table 14.2. Example text for outcomes of Exercises 4–7 (vaccination: parents)

Problem identification	Suboptimal vaccination of children with DTP3 on time in low-performing clinics		
Target group	Parents of children aged 0–3 years		
Target behaviour	Increased uptake of routine vaccination		
	Selected barriers to address (Exercise 4)	Selected intervention types (Exercise 5)	Selected activities (Exercises 6 and 7)
Barriers related to capability*	Capability Not selected	–	–
Barriers related to sociocultural opportunity*	Opportunity (sociocultural) Inadequate support for parents from health workers to help them understand vaccine safety	Environmental restructuring	Health worker training in vaccine safety and parent communication to support them in providing better care
Barriers related to physical opportunity*	Opportunity (physical) Ineffective local call and reminder systems	Environmental restructuring	New letter to parents and training activities to support clinic manager to use national standards for vaccination calls and reminders
Barriers related to motivation*	Motivation Not selected	–	–

*If no barrier is selected related to this COM factor, leave cells on this row blank.

Table 14.3. Example text for outcomes of Exercises 4–7 (vaccination: health workers)

Problem identification	Suboptimal vaccination of children with DTP3 on time in low-performing clinics		
Target group	Health workers		
Target behaviour	More effective support, care and guidance to parents related to vaccination		
	Selected barriers to address (Exercise 4)	Selected intervention types (Exercise 5)	Selected activities (Exercises 6 and 7)
Barriers related to capability*	Capability Low knowledge of vaccine safety and parent communication techniques	Training	Health worker training in vaccine safety and parent communication to support them in providing better care
Barriers related to sociocultural opportunity*	Opportunity (sociocultural) Not selected	–	–
Barriers related to physical opportunity*	Opportunity (physical) Not selected	–	–
Barriers related to motivation*	Motivation Health workers overworked and stressed	Environmental restructuring	Updated standards for clinic planning, working conditions and clarity in roles and responsibilities

*If no barrier is selected related to this COM factor, leave cells on this row blank.

EXERCISE 4

Selecting barriers to target in the intervention



USE FOR

PHASE 3

Translate outcomes into an intervention

The objectives of this exercise are:

- to prioritize between identified barriers to the target behaviour in the target group;
- to agree on up to three barriers that you wish to address with your intervention.

The exercise is recommended for the THP Core Group; however, it could also be considered for group work in a stakeholder workshop.

Steps of the exercise

1. Discuss barriers and rank them

- In your research report, you have identified the barriers and drivers of the target behaviour in the target group, organized by COM factors. In this step, you will focus on the barriers. For each target group and target behaviour, go through the barriers to discuss:
 - Which barriers have an important **impact** on the target behaviour?
 - How **urgent** is it to address these barriers?
 - Which barriers can realistically be **overcome**?
- Be precise and avoid very broad categories (rather than focusing on "low education" as a barrier, it may be more helpful to specify areas where information levels are low, or how low education affects relations with health workers).
- Discuss each barrier and rate them from 1 to 5 for each of the three criteria (for instance, if very urgent, rate 5; if moderately realistic to overcome, rate 3).
 - If the target groups, target behaviours or health topic are sensitive, consider also the possible negative effects or risks associated with addressing each barrier. If necessary, reconsider your scoring with this in mind before making a final decision about targets.
- Do this for each of your target groups and target behaviours. It is likely there will be some overlap

and consistency between groups (for instance, dissatisfaction with information provided may coincide with low knowledge identified among health workers).

- If your research identified many barriers, you may wish to do this exercise as a quick screening process, without the ranking element, in order to select 10 barriers that can then be discussed in greater depth.

2. Use your ranking to select which barriers to address

- Based on your discussion and rating, select up to three barriers to address. How many barriers you select will depend on the resources you have available for your intervention. If you decide later that three is too many or too few, you can return to this exercise to reduce or increase the number.
- Write down which COM factors your three barriers are associated with.

EXERCISE 5

Identify potential intervention types for your selected barriers



USE FOR

PHASE 3

Translate outcomes into an intervention

The objectives of this exercise are:

- to get acquainted with possible overall intervention types;
- to identify the intervention types that are relevant for your barriers (in the target group/behaviour they are associated with).

This exercise is recommended for the THP Core Group; however, it could also be considered for group work in a stakeholder workshop.

Steps of the exercise

1. Review possible intervention types

- Take a look at Table 5.1 to see the full range of possible intervention types that you can use. Take time to read this through.

2. Link your selected barriers with intervention types

In Exercise 4 you selected the barriers (and associated COM factors) you wish to target. This step will help you to decide how you can address them.

- Use Table 5.2 to identify which intervention types are recommended for the COM factor(s) associated with your selected barriers. Boxes marked with an X represent the recommended intervention types for each COM factor. For example, if you have identified a “capability” barrier, relevant intervention types would be “information” and “training”.
- To select one intervention type for your continued work, consider which intervention type:
 - is more likely to lead to the intended health outcome;
 - is more feasible;
 - is more acceptable by the people who will be involved;
 - is not likely to lead to any unintended negative effects or risks for those involved;
 - may realistically improve equity.

If you have the human and financial resources available, you may select more than one intervention type.

- Complete Table 5.3 with your selected barriers (and associated COM factors) and selected intervention type(s).

EXERCISE 5

Table 5.1. Intervention types

Intervention type	Definition	Examples
Information	Increasing knowledge or understanding	Increasing uptake of cervical cancer screening by designing and testing letters and reminders (1).
Training	Imparting skills	Increasing migrants' trust in diagnoses, and increasing doctors' understanding of migrants' symptoms, through health worker training on migrant and ethnic minority health (2).
Incentivization	Creating an expectation of a reward	Working together with nurses to design motivating incentives for their work performance (3).
Persuasion	Inducing positive or negative feelings to stimulate action	Decreasing tobacco initiation through front-of-pack pictures of diseased lungs and mouth cancer (4).
Restriction	Using rules to reduce the opportunity to engage in the target behaviour	Decreasing consumption of high-sugar drinks through new tax design (5).
Coercion	Creating an expectation of a negative cost or outcome	Changing health behaviour by using anticipated regret messaging (6).
Modelling	Providing an example for people to aspire to or imitate	Reducing antibiotic prescribing by informing doctors via a letter that they prescribe more antibiotics than their peers (7).
Environmental restructuring	Changing the physical or social context, including change to: <ul style="list-style-type: none"> • physical environment • infrastructure • visual cues • choice architecture • social engagement • social prescribing • processes • procedures 	<p>Improving surgical safety through simple checklists (8,9).</p> <p>Influencing food choices through nutritional front-of-pack labelling (10,11).</p> <p>Improving health outcomes by introducing intercultural mediators (12).</p> <p>Increasing health effects and cost-effectiveness of physical therapy for children with hemiplegia by making it fun and engaging (13).</p>

Source: Michie S, Atkins L, West R. *The Behaviour Change Wheel: a guide to designing interventions*. London: Silverback Publishing; 2014 (<http://www.behaviourchangewheel.com>).

EXERCISE 5

Table 5.2. Matrix of links between COM factors and intervention types

Intervention type	COM factor			
	Capability	Sociocultural opportunity	Physical opportunity	Motivation
Information	X			X
Training	X		X	X
Incentivization				X
Persuasion				X
Restriction		X	X	
Coercion				X
Modelling		X		X
Environmental restructuring		X	X	X

Source: Michie S, Atkins L, West R. *The Behaviour Change Wheel: a guide to designing interventions*. London: Silverback Publishing; 2014 (<http://www.behaviourchangewheel.com>).

Table 5.3. Template for overview of barriers with COM factors and intervention types

Barrier	COM factor	Selected intervention type(s)

References*

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11. Kelly B, Jewell J. What is the evidence on the policy specifications, development processes and effectiveness of existing front-of-pack food labelling policies in the WHO European Region? Copenhagen: WHO Regional Office for Europe; 2018 (<https://apps.who.int/iris/handle/10665/326187>).
12. Verrept H. What are the roles of intercultural mediators in health care and what is the evidence on their contributions and effectiveness in improving accessibility and quality of care for refugees and migrants in the WHO European Region? Copenhagen: WHO Regional Office for Europe; 2019. (<https://apps.who.int/iris/handle/10665/327321>).
13. Green D, Schertz M, Gordon A, Moore A. A multi-site study of functional outcomes following a themed approach to hand–arm bimanual intensive therapy for children with hemiplegia. *Devel Med Child Neurol.* 2013;55(6):527–33. doi: 10.1111/dmcn.12113.

* All references were accessed 9 January 2023.

EXERCISE 6

Consider possible activities within the intervention



PHASE 3

Translate outcomes into an intervention

The objectives of this exercise are:

- to initiate discussions about the possible activities related to your intervention types.

These initial discussions about activities will make it possible for you to prioritize.

The exercise is recommended for the THP Core Group; however, it could also be considered for group work in a stakeholder workshop.

Steps of the exercise

1. For each barrier, consider what the activities within your intervention might be.

Identify activities relevant to the intervention types that you selected in Exercise 5. One activity can address more than one barrier.

- Go back and use what you already know:
 - **Your literature review:** consider categories of activities that have already proven effective and could be adapted; consider the drivers identified that might be used as the starting point for designing an activity.
 - **Your situation analysis:** consider what has been tried in the past; consider what has been effective in other health areas.
 - **Your research:** activate what you know about the target groups and target behaviours; pay special attention to the drivers that might be the starting point for developing an activity.
 - **Human psychology:** be inspired by what you know about mental shortcuts and human biases, including the need to make things simple, easy, acceptable and socially desirable and to present them at the right time and place ([Inspiration box 15](#)).
- Do a silent brainstorming: in silence, everybody writes down as many possible solutions as possible. Use sticky notes and write one idea per note.
- Discuss your ideas with the group and place similar ideas together. If you get a new idea, feel free to add it.

- Think freely and try to think outside the box. Nobody is allowed to say: "That is not possible." These are just initial discussions, and activities can be revised and refined at a later stage.

2. Create a long list of possible activities.

Stay within the intervention type.

EXERCISE 7

Prioritize and elaborate on activities



USE FOR

PHASE 3

Translate outcomes into an intervention
Engage stakeholders

The objectives of this exercise are:

- to prioritize between your activities and select a few activities using six key criteria;
- to elaborate on these activities, providing details on who will take part and where and when they will take place.

The exercise is recommended for the THP Core Group; however, it could also be considered for group work in a stakeholder workshop.

Steps of the exercise

1. Rate each activity

- Rate each of the activities you identified in Exercise 6, using the following six criteria (score them from 1 = low to 5 = high).

Impact

- Is it **effective**? How much of an impact could it realistically have?
- Is it **cost-effective**? How well does it work relative to its cost?
- Is it **equity-focused**? How much of an impact on equity could it have?

Feasibility

- Is it **affordable**? Can it be delivered to the target group within budget?
- Is it **practicable**? Can it realistically be delivered and is it safe, with no unintended consequences?
- Is it **acceptable**? How appropriate is it for different stakeholders?

- For all six criteria, you may decide that you need more information to do this exercise. For example, you may need to talk to some key stakeholders about feasibility or look at the literature on effectiveness/cost-effectiveness.
- You may want to work in small groups to do the exercise and then come together to discuss your ratings and agree which activities to select.
- If you have more than one target group, you will need to repeat this exercise for each group.
- Complete Table 7.1 with your ratings.

2. Prioritize between activities

- Using Table 7.1, discuss and agree on a few activities that you consider to be affordable, practicable, effective, cost-effective, equity-focused and acceptable. How many activities you select will depend on the resources you have available. You may keep more activities at this stage and do this prioritization exercise again later.
- The activities can address more than one barrier.

3. Brainstorm how your selected activities will be delivered

- Here are some useful questions to prompt your thinking on each activity.
 - What is the content of the activity?
 - When will the activity be delivered?
 - Where will the activity be delivered?
 - Who will deliver the activity?
- Answer these questions for each activity. Continue to think freely at this stage. Focus on opportunities.
- You may want to work in small groups to do this and then come together to discuss your ideas.
- At this stage you may wish to do a further round of prioritization (Step 2) to reduce the number of activities.

Table 7.1. Template for prioritizing activities

Activities from Exercise 6	Impact			Feasibility		
	Effective	Cost-effective	Equity-focused	Affordable	Practicable	Acceptable
SELECTED ACTIVITIES						

INSPIRATION BOX 15

Considerations on unconscious psychological effects



PHASE 3

Refine and plan the intervention

When refining your activities, it is relevant to consider the large amount of research in psychology and behavioural economics related to how humans process information and the unconscious processes that influence decision-making and behaviour.

Table 15.1 presents an overview of biases and heuristics that may be considered in the intervention design and evaluation process. (Further reading regarding unconscious psychological determinants of behaviour are listed at the end).

Table 15.1. Unconscious psychological determinants of behaviour

Psychological effect(s)	What it means	What to do	Examples of activities
Adjustment Anchoring	Once something has been anchored in our perception in a certain way, we filter new information according to this anchor.	Be first. Set the agenda and be the one to set the anchor, creating the filter or main perspective that will be used to understand new information.	<ul style="list-style-type: none"> Ensuring public debate, liaising with opinion-leading stakeholders and building public understanding and even demand before launching health service reforms or new laws (e.g. smoking ban in public places, alcohol advertising bans or required front-of-pack labelling on nutrition) Using prebunking techniques when you anticipate negative framing or anti-science information from others: make people aware that this is what they will hear and why it is not correct
Affect heuristic	Emotions often have a stronger impact on behaviour than knowledge.	Use the context to affect thinking and feeling and use research and testing with target groups to know more about which triggers create positive and negative emotions and behaviours.	<ul style="list-style-type: none"> Providing training to clinicians to identify and overcome emotional reactions to patients that may inadvertently bias their decisions regarding diagnosis and treatment Developing and pretesting different emotional appeals in health communications, for example when encouraging people to attend cancer screening

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Psychological effect(s)	What it means	What to do	Examples of activities
Availability heuristic	Humans are not perfect information processors. We tend to assess risks and make decisions based on how easily examples of an event or a health-related harm come to our mind.	Understand what people's intuition tells them. Make a health risk concrete, relevant and tangible, using examples that are easy to imagine.	<ul style="list-style-type: none"> Communicating about health risks through the personal stories of similar people that are vivid and easy to remember Developing and testing visual illustrations of health risks and using those that are easiest to grasp and recall, e.g. graphs or pie charts Developing and testing messages that speak to factors in people's everyday lives, e.g. by using very local data rather than global data
Confirmation bias	We tend to notice, seek out, remember and trust information that is in line with what we already believe.	Remember that it is difficult to change people's minds. Anticipate potential information needs and offer easy-to-access, evidence-based information which matches what people need and are looking for.	<ul style="list-style-type: none"> Listening to people's concerns and communicating in a transparent way about risk Making sure that there is public understanding of a health problem before a new health law is introduced, so people see the law as addressing a problem, not as an unnecessary constraint Investing in education and critical thinking skills training for young people
Descriptive norms	The behaviour of our peers influences our own behaviour. We look to others to define what is acceptable and desirable.	Tell people that others in their reference group (peers, community members) are undertaking a healthy behaviour (provided it is true). Be careful not to communicate that only very few people are engaging in the positive behaviour, as this may further strengthen the negative norm.	<ul style="list-style-type: none"> Telling people who are not getting screened for diabetes that most in their reference group are doing so Telling family doctors that they are in a minority of doctors within their area prescribing a higher rate of antibiotics
Familiarity backfire effect	We assume that something is correct when we have heard it repeatedly. Even when the intention is to correct a myth, the myth can stay in people's minds just because it is repeated.	Do not repeat myths. Give a positive key message without mentioning the misconception.	<ul style="list-style-type: none"> Avoiding using the myth in a headline when you want to correct it Explaining the reason for the myth when correcting it

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Psychological effect(s)	What it means	What to do	Examples of activities
Framing effect	Our behaviours depend on how issues are presented to us, the choice of words and images, and the ordering of materials.	Choose your words wisely and use testing to select the message frame that has the best effect on the target groups.	<ul style="list-style-type: none"> Considering whether a loss frame or a gain frame works best: loss is a strong motivator; however, loss framing can elicit strong emotional reactions such as anger, leading people to the opposite behaviour Considering whether collective or individualistic framing works best: in some settings, framing public health measures to keep the community healthy may be effective in increasing compliance with measures; in other settings, focusing on keeping the individual healthy may be more effective
Friction cost	Sometimes the small additional effort required to undertake a behaviour can deter us from taking action.	Make it easy. Think about a process from the user's perspective and find ways to reduce the number of steps required to take action.	<ul style="list-style-type: none"> Easy appointment booking systems Including vaccination follow-up in other health-related events Exploring ways to include physical exercise so that it realistically fits into people's daily lives
Habits	Habits are difficult to give up. Replacing them with something else makes it easier to change behaviour.	Rather than asking people to give up a habit, it is easier to replace it with a healthier one. Explore ways to utilize already established habits and structures.	<ul style="list-style-type: none"> Reformulating drinks to include less sugar, rather than asking people to stop drinking sweetened beverages entirely Encouraging people to replace an unhealthy habit, such as snacking on sweets, with a healthier one, such as snacking on nuts or dried fruit
Inertia Status quo bias	We have a tendency to prefer continuity and maintaining things as they are, instead of taking action.	Use the default effect – the tendency to accept choices that are presented to us as a default rather than an open choice – as a way to improve healthy choices.	<ul style="list-style-type: none"> Presenting the desired behaviour as the default, e.g. "It is time for vaccination", rather than "Have you considered vaccination?" Sending out prescheduled appointments with the option to change or cancel, instead of asking people to book Setting the default dose and frequency prescribed by a doctor to a level that can reduce unnecessary prescribing

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Psychological effect(s)	What it means	What to do	Examples of activities
Information overload	Conflicting information and opinions, too many choices and too much information are stressful and make it difficult to make decisions and change behaviours.	Make it simple. When choices are easy to understand, we are more likely to change our behaviours. Provide a clear “call for action” and avoid too much complexity, choice and background information.	<ul style="list-style-type: none"> • Simplified forms for prescribing medication to reduce clinical errors • Flu vaccine posters to indicate when and where people can get vaccinated • Standard questions, checklists and standard operating procedures for health workers or tickboxes (checkboxes) on health cards • A vaccination schedule that is easy to grasp at a first look
Intention-action gap	Often, despite knowing what we should do and being motivated to do so, we do not follow through on our intentions. This can be due to forgetfulness, temptation, procrastination or existing habits.	Encourage people to set goals and make commitments. We feel bound by commitments, especially if they are written down or if failing has consequences. Writing down concrete goals or actions – including time and place, or how we plan to overcome obstacles (“If I encounter obstacle X, I will take action Y”) – increases the likelihood that we follow through on intentions. This idea or strategy is also referred to as “implementation intention”.	<ul style="list-style-type: none"> • Setting individual health goals in a contract or an app • Writing specific plans about when and how one will carry out an action; e.g. taking physical exercise, stopping smoking or attending a cancer screening • Making our goals and commitments public, for example on social media • Collecting a deposit from the target group engaged that is only returned when a certain goal is reached • Including a simple yet motivating consequence/penalty for not following through on agreed actions
Loss aversion Safety effect	When we assess risk and shape behaviours accordingly, we tend to be more concerned about avoiding losses than obtaining gains.	Create a feeling of loss if a behaviour is not sustained. The possibility of losing something is a strong motivator.	<ul style="list-style-type: none"> • Explaining disease risks, focusing on the potential loss • Designing an intervention with a concrete element of loss if people do not follow through, e.g. not having a small deposit returned or not being able to take part in a desirable event in the event of dropout
Negativity bias	We tend to give more attention to negative information and to find it more trustworthy.	Be aware that we have a special awareness for risks. Understand that negative messages of opponents (e.g. against vaccination) can be perceived as trustworthy.	<ul style="list-style-type: none"> • Avoiding repetition of opponents’ negative messages, even when you are trying to debunk them • Balancing your communication and key messages related to risk and remembering that people are more likely to retain the strong and negative messages than the nuances

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Psychological effect(s)	What it means	What to do	Examples of activities
Optimism bias Overconfidence	We tend to overestimate our ability and the likelihood of success and underestimate the likelihood of a negative event.	Provide accurate and easy-to-understand information, using examples that people can identify with. Provide feedback on people's actual performance.	<ul style="list-style-type: none"> Encouraging clinicians to access data on the clinical outcomes for their patients Measuring people's risk perceptions and showing them how their perceptions compare with those of the overall population
Present bias	We tend to prefer immediate rewards over rewards that come sometime in the future.	Find creative ways to provide immediate rewards for healthy choices.	<ul style="list-style-type: none"> Encouraging people to combine something that is healthy but not very enjoyable (e.g. physical exercise) with something enjoyable (e.g. listening to music or watching videos) Making even small, incremental gains visible through regular monitoring and feedback
Priming effect	Our behaviours are often influenced by unconscious triggers that create certain emotions.	Use the context to affect thinking and feeling and use research and testing with target groups to know more about which triggers create positive and negative emotions and behaviours.	<ul style="list-style-type: none"> Considering health facilities' furniture, decoration and sound (playing/not playing music, the kind of music) and health-care workers' attire as possible triggers affecting behaviours Using guidelines for stress and pain relief in vaccination procedures to create a positive experience
Prompt effect	Being prompted at the right time and place increases the likelihood of our changing behaviours.	Prompt the decision at the right place and time. Utilize the times and places where people are open to change and ready to act.	<ul style="list-style-type: none"> Prompting both parents to stop smoking during pregnancy visits Prompting people to commit to organ donation when they are renewing a driving licence Using the "fresh start effect" by encouraging healthier eating or physical activity at the start of a new time period (start of the year/month/week, or when moving jobs or house)

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Psychological effect(s)	What it means	What to do	Examples of activities
Reciprocity	When we know that we can protect others by behaving in a certain way and that they protect us too, we are more inclined to carry out the behaviour.	Communicate the social benefit of behaviours that advantage the community or society as a whole, thereby activating the social motivation to carry out those behaviours.	<ul style="list-style-type: none"> Communicating that those who cannot be vaccinated because they are too young, old or ill rely on those who can be vaccinated to protect them Communicating that one's protective behaviours can protect peers from (e.g.) mpox
Rewards	When we are rewarded for a behaviour, we are more likely to do it again.	Use incentives and consider appropriate ways to use rewards or recognition that may enhance motivation	<ul style="list-style-type: none"> When goals are achieved, rewarding groups that reached the target Setting targets for health workers in order to encourage certain behaviours, and offering financial incentives for reaching them
Social comparison Social networks	We are influenced by our friends and those in our broader social networks. We compare ourselves with the people we identify with.	Utilize the power of communities – groups defined by (e.g.) geography, culture, age, gender, socioeconomic status, education, profession, religion, beliefs, opinions, interests (including online).	<ul style="list-style-type: none"> Community volunteers/advocates/leaders engaged and trained to promote healthy behaviours Apps (mobile applications) where opinions, goals and behaviours are shared or compared with those of friends; consider opportunities to demonstrate positive behaviours: “I get vaccinated”, “I cycle to work” Providing comparative feedback to clinicians on how many brief interventions they have delivered compared to their peers
Worldview backfire effect	When we hear information that contradicts our worldview, this can paradoxically strengthen our worldview, especially if we already hold strong views.	Value, acknowledge and speak to people's worldviews. Focus efforts on the undecided minority, rather than on those who already hold fixed views. Reduce psychological resistance through self-affirmation, where people connect with their values and feel less threatened as a result.	<ul style="list-style-type: none"> Using appropriate spokespersons; for example, a religious leader saying that blood donation or vaccination is allowed Using self-affirmation before presenting a message that potentially conflicts with people's worldview; for example, a testimonial from a young person: “I love cars, I love my friends – and I love my seat belt”

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Further reading regarding unconscious psychological determinants of behaviour

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INSPIRATION BOX 16

Using policy action to support intervention implementation



PHASE 3

Refine and plan the intervention

To ensure feasibility, it is relevant to consider how policy action can support the success of the intervention and its activities. A policy action, often introduced by public authorities, is initiated to support and enact the activities and the intervention as a whole.

Activities themselves may also be related to policy, so the only consideration at this stage is to check if (additional) policy actions need to be initiated as drivers of the intervention. Some possible policy actions are shown in Table 16.1.

Table 16.1. Definitions and examples of policy actions

Policy action	Definition	Example
Official guidelines or standard operating procedures	Creating documents that recommend or mandate practice	If the intervention involves training of health workers in patient communication, new standard operating procedures may be introduced that define this communication as the standard.
Regulation	Establishing rules or principles of behaviour and practice	If the intervention involves introducing intercultural mediators, the training qualifications, pay and rights of such personnel will need to be regulated.
Legislation	Making or changing laws	If the intervention involves new nutritional front-of-pack labelling, a new law may need to be introduced that mandates food producers to use such labels.
Environmental planning	Designing and/or controlling the physical environment	If the intervention involves incentives to motivate people to cycle to work, cycle lanes may need to be improved.
Social planning	Affecting the social environment	If the intervention involves new restrictions on alcohol or tobacco, efforts may be made to increase public acceptability of these measures before implementation.

Source: adapted from Michie S, Atkins L, West R. *The Behaviour Change Wheel: a guide to designing interventions*. London: Silverback Publishing; 2014 (<http://www.behaviourchangewheel.com>).

INSPIRATION BOX 17

Considerations on equity and diversity sensitivity



USE FOR

PHASE 3

Refine and plan the intervention

When refining your intervention, it is relevant to reconsider any possible issues relating to equity and diversity or cultural sensitivity. Revisit your original situation analysis and consult representatives of the target groups and experts who are engaged with the target groups.

Health equity

In developing a THP intervention, special emphasis should be placed on health equity, exploring how interventions affect those experiencing disadvantage and who is being left behind. Factors associated with health equity that may be considered include education, living standards, gender, distribution of power, policy frameworks and social values.

Diversity sensitivity

The intervention may be strengthened by taking into account cultural diversity and differences, including those related to gender, ethnicity, age, socioeconomic status, religion, sexual orientation and other social markers. The THP intervention can strive to achieve cultural proficiency, which comprises several characteristics: holding culture in high esteem; acceptance of and respect for difference; striving to better meet the needs of diverse populations; and seeking to improve relations between cultures.

Self reflexivity

Consideration may also be given at this point to examining the shared understandings and priorities of the THP Core Group itself with respect to the project, and how these may influence decision-making and planning.

INSPIRATION BOX 18

Considerations on sustainability



PHASE 3 Refine and plan the intervention

In a discussion on the short- and long-term sustainability of the planned intervention and its activities and policy actions, it is relevant to consider the following.

Human resources

- Are the necessary human resources available in the short and long term?
- Is the necessary expertise and capacity available in the short and long term?
- Are roles and responsibilities clear? Are they clear if the project is scaled up to cover additional target groups or additional geographical areas?
- Do any external support opportunities exist, such as volunteers or staff from local or nongovernmental organizations?

Financial resources

- Is sustainable funding of this intervention realistic in the short and long term?
- What funding sources exist (internal and external donors)?
- Could a budget increase be obtained through budget negotiations?
- Could there be a reallocation of resources that involved other activities being scaled down?
- Are there opportunities for joint funding with other institutions/programmes/ministries?

Supporting systems and processes

- Are there any existing health system structures or processes to support sustainability?

Content resources

- Are there any existing tools (training programmes, information materials, guidelines, standard operating procedures, project descriptions) that could be adapted and used, so that it is not necessary to develop new ones from scratch? Consider, for example, other countries or other health programmes.
- Are there similar projects in other countries or other institutions that could be adapted?

Political will

- Is the necessary political and management support in place to ensure long-term sustainability?
- How can advocacy activities ensure political and management support? How can partners (WHO or other international organizations, local opinion leaders, community leaders, etc.) help to advocate for the project?

INSPIRATION BOX 19

Project plan



PHASE 3 Refine and plan the intervention

The contents and format of the project plan depend on the context and the intervention. Much of the information needed will be available in the progress report and protocol.

Some key elements to include are:

- Introduction;
- Background (summary of findings and decisions from PHASES 1–3);
- Aims and objectives;
- Target group(s), clearly defined and segmented by activity/policy action;
- Overall presentation of the intervention: intervention types, activities and policy actions;
- Detailed description of each activity: scope (what, where, how and how much), purpose, timing, location, roles, responsibilities at all levels;
- Sustainability;
- Monitoring and evaluation framework;
- Budget, broken down by activity;
- Timeline with milestones.

A summary table can be developed as shown in Table 19.1.

Table 19.1. Template for summary table for project plan

Activity	Scope	Target group(s)	Timing	Location	Roles and responsibilities	Budget	Monitoring and evaluation targets
Intervention type:							
Activity							
Activity							
Policy action							
Intervention type:							
Activity							
Activity							
Policy action							

INSPIRATION BOX 20

Theory of change



PHASE 3
Plan evaluation
PHASE 4
All steps

A theory of change is a description of the logic behind the intervention. It describes how and why the intervention is expected to be effective.

Writing down the theory of change provides an overview and summary of all key elements of the THP process and how they relate to each other:

- Problem identification and target groups/target behaviours derive from PHASE 1 Situation analysis
- Barriers and drivers derive from PHASE 2 Research
- Intervention derives from PHASE 3 Intervention design
- Output, behavioural outcome and health outcome derive from PHASE 4 Implementation and evaluation.

Fig. 3 (page 10) provides a visualization of the theory of change, with example text dealing with the problem of reducing the high level of morbidity and mortality due to breast cancer among women aged 50 years and over.

External influencing factors (confounding factors)

External influencing factors – also referred to as confounding factors – are factors external to the intervention that are likely to influence the ability of the intervention to bring about the desired outcome. Consider, for example, societal events or initiatives, policy changes, societal or structural changes, or economic or labour developments, as well as more specific project-related factors such as financial and human resources available for the project, ownership and interest among key stakeholders, and participation by the target groups, among others.

You may group these factors by **assumptions**, meaning the conditions that need to be in place for the intervention to be implemented as planned; and by **risks**, meaning the factors that may prevent this.

Using the theory of change to understand project outcomes

If a positive change in a barrier that has been identified is found in an evaluation, it indicates that the barrier was successfully addressed. For example, knowledge (capability) increased. However, in some cases you may find that the intended positive change in the behavioural outcome or health outcome did not occur. This indicates that addressing this barrier (alone) did not lead to the intended change, and the theory of change needs to be revised. In this case, it is worth revisiting Exercises 4–7 to identify other barriers that you need to address as well to reach your targets.

INSPIRATION BOX 21

Key concepts of monitoring and evaluation



USE FOR

PHASE 3
Plan evaluation
PHASE 4
All steps

The core of the monitoring and evaluation (M&E) framework is a set of targets and indicators related to the implementation of the intervention and its impact.

It also comprises an overview of baseline data and considerations related to external influencing factors, equity, cost-effectiveness and broader unintended effects.

Baseline

The baseline is the situation before an intervention occurred. Collecting the same type of data before and after an intervention allows to compare any change that has occurred over time.

Targets

Targets represent the change you wish to see. They are expressed as specific increases or decreases that are aimed for – for example, a percentage increase in the uptake of a health behaviour or a reduction in disease incidence or mortality rate.

As illustrated in the theory of change ([Inspiration box 20](#)), targets are set for both the process (intervention implementation) and the impact (output and outcomes).

- **Process targets** are set to understand the success of the intervention implementation: why it has or has not worked, its quality and its acceptability among targeted stakeholders ([Inspiration boxes 22–23](#)).
- **Impact targets** are set to document the possible impact on the barriers and drivers identified (output); on the target behaviour (behavioural outcome); and on the health topic (health outcome/THP goal) ([Inspiration boxes 22–23](#)).

Indicators

Indicators are the type of data or information used to measure whether the targets were reached. Indicators need to be defined for each target and for both process and impact targets. Targets and indicators are thus interconnected, as indicators are used to see if targets were reached ([Inspiration boxes 22–23](#)).

External influencing factors (confounding factors)

The evaluation may not document any change, and any change documented may not be attributable to the intervention. The explanation of this may lie not in the intervention itself but in factors outside your control.

Therefore, any evaluation must consider external influencing factors (also referred to as confounding factors) in the interpretation of data. The theory of change outlines the expected external influencing factors – for example, other activities implemented in parallel, legislative, political, societal and structural changes, and project funding and support.

Special focus

In monitoring and evaluating an intervention, it may be decided to place extra emphasis on one or more specific dimensions and integrate these aspects into the M&E framework. Such aspects include equity, cost-effectiveness and broader unintended effects.

Equity

M&E may be done with a special focus on equity and on how the intervention affects those experiencing disadvantage in a broader sense. To focus on equity and allow segmentation of target groups, M&E data can be broken down (provided there is a sufficient sample size) by characteristics such as:

- socioeconomic factors, including income, education and living standards
- ethnicity, nationality or religion
- gender
- location, such as geographical area or urban/rural residence.

Cost-effectiveness

Economic and value-for-money factors can be monitored and evaluated to assess if an intervention is cost-effective. An economic evaluation compares the cost of delivering the intervention with the costs saved. The latter may include savings in disease treatments and hospitalizations, reduction in the quality-adjusted life year burden on the population due to a disease outbreak, etc. A range of frameworks exist for conducting economic evaluations.

Unintended effects

An intervention may successfully reach its targets and at the same time have unintended negative or positive effects. Such unintended effects may relate to well-being, trust or social cohesion of people affected or involved in the intervention. It is recommended that these possible unintended effects of the intervention are evaluated alongside the targets set for it.

INSPIRATION BOX 22

Process monitoring and evaluation

USE FOR

PHASE 3

Plan evaluation

PHASE 4

Evaluate the impact

Monitor

Conduct long-term evaluation

The monitoring and evaluation (M&E) framework should include a description of what data are collected and how, including data related to process M&E.

The aim of process M&E is to understand and document the functioning of an intervention. Monitoring and evaluating the process is always additional to evaluating the impact of an intervention, not a substitute for it.

Targets and indicators

Process targets/indicators may relate to:

- quantity of activities (how many activities);
- extent of activities (how many people engaged, how many from the target group);
- quality of activities (satisfaction among participants, objective quality criteria);
- acceptability of activities (satisfaction among participants);
- use of activities (whether used as intended);
- successes and shortcomings in the process and implementation of activities or policy actions.

At a minimum, it is proposed that targets and indicators are selected that help to measure whether the planned activities and policy actions were conducted at all. If resources are available, it may be relevant to add additional process targets and indicators for some or all activities.

Data collection

Relevant data collection methods include:

- retrieving data from official health registers;
- retrieving data reported from health or social facilities;
- registering participation in interventions through lists or forms;
- collecting data through participant evaluation forms;
- conducting intervention observations using checklists, with checks for (e.g.) quality, level of participation, participant response and engagement;
- conducting stakeholder interviews, surveys or workshops;
- conducting interviews with or obtaining reports from people involved in implementing interventions;
- conducting participant interviews or focus groups
- implementing participant surveys, questionnaires or tests.

An example of process indicators and targets, data sources and collection methods for an intervention involving training of health workers is shown in Table 22.1.

Table 22.1. An example of process indicators and targets, data sources and data collection: training healthtraining health workers

	Quantity	Extent	Quality
Indicators	Number of cascade trainings	Number of low-coverage clinics trained	Number of quality measures approved per training
Targets	Five or more cascade trainings conducted	Fifty or more trainings conducted in low-coverage clinics	At least 90% of quality measures approved for each training observed
Data sources	Training registration lists	Training registration lists	Quality observation checklist, conducted for 10% of trainings
Data collection	Registration lists sent to project coordinator	Registration lists sent to project coordinator	Quality checklists sent to project coordinator

INSPIRATION BOX 23

Impact evaluation



USE FOR

PHASE 3

Plan evaluation

PHASE 4

Evaluate the impact

Conduct long-term evaluation

The monitoring and evaluation (M&E) framework should include a description of what data are collected and how, including data related to impact evaluation.

Impact evaluation can help to determine an intervention's impact in specific contexts and with specific target groups. It can be done as part of a pilot phase (with a smaller group before rollout) and/or longer-term (after rollout and scale-up).

Outputs and outcomes

The aim of impact targets/indicators is to document the change that has occurred with respect to the output, the behavioural outcome and the health outcome. At a minimum, it is recommended that one target and one indicator for each output and outcome are defined.

Output

The output is the change we wish to see with respect to the barriers and drivers, whether associated with capability, sociocultural opportunity, physical opportunity and/or motivation factors (for example, documented increase in knowledge/capability). Any change in barriers may be measured in an experiment before rollout of the activity. Any change in barriers may be measured in the short or medium term.

Behavioural outcome

The behavioural outcome is the change in behaviour we wish to see (for example, documented increase in cancer screening attendance). Intentions about behaviours may be measured in an experiment before rollout of the activity. Behavioural outcomes may be measured in the medium or long term.

Health outcome/THP goal

The overall health outcome/THP goal is the change in health we wish to see (for example, documented reduction in disease prevalence or mortality). Health outcomes are often only measured in the long term (potentially years).

An example of impact indicators and targets for an intervention aiming to reduce mortality from breast cancer is shown in Table 23.1.

Table 23.1. An example of impact indicators and targets: reducing mortality from breast cancer

	Output: Increased knowledge among health workers (capability)	Behavioural outcome: Uptake of breast cancer screening in target group	Health outcome/THP goal: Reduction in mortality from breast cancer in target group
Indicators	Percentage of correct responses in questionnaires after training	Percentage of breast cancer screening uptake per clinic	Annual number of breast cancer-related deaths among women aged 35–70
Baseline	Average of 53% correct answers in test group before intervention	Average of 65% uptake per clinic	865 annual breast cancer-related deaths among women aged 35–70
Target	At least 90% correct responses from 90% of people targeted with training	At least 85% uptake in all clinics	Less than 250 annual breast cancer-related deaths among women aged 35–70
Data sources	Online questionnaire for all health workers in all low-performing clinics	Monthly reporting from clinics	National registry

Impact evaluation design

An impact evaluation is a systematic and empirical investigation of the effects of an intervention; it assesses to what extent the outcomes experienced by affected individuals were caused by the intervention in question. The design of an impact evaluation will depend on the intervention and activities planned and should be proportionate to the available resources and scale of the project, as well as agreeable to everyone involved and affected.

Evaluation designs may be quantitative, qualitative or mixed. Qualitative methods can involve observational studies to observe and document any possible changes in behaviour. Qualitative methods such as in-depth interviews or focus groups can be used to explain the quantitative findings (for an introduction to different research methods, see [Inspiration box 11](#)). Three quantitative evaluation design methods are described below.

Nonexperimental designs

Nonexperimental designs can be used to assess whether the intervention has led to a change in health behaviour by establishing a baseline of data documenting the situation before the intervention. The baseline is then compared with the situation after the intervention within the same target group. The main drawback with such pre-test/post-test designs is that there may be confounding factors that have led to the observed change in health behaviour or to outcomes that are unrelated to the intervention. If a nonexperimental design is the most practical solution,

specific attention should be given to a strong theory of change and to measuring potential confounding factors that can be included in the analysis.

Nonexperimental designs can also be used to evaluate long-term impact after an intervention has been rolled out on a larger scale.

Experimental designs

In experimental designs, both an intervention group and a comparison group are established. Experiments can be done in different settings, from relatively artificial laboratory or online environments to real-life settings. In behavioural science, experiments often take the form of randomized controlled trials (RCTs). In RCTs, people in the target group are randomly allocated into two or more groups. The intervention group is exposed to the intervention that is being tested (such as a simplified information leaflet). The comparison or control group is exposed to no intervention or “business as usual” (such as a standard leaflet). Because of the random allocation, the groups are identical except for the intervention they receive. In this way, it can be determined whether a change in observed behaviour or other outcome measure was due to the intervention, rather than other coinciding factors.

This ability to measure if an intervention has actually led to a change in behaviour is the major advantage of RCTs. With a sufficient sample size, it is possible to test multiple interventions, or versions of the same intervention in parallel. It is also possible to analyse

the impact of the intervention on different subgroups to see if the intervention impacts different population groups differently.

RCTs can be complemented with other, more qualitative research methods, to understand the experiences of those receiving the intervention. This can allow the way in which the intervention is implemented to be improved before it is rolled out on a larger scale, or it can help to understand why an intervention was not as effective as hoped for all or some groups of the population.

Quasi-experimental designs

Like experimental designs, quasi-experimental designs test whether an intervention has led to or caused a change in health behaviour. However, in a quasi-experimental design the intervention is not randomly assigned to people in the target group. Instead, the comparison group is established by identifying a group that is as similar as possible to the intervention group in terms of baseline characteristics. This could, for example, be sociodemographic characteristics or health conditions. The comparison group then captures what would have been the outcomes if the intervention had not been implemented. In this way, the intervention can be assumed to have caused the difference in observed behaviours or other outcomes between the intervention and comparison groups. Quasi-experimental research designs are most often used when it is not possible to randomly divide individuals or groups into intervention and comparison groups.*

* White H, Sabarwal S. Quasi-experimental design and methods. Methodological briefs: impact evaluation 8. Florence: UNICEF Office of Research; 2014 (<https://www.unicef-irc.org/publications/753-quasi-experimental-design-and-methods-methodological-briefs-impact-evaluation-no.html>, accessed 11 January 2023).

The WHO Regional Office for Europe

The World Health Organization (WHO) is a specialized agency of the United Nations created in 1948 with the primary responsibility for international health matters and public health. The WHO Regional Office for Europe is one of six regional offices throughout the world, each with its own programme geared to the particular health conditions of the countries it serves.

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