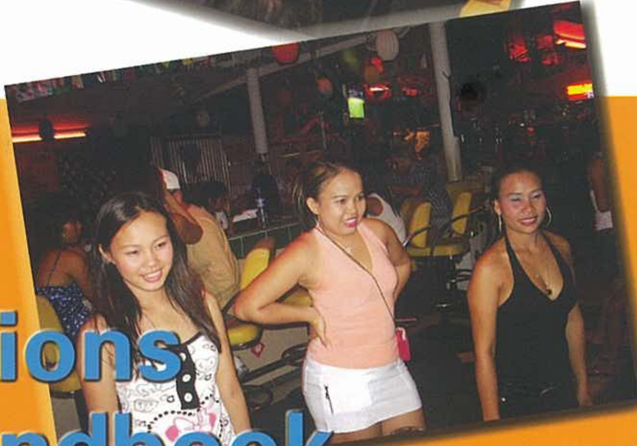

Planning BCC Interventions A Practical Handbook

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2006

Planning Behaviour Change Communication (BCC) Interventions: A Practical Handbook

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UNFPA, the **United Nations Population Fund,** is an international development agency that promotes the right of every man, woman, and child to enjoy a life of health and equal opportunity. UNFPA supports countries in using population data for policies and programmes to reduce poverty and to ensure that every pregnancy is wanted, every birth is safe, every young person is free of HIV/AIDS, and every girl and woman is treated with dignity and respect.

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Foreword

The Programme of Action of the International Conference on Population and Development (ICPD) held in Cairo in 1994 recognized that effective information, education and communication are essential for attitudinal and behavioural change. In line with this Plan of Action, UNFPA country programmes have been using behaviour change communication (BCC) strategies in support of reproductive health (RH) in general, adolescent reproductive health (ARH) and HIV/AIDS prevention in particular.

A review of the implementation of the above programme components in East and South-East Asia region in 2005 by Mr. Peter Chen, Advisor on Adolescent Reproductive Health in CST Bangkok suggested that there was a need for a practical handbook on planning BCC interventions at the country level to help UNFPA country offices and partners to more effectively introduce behaviour change in the context of RH, ARH and HIV prevention. The need for such a handbook was expressed by UNFPA colleagues from East and South-East Asia at a workshop held in July 2005. Subsequently, the steps for the planning of BCC interventions outlined in this handbook were tested and used by the UNFPA Indonesia and UNFPA Viet Nam country offices to draft their Country Programme BCC strategies.

We would like to acknowledge Mr. Peter Chen's efforts in bringing out this BCC handbook at a time when a number of UNFPA country offices are preparing their new Country Programmes Action Plans and Annual Work Plans. We hope this handbook will be useful to all of them.

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December 2006

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Acronyms

AAM:	audience analysis matrix
ACADAE:	assessment **(A)**, communication analysis **(CA)**, design & development **(D)**, action **(A)**, evaluation **(E)**
AWP:	annual work plan
BAM:	behaviour analysis matrix
BCC:	behaviour change communication
CAM:	causal analysis matrix
CBO:	community-based organization
CCA:	common country assessment
CCAM:	communication channel analysis matrix
CP:	Country Programme
CPD:	Country Programme Document
CPAP:	Country Programme Action Plan
DOH:	Department of Health
DOPA:	direct, objective, practical, adequate
HIV/AIDS:	human immunodeficiency virus/acquired immune deficiency syndrome
IA:	intended audience
ICPD:	International Conference on Population and Development
IEC:	information, education, and communication
JOICFP:	Japanese Organization for International Cooperation in Family Planning
MDGs:	Millennium Development Goals
M & E:	monitoring & evaluation
MOH:	Ministry of Health
MYFF:	multi-year funding framework
MMR:	maternal mortality rate
NGO:	non-governmental organization
PA:	primary audience
PD:	population and development
PoA:	plan of action
PRSP:	poverty reduction strategy paper
RTI:	reproductive track infection
SA:	secondary audience
SAM:	stakeholders analysis matrix
SDP:	service delivery point
SMART:	specific, measurable, achievable, relevant/realistic, time-bound
STI:	sexually transmitted infection
TOT:	training of trainers
UNICEF:	United Nations Children Fund
UNDAF:	United Nations Development Assistance Framework
UNFPA:	United Nations Population Fund
VCD:	video compact disc
VCPFC:	Viet Nam Committee for Population, Family and Children
VCR:	video cassette recorder
VCT:	voluntary counselling and testing

Chapter-1: Introduction to the Handbook

Overview and Rationale for the Handbook

ICPD and communications

The International Conference on Population and Development's (ICPD) Programme of Action (PoA) recognized that *"effective information, education and communication are prerequisites for sustainable human development and pave the way for attitudinal and behavioural change."*

Review of UNFPA East & Southeast Asian countries' communication initiatives

In 2005 UNFPA CST, Bangkok, conducted a desk review of the understanding and applications of "advocacy," "BCC" and "IEC" activities in country programmes in the East and Southeast Asia region. As part of the review process, a 3-day regional consultation was organized among colleagues from the subregion. Participants were staff who had major responsibility for implementing the advocacy, BCC and IEC projects in their respective countries.

UNFPA Global Technical Meeting on BCC - 2005

This was followed by the Global BCC Technical Meeting of UNFPA communication specialists in Tokyo from 6 - 8 December 2005. Advisors from seven CST offices who have major responsibilities for BCC interventions, four UNFPA Representatives (three of whom were former CST Advocacy/BCC Advisors) and the Chief of RH Branch at TSD met at the JOICFP headquarters to discuss the role and future of BCC in UNFPA programmes.

The literature review and above two consultations pointed to the need for a common understanding and clear guidelines on planning and implementing BCC interventions to develop results-oriented programmes at the country level. This Handbook attempts to address these needs and thus lead towards that end.

The term "IEC" is variously understood and used by UNFPA staff and partners. It is used for describing programmes for family planning, population education in schools, public media campaigns, print and other communication materials, etc. In recent years, the emphasis has been on the production of communication materials, especially printed materials with very little reference to the process of communication that is critical for modifying or changing individual health risks behaviours.

The terminology of BCC was brought into UNPFA use in the late 1990s in line with the use of the logical framework ("logframe") and results-based programming. However, there were difficulties in demonstrating results in terms of individual, group or community behaviour changes due to UNFPA

programme interventions. Many projects supported the production and utilization of IEC materials as an end itself rather than as a means to an end. This was due mainly to difficulties in setting measurable result indicators while designing the projects. Often, projects did not have proper baseline and endline surveys to measure intervention results or their impact on intended population's behaviours.

Why write a BCC Handbook for UNFPA?

This handbook is a hands-on document developed to help UNFPA country offices and their partner agency staff to incorporate behaviour change communication (BCC) interventions into their policies and programme designs. The handbook hopes to enhance staff capacities in the planning, implementation and managing of evidence-based communica-tion strategies.

The handbook begins with clarification of the concepts of BCC interventions in the context of UNFPA programmes. This is followed by a brief presentation of some of the most common theoretical frameworks that serve to help us understand the processes that can influence health-related behaviours. An important aspect of the handbook is the step-by-step guide on following a process or chain of events to plan, design, execute, monitor and evaluate BCC interventions.

Breaking Down Resistance to Reproductive Health Education in Indonesia

From 2002 to 2004, the Indonesian Planned Parenthood Association's (IPPA) Centra Remaja Khatulistiwa (CRK) Youth Centre in West Kalimantan trained 138 teachers of elementary and junior high schools as facilitators in their respective schools to provide reproductive health information to students. Initially, the teachers did not receive much support from their Principals for their activities as they were not in the regular curriculum. These trained teachers then set up an "Education Forum for Adolescent Reproductive Health" and invited the Principals of local schools to meet with them. The advocacy meetings resulted in their receiving permission and critical support from their school Principals to provide the ARH information to their students through extra-curricula activities.

Source: PKBI, BKKBN, UNFPA. (2006). *Lessons Learnt – A Model of Youth Friendly Services in Indonesia: A Commitment for Young People.*

Chapter-2: Rethinking Behaviour Change Communication

Behaviour change communication is a critical component to achieve the Millennium Development Goals (MDGs). For example, in order to achieve;

BCC and the Millennium Development Goals (MDGs)

MDG 1 - ***"Eradicate extreme poverty and hunger"***: BCC interventions can promote family planning for smaller family size, higher female participation in the labour force and thus reduce poverty by increasing the household income.

MDG 2 - ***"Achieve universal primary education"***: BCC interventions can promote the elimination of harmful practices such as early marriage so that girls are able to attain the highest level of education.

MDG 3 - ***"Promote gender equality and empower women"***: BCC interventions can encourage male participation to reduce gender based violence and promote gender equality. Similarly, BCC interventions contribute immensely to ARH and RH programmes in reducing child mortality, improving maternal health and prevention of HIV/AIDS through provision of appropriate information and communication skills to negotiate for safer health behaviours.

MDG 4 and 5 - ***"Reduce Child Mortality"*** and ***"Improve Maternal Health"***: BCC interventions can promote behaviours related to safe motherhood and child immunization thus reducing maternal and child mortality and morbidity.

MDG 6 – ***"Combat HIV/AIDS, malaria and other diseases"***: BCC interventions are critical for reducing health risk behaviours to prevent the spread of HIV/AIDS.

The success of UNFPA programmes depend on behaviour change of society and individuals

While the UNFPA Multi-Year Funding Framework (MYFF)[1] does not explicitly refer to BCC *per* se, behaviour change underlies achievement of expected outputs, with special focus on key change agents such as service providers at service delivery points (SDPs), government officials and educators. Service providers are expected to make comprehensive reproductive health services available by offering the following reproductive health services:

[1] UNFPA MYFF will be replaced by MTSP (Medium Term Strategic Plan) from 2008-2011.

- modern family planning methods; maternal health and assisted delivery;
- prevention and management of reproductive track infections (RTIs) including sexually transmitted infections (STIs) and HIV/AIDS;
- management of the consequences and complications of unsafe abortion;
- information, education and counselling on human sexuality and reproductive health including family planning;
- information, education, counselling and access to services to adolescents.

BCC and quality of care

Quality of care in reproductive health (RH) also depends on the behaviour and attitudinal change of service providers in accordance with established protocols. Finally, the MYFF suggests that UNFPA would contribute to disseminating information materials on gender issues specifically intended for men.

Increasing incidence rates of sexually transmitted and HIV infections especially among young people have necessitated the need to focus on risk behaviour change interventions to stem the HIV epidemic. The emergence of other behavioural issues such as domestic violence, sex work, injecting drug use among others, have also raised the importance of interventions to promote behaviour change and harm reduction.

As human behaviour is an important factor in population and development (PD), gender and RH approaches, behaviour change strategies become the keys. These require proper understanding and application of effective methods to change behaviour through communication. Spurred by the increased global interest in health promotion in the efforts to strengthen HIV prevention programmes in the eighties and nineties as well as the innovations of the ICPD PoA, it is clear that a more targeted and comprehensive approach is needed to assist people to live healthier lives.

BCC and reproductive health issues

Today, BCC interventions have become even more crucial to increase the demand for and access to quality RH services. Sexuality and life-skills education in formal and non-formal settings provide information leading to improved health seeking behaviours and attitudes, crucial in the development of informed choice among young persons. Young people in turn can influence family members, siblings, and the extended family. In this context, providers' attitudes and practices are important, thus BCC interventions should also aim to develop interpersonal communication skills to enhance client - provider interactions leading to improved quality of RH services.

To increase their effectiveness, BCC initiatives need to prove their value as investments. It is critical to provide evidence that BCC interventions make a difference in people's lives. Practitioners have to endeavour to document and show the value of BCC intervention efforts. New analytical skills and evaluation techniques are needed to evaluate the implications and impact of BCC interventions in health investments.

The New Paradigm

The field of behaviour change has now moved from theories and models to focusing on individual and group behaviour changes on larger contextual factors. Models have been established to show how to mobilize community members and organizations for behaviour change in schools, workplaces, health institutions, and community group settings. This change is critical in order to respond to the ICPD Plan of Action and Millennium Development goals (MDGs); to rapidly scale up and integrate BCC interventions into development programmes in a coordinated and sustained manner.

Change affects all aspects of life

Sustained behaviour change is effective only when combined with changes in the broader socio-economic environment within which communities and individuals live. These include a number of underlying and contextual factors such as government and international policies, national structures and systems. Examples are changes in values and practices; changes in traditional, cultural and religious beliefs; changes in the perception of boys and girls' education; changes in socio-economic status and gender relationships of people. In addition, national policies, availability and accessibility of quality sexual and reproductive health services, including customer-client care influence behaviours and practices of individuals and communities.

Paradigm shift from IEC to BCC in programmes

This paradigm shift from IEC to BCC interventions implies not just a categorical change, but more importantly, a conceptual and programmatic refocusing on the strategic elements of social and behavioural change that is needed in all UNFPA programmes. It is unfortunate that in spite of the simplicity of meaning and linguistic interpretations of the terms "information," "education," and "communication," the acronym IEC has become largely synonymous with nothing more than awareness creation and materials production. It is for this very reason, that this planning handbook and guidance note on behaviour change communication is both relevant and necessary.

Chapter-3: Clarification of the BCC Concepts

A simple definition among many definitions

Behaviour change communication or "BCC" is a set of organized communication interventions and processes aimed at influencing social and community norms and promote individual behavioural change or positive behaviour maintenance for a better quality of life.

The purpose of BCC

In the context of UNFPA programmes, BCC is critical to addressing among others, responsible sexual behaviour; age at marriage; teenage pregnancy; prevention of sexually transmitted infections and HIV/AIDS; gender-based violence; male responsibility for RH; gender equality; safe motherhood, maternal and child health, family planning, reproductive rights, discrimination against the girl child and persons with disabilities, and reduction of harm and risks among identified vulnerable population groups.

BCC is one of the strategic components of communication for population and development along with advocacy, social mobilization, community mobilization and social marketing. In a specific population or RH communication intervention, these components can be judiciously combined.

As mentioned in Chapter-2, there is need to focus on behavioural change of individuals and societies to stem the epidemic of HIV infections. Strategic behaviour change interventions incorporated within the human rights framework are crucial to the success of UNFPA programmes. This requires understanding of change theories as well as actual communication strategies and programmes.

BCC helps increase demands for quality RH services

Attitudes and behaviours of service providers are important for increasing the demand for and access to quality RH services. They need to be non-judgmental especially towards adolescents. BCC interventions aim to develop interpersonal communication skills to enhance client-provider interactions. The ability to formulate the right messages targeted to specific audiences using the most appropriate channel is critical for success, especially in efforts to promote health-seeking behaviours among individuals and communities. Influencing behaviours and changing attitudes with the view towards preventing STIs, particularly HIV/AIDS require persistent and sustained multi-media efforts. Sexuality education in formal and non-formal settings has assumed significance in influencing young people's attitudes, behaviours and decision-making skills. These skills have also enabled many young people to have positive influence on their peers, family members, siblings, and the extended family. As much as possible, BCC interventions should be participatory and gender-sensitive, especially at the community level. Gatekeepers and stakeholders including vulnerable groups should participate in the planning, implementation, delivering and evaluation phases in order to foster ownership, sustainability and empowerment.

BCC is Based on Behaviour Change Theories and Models

BCC has its origins from and draws on over 70 behaviour change theories and models including the *Health Belief Model, Theory of Reasoned Action, Transtheoretical Model, Stages of Change Theory, Steps in Behaviour Change, and, Diffusion of Innovations* to name a few. These theories and models help in understanding what influences behaviour adoption or maintenance and contribute to the planning, implementation and evaluation of evidence-based BCC interventions. Discussion of all these theories is beyond the scope of this handbook but readers are encouraged to visit the Communication Initiative's website *http://www.comminit.com* which is a good source for behaviour change theories, models and current practices. While UNFPA does not endorse any specific model or theory, it is important to take into account some of these theories in the programming process and in designing of BCC interventions to ensure the achievement of intended results. All of these models have in common the fact that individuals are not isolated from their families and communities, and that adoption of new behaviours or modification of old ones is a process and as such, it takes time and dedication to see the change.

Health Belief Model

The Health Belief Model stipulates that a person's health-related behaviour depends on the person's perception of four critical areas: the severity of a potential illness, the person's susceptibility to that illness, benefits of taking preventive action, and the barriers to taking that action. The model incorporates actions as important elements in eliciting or maintaining patterns of behaviour. For example, writing a note to remind oneself to exercise.

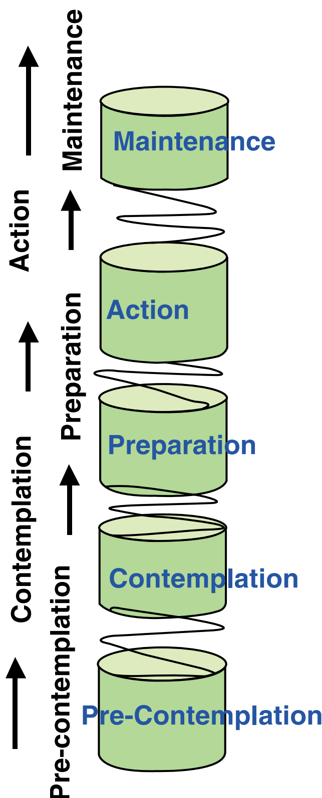
Theory of Reasoned Action

Theory of Reasoned Action states that an individual's behaviour is primarily determined by the person's intention to perform that behaviour. This intention is determined by two important factors: the person's attitude toward the behaviour (i.e., beliefs about the outcomes of the behaviour and the value of these outcomes) and the influence of the person's social environment or subjective norm (i.e., beliefs about what other people think the person should do, as well as the person's motivation to comply with the opinions of others).

Stages of Change Theory

Stages of Change theory has been conceptualized as a five-stage process or continuum related to a person's readiness to change: (i) pre-contemplation, (ii) contemplation, (iii) preparation, (iv) action, and (v) maintenance. People progress through these stages at varying rates, often moving back and forth along the continuum a number of times before attaining the goal of maintenance. The stages of change are better described as spiralling rather than

linear. In this model, people use different processes of change as they move from one stage of change to another. Efficient self-change depends on doing the right thing (processes) at the right time (stages). According to this theory, tailoring interventions to match a person's readiness or stage of change is essential. For example, for people who are not yet contemplating becoming more active, encouraging a step-by-step movement along the continuum of change may be more effective than encouraging them to move directly into action.



The Behaviour Change Spiral
(Begin the spiral from the bottom)

Maintenance: The individual needs to continuously maintain the new behaviour or she/he will relapse back to the older unhealthy behaviour.

Action: The individual takes appropriate action to change her/his behaviour.

Preparation: The individual collects information and assesses her/his skills required to effect the change. She/He will also consider what impact it will have on herself/himself and others.

Contemplation: An event or a trigger prompts the individual to consider that she/he should change his/her behaviour.

Pre-Contemplation: The individual has not thought of changing her/his behaviour.

Chapter-4: The ACADAE Process for Planning BCC Interventions

Many communication tools are available

A successful BCC intervention uses various communication methods and tools, including face-to-face communication, training, community media, mass media, information and communication technology (ICT), life-skills education and counselling to develop the skills and capabilities of targeted audiences to manage their own health and development. Methods to foster positive changes in individual behaviours as well as increase knowledge and affect the attitudes of the intended audiences are needed. It is in this context that UNFPA country programmes plan and implement BCC interventions to improve maternal health so as to achieve ICPD and MDG goals; to reduce teenage and unplanned pregnancies and in support of RH, ARH, HIV/AIDS and STI prevention.

UNFPA Country Programme implementation

UNFPA partner with governments and non-governmental organizations to execute country programmes through *Annual Work Plans* to achieve the *Outcomes* and *Outputs* that are synchronized with those of the United Nations Development Framework (UNDAF) outcomes drawn up jointly by the UN Country Team of the country. The emphasis is on results such as the increased use of condoms for dual protection of HIV/STI prevention and unplanned pregnancies. BCC outcome and output indicators are thus important for monitoring risk behaviour changes.

The **ACADAE** planning process for BCC

As mentioned earlier, while UNFPA does not endorse any specific model of behaviour change, it is nevertheless important to point out that an effective BCC intervention follows the sequential steps of **assessment, communication analysis, design and development, action** and **evaluation** referred to as the ***"ACADAE"*** process. The process is quite universal and is applicable to all models for the development of a BCC intervention.

The different steps of the process are described in the following pages.

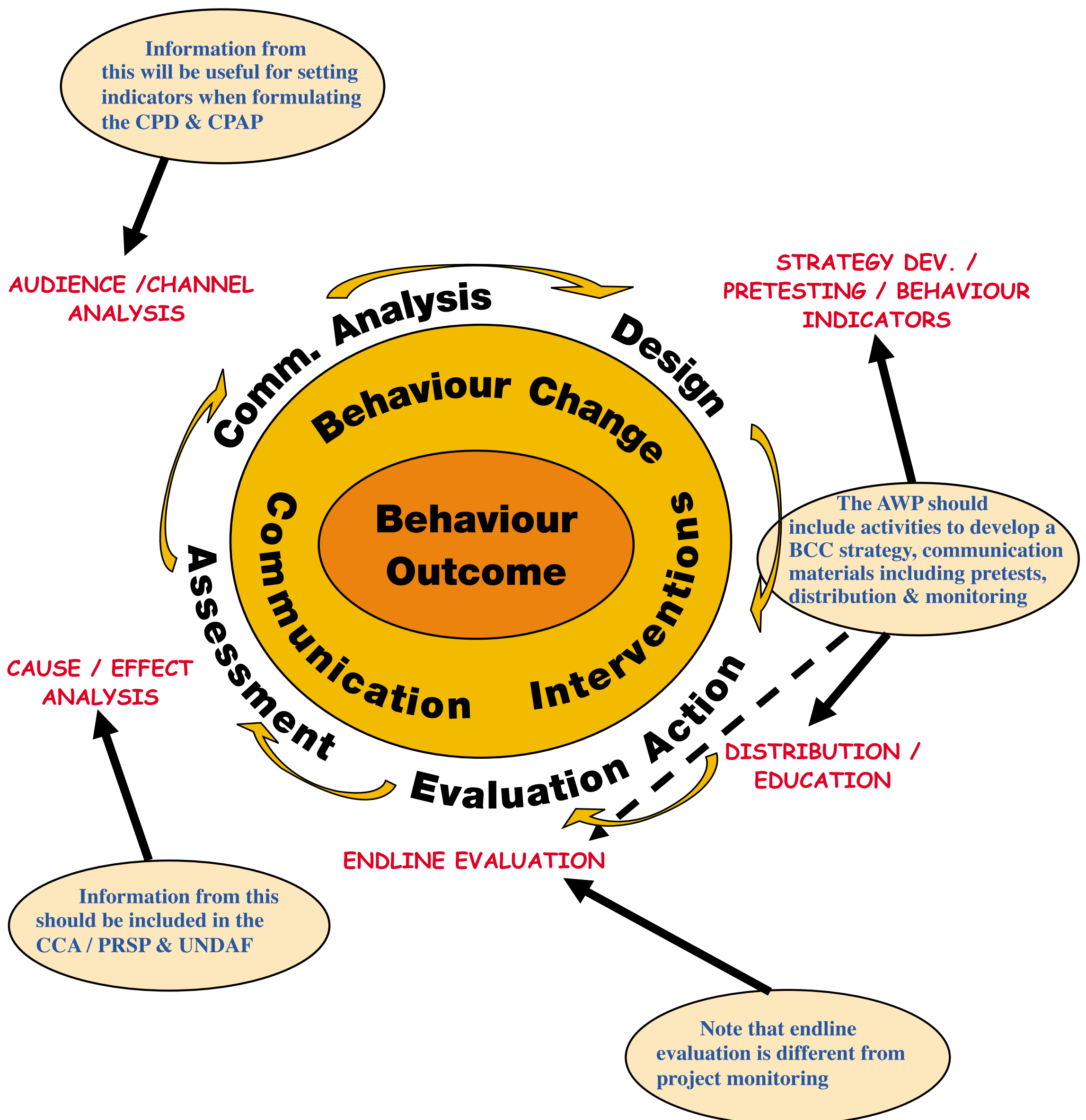


Fig 1. The ACADAE Communication Planning Process

Step 1: ASSESSMENT

An ***assessment*** of the situation is the first step in the ACADAE process of communication planning

Assessment of critical societal and individual behaviours that impact on RH, ARH and public health issues such as HIV/AIDS should ideally be integrated into the Common Country Assessment (CCA), Poverty Reduction Strategy Paper (PRSP) or Situation Analysis prior to development of the Country Programme Document (CPD) and Country Programme Action Plan (CPAP).

The Common Country Assessment (CCA) should ideally include information on populations' health seeking and health risk behaviours beside socio-economic and social infrastructural analysis. It should be evidence-based using both empirical and qualitative data to provide information on what people do, to what extent, why they do it as well as identify influencers of such behaviours and practices. It should provide answers to a number of questions such as, "What is the behaviour problem?" and "Why are some people behaving this way?" A problem cause and effect analysis could provide indication of the immediate, underlying and root causes for the problem.

The UNFPA Country Programme Document (CPD) and Country Programme Action Plan (CPAP) should be designed, taking into consideration the cultural, gender elements and human rights-based approach to programming. This includes the stages of behaviour adoption or change of individuals/groups so as to cultivate skills needed to enable and sustain change.

Additional research may be necessary to complement the CCA

Planning of an effective BCC intervention strategy may require detailed information that is not normally available in the broader CCA, UNDAF and CP documents. In a number of cases a separate survey may be required to collect specific data such as the level of knowledge, attitudes and behaviours of the intended population groups. The situation analysis for BCC interventions should also differentiate between behavioural and non-behavioural causes of the problem(s) identified.

Data can be quantitative or qualitative; primary or secondary

Data for analytical work is divided into two types:

- New data from surveys known as "primary" data.
- Existing data from reports known as "secondary" data

Data and information can also be qualitative or quantitative.
Quantitative data is expressed in numbers (e.g. number of hours a woman watches TV programmes). It is used in audience analysis to provide information such as what type of media the subject uses or the number of people who have comprehensive knowledge of HIV/AIDS. Quantitative data can be generalized to larger population groups if they are statistically significant. On the other hand, qualitative data is subjective (e.g. a woman may "feel good" when she watches a TV soap opera).

Primary qualitative and quantitative data / information are obtained through:

- Survey questions and interviews
- Focused group discussions
- Field visit observations
- Rapid participatory appraisal

Interviews, surveys and the use of questionnaires are especially useful for recording behavioural data for monitoring and evaluation purpose. A baseline survey should always be conducted either prior to or at the onset of a programme – focusing on behavioural data relevant to the desired behaviour outcomes and outputs. This will be discussed further in the section on monitoring and evaluation below.

Qualitative data is often descriptive and narrative. It gives information about the problem, causes and effects that cannot easily be expressed by numbers. Qualitative data can help explore an issue in depth; how and why events occur, local perspectives and priorities. It can also provide information on relatively complex issues such as reasons for certain attitudes and practices (for uncovering norms and values). Qualitative data is sensitive to unexpected, unforeseen responses and information.

Data can be obtained from numerous sources and through various methods

Secondary data / information can be obtained from:

- National, regional, and/or local databases;
- Government, UN, and NGO reports;
- Reports from community groups and other partners (and sometimes opponents);
- University thesis/dissertations and research reports;
- Peer reviewed articles published in scientific journals;
- Health clinic logbooks and reports;
- Project monitoring and survey reports;
- Electronic media including radio, TV, and
- The Internet and printed mass media.

Secondary data helps to present the context, identify subtopics, cross-check other data or provide a standard for comparison, and in creating a basis for

"before and after" comparisons. It is important to apply validity and reliability assessment of sources as some data and information are closer to describing true situations than others.

Need for collecting data relating to behaviour aspects of the problem

A BCC intervention requires thorough analysis of the identified problem behaviours, the context in which the problem behaviours exist and an in-depth analysis of the people whom UNFPA and its partners need to communicate with. The challenge is to collect data that not only inform about problematic behaviours but also data and information on factors that are known to influence behaviours. Before moving on in the planning process it is therefore useful to take a look at some of these factors.

Analyzing a Problem's Causes and Effects

A problem tree is a good analytical tool

The solution to a problem begins with an in-depth analysis of the causes and effects created by the problem. This analysis can be done through the use of a cause/effect problem tree. A problem can be due to behavioural or non-behavioural causes.

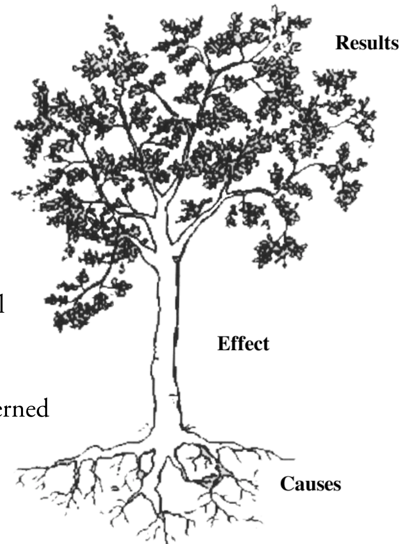


Fig. 2 Problem Tree

In BCC interventions, we are concerned with identifying behaviour problems that communication can influence and change. Non-behavioural problems such as the absence or lack of a health clinic or hospital cannot be addressed through communication intervention alone but has to be solved by appropriate advocacy and capacity building programmes.

A problem can be the <u>result</u> of one or more <u>immediate causes</u> which may or may not be behaviour related. Each of these causes may be due to several <u>underlying causes</u> that in turn are due to some basic, structural, or <u>root causes</u> forming a results-chain of causes and effects. Causes are usually inter-related. An illustration of a problem tree and an example of the different levels of behavioural and non-behavioural causes that finally culminate in a particular result can be seen in Table 1 and Fig. 3.

Result : Death of a woman due to childbirth		
Causes	**Effects**	
	Behaviour Related	**Non-behaviour Related**
Immediate (e.g. status)	▪ Unsafe delivery by untrained midwife	▪ Complication in delivery
Underlying (e.g. access, practices, services)	▪ The woman had too many children, too soon between the last delivery and present one or too young (early) to bear a child ▪ The woman did not go for pre-natal checkup	▪ Lack of available trained health staff ▪ Lack of EmOC facility ▪ Poor referral system
Root (e.g. society, policies, resources, geography)	▪ Cultural and religious practices	▪ Poverty ▪ High illiteracy rate ▪ Topography (mountainous country / lack of roads) making access to RH services difficult

Table 1. Causes & Effects Results-Chain

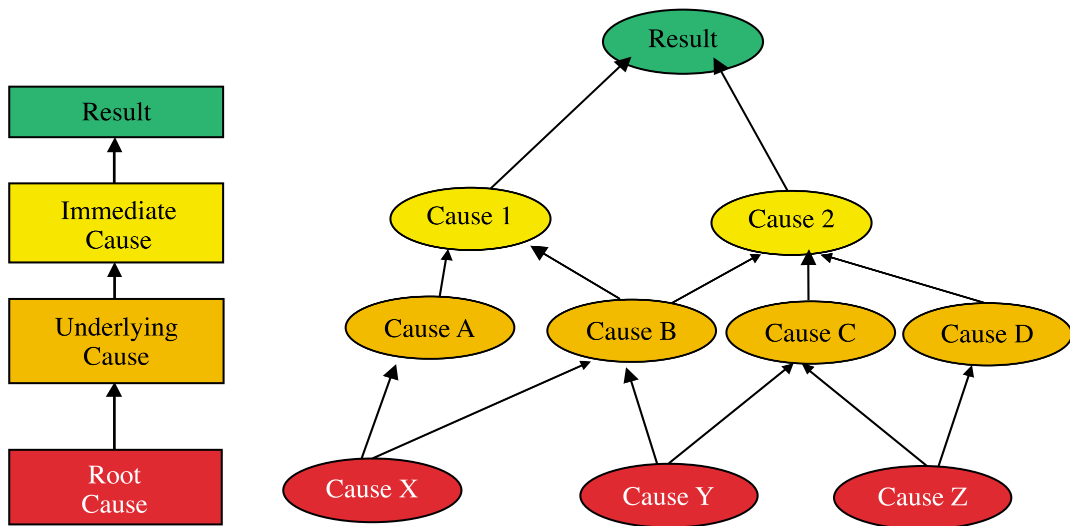


Fig. 3 The Results-Chain

Problem Analysis

Find out what the behaviour problems are

The problem analysis may begin with the question, "What did the intended audience do or did that resulted in the situation?" For example - to enquire into the death of a rural woman who died from childbirth, answer to the question may be that the immediate cause was a complicated delivery conducted by an untrained midwife who was not in a position to save her life. The underlying cause could be that the woman already had many children and it was too soon after the birth of the last child. Another possible underlying cause could be that she did not go for pre-natal check-ups due to her ignorance or lack of information. If she had gone for an ante-natal check-up, the trained nurse could have assessed her difficult birth and could have referred her to the nearest hospital for delivery. The root cause for the woman having many children could have been due to her and/or her husband's non-acceptance of modern family planning methods stemming from her and/or her husband's cultural/religious beliefs and values.

Behaviour Analysis

Behaviour analysis help in identifying what behaviours to promote

Having identified the problem behaviours, another important step in the **ACADAE** process of planning a BCC intervention is to conduct a ***behaviour analysis*** to identify barriers to desired behaviours and factors that encourage certain behaviours. A problem tree analysis shows the cause-and-effect results-chain while a behaviour analysis seeks answers to the question as to why people behave the way they do. Health outcomes of people depend on their health-seeking and health-practice behaviours. To maintain good health require people to affect certain desired behaviour(s) and/or maintain positive behaviours.

Some behaviour related questions

Questions to be answered in a behaviour analysis may include the following:

- What is the problem behaviour that needs to be addressed?
- Do women and men exhibit different behaviour patterns related to the public health issue under investigation?
- What are the consequences for the particular behaviour(s)?
- What are the desired behaviour(s)?
- What are some of the barriers to "ideal" or acceptable behaviour(s)?
- What existing factors can encourage ideal behaviour(s)?
- What are the behaviours/practices that are to be promoted?
- Who is or should be performing these practices / behaviours?
- Who are the partners & allies we should engage?
- What are the gender stereotypes and expectations surrounding the problem behaviour(s)?

Problem Behaviour	Consequence	Desired Behaviour	Barriers to Desired Behaviour	Factors Encouraging Desired Behaviour
Pregnant women don't seek pre-natal care from trained health staff	- Risk of delivery complication - Maternal death	Pregnant women attend regular pre-natal check-up at local health centre	- Ignorance - Unsupportive husbands - Negative traditional beliefs	Supportive local leaders
Preference of home delivery	- Unsafe delivery - Maternal death	Delivery at health post & by trained health staff	Traditional practice	Friendly and supportive health staff
Pregnant women not accepting VCT for HIV infection	May pass HIV to the baby	Acceptance of VCT and PMTCT service package	Unsupportive husband, family and/or community	Friendly and supportive health staff

Table 2. Example of a Behaviour Analysis Matrix (BAM)

Targeting Young People Using Behaviour Change Communication (BCC) Interventions and Approaches

BCC interventions are often viewed more as add-ons to health programmes than as integrated components. However, evidence suggests that comprehensive and integrated BCC interventions are critical to improving health outcomes including those related to family planning/reproductive health (FP/RH) and HIV/AIDS prevention and stigma reduction.

Promoting positive behaviour change among adolescents is a complex process requiring an understanding of culture, psychology and behaviour science. Presenting facts alone does not ensure behaviour change. BCC intervention strategies should be designed to accommodate the stage of behaviour adoption of an individual or target group and to cultivate skills needed to enable and maintain the behaviour change.

In a random controlled trial of 522 sexually experienced African American girls aged 14 to 18 years conducted from December 1996 through April 1999 at four community health centers in the United States, all the participants received four 4-hour group sessions. Half of the participants received specially tailored BCC intervention messages that emphasized ethnic and gender pride, HIV knowledge, communication, condom use skills, and healthy relationships. The other half became the comparison group with emphasis on exercise and nutrition only. Analysis of data from a 12-month follow-up showed that adolescents in the intervention group were found to more likely use a condom at last intercourse, less likely to have a new vaginal sex partner in the past 30 days, and more likely to apply condoms to sex partners and had better condom application skills, a higher percentage of condom-protected sex acts, fewer unprotected vaginal sex acts, and higher scores on measures of mediators.

Source: DiClemente, R.J., Wingood, G.M., et.al. *Efficacy of an HIV Prevention Intervention for African American Adolescent Girls: A Randomized Controlled Trial.* JAMA. 2004 Jul 14;292(2): 171-9

Step 2: COMMUNICATION ANALYSIS

A communication strategy must be based on sound communication analysis

An important step in the BCC planning process is to conduct a ***Communication Analysis.*** This includes identification of communication networks within the community. Health service providers will need to work with these communication networks to affect desired behaviour change or maintenance of healthy behaviours among their intended audiences.

Communication channels can include community media such as street or community theatre, folk-media, story telling, and artefacts. It is crucial at this stage to find out how different channels are used by whom, when and for what purpose. The communication analysis also identifies the primary and secondary audiences as well as potential partners for carrying out the communication interventions.

Communication Analysis consists of:
a) stakeholder analysis
b) audience analysis
c) channel analysis
d) media/materials analysis

Questions to be answered in the communication analysis may include, among others, the following:

- Who are the primary and secondary intended audiences?
- What communication channels are the intended audiences most exposed to that can help us reach them? (e.g. interpersonal, community, group or mass media; traditional or modern media)
- Who are the partners & allies we should engage to carry out the communication intervention(s)?
- What are the existing opportunities or new partnerships to work with? e.g. existing programmes, other agency programme.
- What communication media will be the most cost effective to reach the intended audience?

There are several components in a communication analysis. We shall deal with the most relevant ones in this handbook. These include; a) stakeholders analysis, b) intended audience analysis, c) communication channels analysis, and d) communication media analysis. Information from these analyses will feed into our BCC planning process.

Stakeholders Analysis

Who are the stakeholders? A stakeholder is anyone or any institution (it can also be a community) that has an interest and involvement in the problem behaviour(s) that affects the life/lives of the intended audience(s). For example, the stakeholders in a youth health programme are the immediate family members of the youth; parents, teachers and Principal of the school, health workers, local leaders, Department/Ministry of Education, Department/Ministry of Health, etc.

A stakeholder's analysis provides an understanding of the people that can influence the programme and create an enabling environment for young people. Stakeholders can be classified as primary and secondary stakeholders or in order of priority in influencing or affecting the health behaviour of the intended audience.

Let us take the example of a stakeholder's analysis to reduce maternal mortality using BCC interventions. The primary intended audiences are the pregnant women. Other key stakeholders and intended audiences include their husbands, mother-in-laws and close family members, friends, peers, community leaders, health staff/officials in the Department and Ministry of Health.

Problem Behaviours	Primary/Secondary (P/S) Stakeholders	Role in BCC intervention strategy
a) Pregnant women not seeking pre-natal care from trained health staff	Pregnant women and their husbands (P)	Targeted directly to influence sexual behaviour for birth spacing and for pre-natal checks
	Mother-in-laws (P)	Directly influences daughter-in-law's method of child delivery and accessing of pre-natal care
	Other family members, brothers/ sisters (S)	Can influence where baby is to be delivered
b) Preference for home delivery	Friends / peers (S)	Can have strong peer influence and apply peer pressure
	Schools (S)	Can be entry point for introducing and sustaining BCC intervention programmes on RH
	Social Workers (S)	Can provide support and guidance for RH programmes
	Community / religious leaders (S)	Can have strong influence on RH programmes by supporting or rejecting them
	Min. of Health (P)	Responsible for national RH policy and can institute and support RH BCC programmes through the health services sector
	Min. of Education (P)	Responsible for national education policy and can institute BCC programmes on RH through education institutions
	Community Based Organizations (CBOs)	Support and/or implement BCC programmes on RH

Table 3. Example of a Stakeholders Analysis Matrix (SAM)

Audience Analysis

Messages can be directed specifically at primary or secondary audiences

A behaviour change communication message is targeted at specific audiences aimed at affecting a change in their behaviour(s) or to have them maintain their current positive behaviour(s). Hence it is important to know who your ***primary*** audience is as well as who is your ***secondary*** audience.

The primary audience is the person or group of people whom you want to address directly (i.e. target) with specific messages with the intention to change or modify her/his or their behaviour(s) in order to improve their health. The secondary audience is the person or group of people who can influence the primary audience to change her/his or their behaviour(s). The secondary audience is usually the supportive partner, friends/peers, relatives, and/or community leaders.

Stakeholders are important people who can support your BCC intervention project

A list of stakeholders or people whom we can ***mobilize*** to help or support the programme, or whom we need to ***advocate*** with, to get their support should be included in the audience analysis. For example, school teachers, community leaders and religious leaders can be mobilized to support the BCC interventions at local levels. On the other hand, in order to use the community hall as a youth club in the evenings, we may need to advocate with the Village Headman to get permission from him as well as his support for the programme or project.

Problem behaviour	Intended Audiences (IA)			
	Primary Audience (PA)	Secondary Audience (SA)		
		For immediate support to PA	For Social Mobilization	For Advocacy
Pregnant women not seeking pre-natal care from trained health staff	- Women - Husbands	Close family members (husband, mother, sister, etc.)	- Religious leaders - School Teachers - Social Workers - CBOs	- Local leaders - Religious leaders
Preference of home delivery	- Pregnant women	Mother-in-law, husband, sister-in-law	Community & CBOs	Friendly and supportive health staff
Pregnant women not accepting VCT for HIV infection	- Pregnant women	husband, mother-in-law, sister-in-law	Health workers, community & CBOs	- Local leaders - Religious leaders - Business leaders

Table 4. Example of Audience Analysis Matrix (AAM) incorporating different target audiences

Communication Channels Analysis

It is important to identify and analyze the channels through which people communicate with each other

We must not confuse communication channels analysis with analysis of the various media used for communication (more on this in the next section). Communication channels analysis examines the ***channels*** people use for communicating with each other, when and how much time spent on communicating with each other, etc. While the mass media may reach a large number of audience, it may not reach those intended audience who do not have access to the media, be it radio, television or newspapers. Answers

to some of the questions below will aid in the communication channels analysis (they are by no means exhaustive).

- What groups do your intended audiences (primary and secondary) belong to? e.g. Women's Association/Union, religious groups, Youth Unions/clubs, Sports Team, community-based organization [CBO], etc.
- Where does the intended audience spend most of her/his time? e.g. at the workplace (factory/office/shop), home / neighbourhood, church / mosque / temple and other religious places, etc.
- Who does the intended audience consult on health issues and in what order? e.g. friends, relatives, health workers, religious leaders, community workers, etc.
- Who can and does influence the intended audience on health issues? e.g. friends, relatives, health workers, religious leaders, community workers, etc.

Communication Channels Analysis					
Intended Audience (IA)	**Group affiliation (social, religious, economic)**	**Where does the IA spend a lot of time?**	**Who does the IA consult health issues / problems?**	**Who can influence the IA?**	**Media accessible to IA**
Pregnant women	Women's Union, Farmers' Association, church groups, CBOs	Home, farms, waiting at health clinics	Peers, sisters, friends, religious leaders	Mother-in-law, husband, married female relatives	Radio, community broadcast, TV, IEC materials from health centre
Young people	Youth union, sports clubs, social clubs CBOs, Professional groups	Workplace, schools, "hanging out" with friends	Peers, doctors & health workers	Idols (film & sports personalities)	Radio, community broadcast, TV, newspapers, magazines & IEC materials from health centre

Table 5. Example of a Communication Channel Analysis Matrix (CCAM)

Communication Media/Materials Analysis

There are advantages and disadvantages in the use of different communication media.

We have mentioned in an earlier section that we should not confuse communication media / materials analysis with communication channel analysis. There are many publications on the advantages and disadvantages of using different types of communication media, their cost benefits and cost effectiveness for achieving the objectives of programmes. Communication

media and materials should be country specific and culturally relevant to be effective. Quite often, communication channels and communication media are used interchangeably. We should avoid this. Typical questions for analyzing communication media include some of the following:

A cost-benefit and cost-effective analysis of different communication media will be useful for planning.

- What kind of communication media does the intended audience have access to? e.g. radio, TV, VCR / VCD / DVD, the internet, printed reading materials, etc.
- What are the advantages of using one communication media over the other with certain or specific intended audiences? e.g. street theatre vs. radio/TV programme for discussing a local public health issue.
- What are the cost benefits and/or cost effectiveness of using one communication media over the other with certain or specific intended audiences? e.g. use of village loud speaker broadcast system vs radio/TV to announce a local public health campaign.

Communication Media/Material	Advantages	Limitations
Printed Media	**Some learn best through reading**	**Require certain level of literacy**
Posters	Cheap and localized broadcast to targeted communities	Good only for limited number of messages. Best for single message only.
Handouts/leaflets	Intended audience can take home and read / re-read at leisure or when convenient.	Can be used for providing very basic information only and is limited to individual reader
Brochures	Same as above with addition of more information.	Same as above
Flip Charts	Useful for training situations	Not intended for self study.
Magazines	Can reach many readers	May not reach the intended audience
Newspapers	The printed "mass media" reaches thousands daily.	May not reach the intended audience, particularly those who are illiterate
Electronic Media	**Used widely and are popular**	**Needs electricity & can be expensive**
Radio	Can reach large numbers of audiences cheaply and simultaneously.	▪ Depends on economic status of audience. ▪ Limited to availability of electricity or batteries.
TV	Display of sound and visuals simulate real life situations to convey messages more effectively	Depends on economic status of audience. In terms of affordability.
VCR/DVD	Same as for TV with addition of being able to play "re-runs" whenever it is needed.	Depends on economic status of audience. In terms of affordability.
Other Media		
Films	Can inform and educates while entertaining the audience	Film producers are more interested in producing entertainment rather than social films.
Loud-speaker broadcast	Cheap and localized broadcast to targeted communities	Reach limited to small local area
Folk-media	Low cost and acceptance by local audiences	▪ Many folk-media are "dying." ▪ Requires constant financial inputs for sustainability

Table 6. Example of a Communication Media Analysis Matrix (CMAM)

Step 3: DESIGN and DEVELOPMENT

Design & Development is the next stage of the ACADAE process

Moving from a situation analysis to identifying problem behaviours and conducting the necessary communication analysis, we now come to the ***design and development*** of communication strategies using all the information we have gathered so far. There are many publications explaining how to design a communication strategy. Data from previous sections on ***assessment*** and ***communication analysis*** must be incorporated into the communication strategy.

The communication strategy should support the Country Programme Document (CPD) and the Country Programme Action Plan (CPAP) of a UNFPA country programme. These documents have stated **outcomes, outputs and activities** together with their corresponding indicators for measuring results (see section on Evaluation for different types of indicators).

It is important to have clearly stated BCC outcome and outputs statements and their corresponding result-based indicators

Ideally the communication outcome and output statements should match or correspond to the Programme outcome and output statements of the CPD and the CPAP (see Table 7 and Table 8 for an example of CPAP/RRF adapted for BCC interventions). But if communication analysis was not conducted at the time of drawing up the CPD and CPAP, the statements may not match. We will then need to restate the CPD/CPAP outcomes and outputs while drafting the behaviour change communication strategy.

The BCC outcome statement attempts to answer questions such as, "What behaviour outcome do we ultimately want the intended audience to have?" An example of a BCC outcome indicator can be, "increased child deliveries by trained health staff X% to Y%." This behaviour will contribute to the reduction of maternal mortality ratio which could be an UNDAF outcome.

On the other hand, a BCC output statement would lead to the intermediate results of a behaviour change continuum as we all know that a society's behaviour change cannot be measured within a short time-frame. An example of a BCC output statement can be, "increased demand for and utilization of family planning and safe motherhood/RH information and services from A% to B% by young people, particularly pregnant women." This will contribute not only to the reduction risk behaviours but reduction in the number of teenage and unplanned pregnancies and increased in safe deliveries.

A communication strategy includes *BCC intervention, advocacy,* and *social mobilization*

A BCC strategy has three components; i) ***BCC intervention,*** ii) ***Advocacy,*** and iii) ***Social Mobilization.*** Each of these components can warrant sub-strategies of their own or they can complement each other in a larger BCC intervention strategy. Let us examine each component more closely.

BCC interventions strive to change individual and societal behaviours

In tackling a public health issue such as prevention of HIV/AIDS or birth spacing in a family planning programme, BCC interventions are directed at individual and societal behaviour change. For example, we know that risky behaviour such as having many sex partners and engaging in unprotected sex can lead to being infected with the HIV virus when one does not know the HIV status of the sex partner. It is the individual's choice to continue in practising risky behaviour or engaging in unprotected sexual intercourse. Hence, the BCC intervention addresses an individual directly to inform, educate and persuade her/him to change her/his sexual behaviour.

Depending on the situation, social marketing may be incorporated into the BCC intervention strategy as it can play a role in changing a person's behaviour. *Social marketing* is a set of interventions using commercial marketing principles to "market" or sell intangible social products. For example, social marketing of family planning is *not about the sale of condoms* or other FP products but the *idea* of a small family or birth spacing for improved health outcomes of women.

Advocacy is a process of creating support, building consensus and fostering a favourable and supportive climate towards a specified cause or issue through a set of well planned and organized actions that are undertaken by a group of individuals or organizations working in concert.

Advocacy works to lobby for policy change or involvement

Advocacy in a BCC intervention strategy is directed at high level stake-holders to solicit their support at the policy and legislation levels. An example of a high level advocacy is to lobby with legislatures to introduce and pass an education policy and regulations to mandate the compulsory teaching of reproductive health curriculum in schools. Most countries in Asia do not have such a policy though many countries have allowed some schools to introduce RH and life-skills education supported by UNFPA on pilot basis.

Social mobilization garners community support and involvement

On the other hand, social mobilization can garner support and acceptance of the BCC interventions at the community level. An example of social mobilization is getting the community in a remote rural village to provide transportation to take pregnant women to the health clinic located several kilometres away for her prenatal check and for the delivery of her baby by a trained health staff. This may be in the form of a pooled horse-drawn or bullock cart or mobilizing several stalwarts of the village to carry the pregnant woman.

Social mobilization is thus a process of bringing together all potential partners and allies to carry out a common development objective on a cost-efficiency basis whereas community mobilization is rather a process through which action is stimulated by a community itself or by external stakeholders, planned, carried out and evaluated by community's individuals, groups and organizations on a participatory and sustained basis to improve health.

BCC Interventions in Action

Using the joint UNICEF/UNFPA/UNDP/UNAIDS/WFP/ WHO/ World Bank **"Facts For Life"** (FFL) publication as entry point, UNICEF Myanmar trained facilitators of a number of faith-based organizations through a BCC intervention strategy aimed at improving the quality of life of children. There are 13 topics in the FFL including birth spacing, safe motherhood, immunization, HIV/AIDS, diarrhoea and, hygiene.

Facilitators of the Young Men's Buddhist Association (YMBA) were trained in the use of participatory communication skills to disseminate the FFL messages to religious communities and villages. As a result of the BCC intervention, the Abbot of a Buddhist Monastery in Yangon, capital city of Myanmar, instructed his disciples not to dip their hands into the washing bowl presented before meals to clean their hands as per tradition. He told them that doing so dirtied the water for other users. Instead, he advised that water be poured from a jug and the bowl be used for collecting the soiled water.

In another case, a village in Shan State that previously had no community toilets or latrines in their houses worked collectively to construct sanitary latrines for each house. This societal behaviour change was the result of BCC interventions by the Christian Baptist Church of Myanmar (CBCM) sponsored by UNICEF. The use of sanitary latrines has improved the health outcome of the community and reduced the monthly incidents of diarrhoea in the village.

Source: UNICEF Myanmar

CPAP Results and Resources Framework

Country Programme Outcome	Country Programme Output	Output Indicators (*)	Implementing Partners	Indicative resources by output (in $1,000 per annum)					
				2006	2007	2008	2009	2010	Total
UNDAF outcome: improved quality of delivery and equity in access to social and protection services									
Outcome 1: Improved quality and utilization of gender-sensitive reproductive health information and services, including sexual health and family planning, for the population, particularly adolescents and youth, ethnic minorities and migrants	**Output 1:** Increased availability of high-quality, gender-sensitive reproductive health information and services, including family planning and sexual health	▪ Increased % of service delivery points offering more than three modern methods of contraception, including condoms ▪ Increased % of service delivery points offering appropriate diagnosis, treatment and counselling for RTIs following the national standards and guidelines for reproductive health care services, including migrants ▪ Increased % of service delivery points providing youth-friendly reproductive health care services ▪ Increased % of emergency obstetric care facilities complying with steps to treat major obstetric complications as identified in the national standards and guidelines for reproductive health care services ▪ Increased proportion of service delivery points providing reproductive health care counselling services ▪ Increased % of service delivery points offering basic neonatal intensive care ▪ Increased proportion of service providers able to provide reproductive health-related counselling on violence against women ▪ Increased % of clients expressing satisfaction with quality of health care services	MOH, and 7 provinces (VCPFC, DOH, related provincial sectors)	**Regular Resources**					
				1,224	2,224	2,224	2,024	1,424	**9,120**
				Other Resources					
				200	900	1,000	1,000	1,000	**4,100**
	Output 2: Increased demand for high-quality, gender-sensitive reproductive health information and services	▪ Increased proportion of people having adequate knowledge of more than three modern contraceptive methods ▪ Increased proportion of people who can recognize danger signs during pregnancy, delivery and post-delivery ▪ Increased proportion of people having adequate knowledge of STI/HIV prevention ▪ Increased proportion of people who prefer to have skilled health personnel at delivery (by ethnicity and in mountainous areas) ▪ Increased proportion of fathers and mothers who accept having their adolescent children access adolescent reproductive health information and services ▪ Increased % of young people, ethnic minorities and migrants receiving reproductive health and family planning information ▪ Increased % of men and women who discuss reproductive health issues, including the prevention of domestic and reproductive health-related violence, with their spouses or partners	MOH, and 7 provinces (PCPFC, DOH, related provincial sectors)	**Regular Resources**					
				900	1,100	1,100	1,000	900	**5,000**
				Other Resources					
				0	500	900	1,000	500	**2,900**

Table 7. Part of UNFPA Viet Nam's 2006 – 2010 CPAP

Behaviour Change Communication Strategic Activities & Indicators

CP Outcome: Improved quality and utilization of gender-sensitive RH information and services, including sexual health and family planning for the population, particularly adolescents and youth, ethnic minorities and migrants (from Vietnam 2006 – 2010 CPAP)

Outcome Indicators:

- Increased number of babies delivered in health centres and hospitals
- Reduction in the incidence of HIV infections from 2005 levels

Output 1: Increased demand for high-quality, gender-sensitive reproductive health information and services. (from Viet Nam 2006 – 2010 CPAP)

Text from original CPAP

Output Indicators: (from Viet Nam 2006 – 2010 CPAP)

- Increased proportion of people having adequate knowledge of more than three modern contraceptive methods
- Increased proportion of people who can recognize danger signs during pregnancy, delivery and post-delivery
- Increased proportion of people having adequate knowledge of STI/HIV prevention
- Increased proportion of people who prefer to have skilled health personnel at delivery (by ethnicity and in mountainous areas)
- Increased proportion of fathers and mothers who accept having their adolescent children access adolescent reproductive health information and services
- Increased % of young people, ethnic minorities and migrants receiving reproductive health and family planning information
- Increased % of men and women who discuss reproductive health issues, including the prevention of domestic and reproductive health-related violence, with their spouses or partners

Strategic Activities

BCC Interventions		Social Mobilization		Advocacy	
Activities	Indicators	Activities	Indicators	Activities	Indicators
▪ TOT of peer educators	▪ # of YP covered by the peer education programme	Organize provincial level dissemination of national BCC strategy and development of local BCC strategies and action plans	▪ # provincial strategies and Action Plans developed ▪ Provincial allocation of budgets for HIV/AIDS prevention	Assist VCPFC to finalize the "National BCC Strategy for Population/RH/FP and Children: 2006 – 2010"	▪ BCC strategy document approved by government ▪ Budget for BCC activities in various ministries and provincial budgets
▪ Develop, produce and broadcast series of 25 radio soap opera prog. on HIV/AIDS prevention	▪ % recall by listeners on HIVAIDS prog. content	Involvement of CBOs, teachers, military personnel, TBA in providing safe motherhood & HIV/AIDS information and home / community services	▪ # of activities implemented by partners (ministries / CBOs)	Lobby to integrate MMR issues into instructions issued at the political and administrative levels	▪ # political statements and office circulars on HIV/AIDS prevention

Table 8. Hypothetical BCC Intervention, Social Mobilization & Advocacy Strategic Activities

BCC Message Design: Concepts and Development

Development of BCC messages is one of the most important elements in programming BCC interventions. BCC messages should take into account use of local languages, cultural sensitivities, gender and the stages of behaviour change the intended audience is in. Thus design of a BCC message should be different for different intended audiences.

The approach and tone of delivery of a BCC message is important

An important point to consider while designing BCC messages is the ***message approach.*** By this, we mean whether the message should be informational, persuasive, encouraging, educational, gender sensitive, or action oriented, etc.

The BCC *message can be encouraging, educational, informational, persuasive, etc.*

A message using the *educational approach* provides not only basic information but attempts to educate the intended audience as well. Such an example could be "The human immunodeficiency virus (HIV) can be transmitted in one of four ways. They are through a) blood transfusion, b) unprotected sexual intercourse, c) exchange of contaminated needles, and d) from a pregnant mother to her new born child. HIV cannot be transmitted through mosquito bites or shaking the hand of an HIV positive person."

An *informational approach* is used for providing information only – by stating facts such as "there is no cure for AIDS" or, "Avian or bird flu is caused by the H5N1 virus."

A message's appeal and tone can be positive, negative, threatening, encouraging, rational, emotional, etc., or in combinations.

A *persuasive approach,* as the term suggests, attempts to persuade the intended audience to take up an action or change her/his behaviour. An example of such a message can be, "do not litter, please help to keep our city clean."

Negative Appeal Positive Tone	Positive Appeal Positive Tone
Negative Appeal Negative Tone	Positive Appeal Negative Tone

The ***language, tone and appeal*** of a message play an important part in it being accepted easily or rejected by the intended audience. A message's appeal and tone can be positive or negative, threatening or encouraging, appealing to individuals or to the masses, rational or emotional. Research and experience has shown that using a positive appeal rather than a negative appeal is more effective for conveying social messages. For example, immunization campaign posters in India during the 1980s showing a healthy baby playing happily with her parents with the caption "ensure your child's health – get your child immunized" was more effective than posters showing a child on crutches and emancipated legs with the caption "polio can cause disability or death, immunize your child against polio." A negative message may be counter productive to getting desired behaviour change.

While developing messages and communication media materials, it is very important to ***pretest*** both the messages and the materials to see if they are appropriate for the intended audiences and that they will help achieve the desired impact. We have heard of the often repeated story of the display of a large insect (a fly, a mosquito) on a poster aiming to "inform, educate and communicate" with intended audiences about the spread of diseases only to find the audiences reacting with the remark, "thank *** that we don't have such large insects here in our country."

Pretest the message and media before final production and dissemination

Pretesting the messages and proposed media through which it is to be conveyed can help clarify concepts and whether the messages are clearly understood. Pretesting also helps in identifying any cultural and gender issues that may arise in the presentation of communication messages. For example, displaying pictures of ethnic/tribal minorities on a poster targeted at metropolitan urban youths may not be as effective as using appropriately dressed models even if the message wordings are correct. In Mongolia, a poster displaying a young and happy couple intended to convey the message to use condoms for dual protection of HIV/STD infections and unplanned pregnancies was misunderstood at first sighting as an advertisement for clothes worn by the models before the audience read the "fine" prints.

Some Guidelines for Pretesting

Basic principles of pretesting should be followed

When conducting the pretest, we expose a small number of the intended audience group to the messages and materials that we plan to use. Here are a few, but not exhaustive, suggestions and guidelines for conducting a pre-test:

- ***Audience:*** Use persons who are from the demographic profile of the intended audience group. We should not rely on tests done with urban audiences if the communication message(s) and materials are to be mainly used in rural areas.
- ***Media:*** Do not use only the script of a video to pre-test a video; make a draft version of the video and then pre-test.
- ***Place:*** Materials that we intend to use in somebody's home should not be tested in an office in the Ministry of Health or other official place.
- ***Frequency:*** If the audience is only supposed to be exposed to the communication materials once, for example through a one time only broadcast of a radio programme, then do not repeatedly re-play the tape during the pre-test even at the request of the pre-test members. If the material is a 30-seconds audio spot that will be played 10 times a day on a radio station, then it is acceptable to play it more than once during the pre-test.

Changing the public's attitudes and behaviours towards stigma and discrimination against people living with HIV and AIDS (PLWHA) in Viet Nam

Phong, a 7-year old boy in the district of Tan Phuoc in Tien Giang Province, lost both his parents to HIV/AIDS. His mothers' sister took him into her family to look after him. As Phong was of school going age, his aunt sent him to the local primary school. Somehow, his HIV status became known to the village community and many parents of children in the school protested to the school authorities about his attendance in school. They feared that he would "give them AIDS." Under intense pressure from the children's parents, Phong was dismissed from the school.

Upon hearing of this sad story from the local officials, UNFPA in 2004 decided to produce a documentary film about Phong in order to illustrate the stigma and discrimination against PLWHA in the province. It was the first such documentary film in Viet Nam on HIV/AIDS. The film highlighted the fact that due to the lack of awareness among the general population on the mode of HIV/AIDS transmission, stigma and discrimination against PLWHA was common.

The film was used by the local authorities for discussion in many advocacy workshops and training forums on HIV/AIDS in the locality. The film was also broadcast on local television in order to reach a broader population in the province and the surrounding area of the Mekong River Delta. As a result, Phong was allowed to go back to school again, but he still has difficulty in accessing anti-retrovirus therapy (ARV) and so his health is getting worse. The film contributed to an increase in the public's awareness of HIV/AIDS prevention in general and HIV/AIDS-related stigma and discrimination, in particular.

Speaking at the conclusion of an advocacy workshop held in Tien Giang Province for local policy makers and community leaders, Mr. Phan Van Ha, Vice Chair of the Provincial People's Party stated, *'We fight HIV/AIDS related stigma and discrimination not only because of regulations and laws, but also because of our precious Vietnamese traditions... Phong needs to be treated as fair and equal as any of our children, and the Education Sector should collaborate with other sectors in the province, especially the Women's Union to provide adequate information on HIV/AIDS to parents to address HIV/AIDS related stigma and discrimination issue'.*

Source: UNFPA Viet Nam. (2005). *Final Project Report: Danish Support to Prevention of HIV Transmission in Viet Nam with special focus on Mother-to-child Transmission.*

Step 4: ACTION

List all details in the Annual Workplan (AWP)

As with all strategies, a BCC intervention strategy has to be put into action if it is to succeed in achieving the behavioural outcomes. Major activities are listed in the Annual Work Plan or AWP (see Table 9 for example). Elements of a detailed BCC intervention workplan could include the following:

Preparation:

- Recruitment
- Capacity building
- Procurement
- Planning workshops (needs assessments, consulting and involving stakeholders including target groups)
- Drafting messages and preparing media materials with participation of partners and target group/beneficiaries
- Pre-testing, revising, finalizing the production
- Organizing display venues and distribution of materials
- Training of volunteers and/or staff

Implementation:

- Geographic coverage (national, regional/provincial or local)
- Level (macro and micro level)
- Timing (month, week/day, duration)
- Actors / players (peer, parent, health worker, journalist, artists, role model, youth worker,...)
- Methods / modality (performance, participatory workshop, distribution of material, video performance...)?
- Partnerships (funding and resources such as media, expertise and technology)

Budget:

- Costing for various activities
- Costing for human resources
- Costing for production and distribution of materials

It would be useful to have all these details displayed in a Gantt chart so that each item, be it activity or budget or timeline can be monitored. Table 9 gives an example of a standard UNFPA Annual Work Plan sheet used for monitoring the activities. Colours in the activity column follows the colours used to indicate BCC interventions, social mobilization and advocacy as used in Table 8.

ANNUAL WORK PLAN
CP Component: ____________________

Year __________

Implementing Partners: ______________

Project IDs (use ATLAS code): ______________

EXPECTED CP OUT-COME: *Improved quality & utilization of gender-sensitive RH information & services, including sexual health & FP for population, particularly adolescents & youth, ethnic minorities and migrants.*	**PLANNED ACTIVITIES** *List all the activities, incl. M&E activities, to be undertaken during the year towards stated CP output*	**TIMEFRAME**				**RESPONSIBLE PARTY** *(can be the implementing partner or the contractee. When listing the contractee, also specify the implementing. partner)*	**PLANNED BUDGET**		
		Q1	Q2	Q3	Q4		Source of Funds	Account Description	Amount
Outcome Indicator: *Increased number of babies delivered in health centres and hospitals*									
Output 1: *Increased demand for high-quality gender-sensitive RH information & Services.* **Output Indicators:** ■ *Increased proportion of people having adequate knowledge of more than three modern contraceptive methods.* ■ *Increase proportion of people who can recognize danger signs during pregnancy, delivery & post-delivery.* ■ *Increased proportion of people who prefer to have skilled health personnel at delivery.*	Develop provincial BCC strategies through community participation		X	X	X	PCPFC, Provincial counterparts & NGOs	UNFPA		$$$
	Develop, pretest and production of IEC materials			X		PCPFC, Provincial counterparts & NGOs	UNFPA		$$$
	TOT of peer educators				X	PCPFC, Provincial counterparts & NGOs	UNFPA		$$$
	M & E Visits to the field		X	X	X	UNFPA, VCPFC			$
	Organize provincial level dissemination of national BCC strategy and development of local BCC strategies and action plans	X	X			VCPFC & Provincial CPFCs	UNFPA		$$$
	Assist VCPFC to finalize the "National BCC Strategy for Population/RH/FP and Children: 2006 – 2010"	X				VCPFC, UNFPA CO & CST	UNFPA		$$$
TOTAL									

Note: (a) Where the CP is more complex, the matrix can be adapted by breaking CP outputs into sub-outputs, each with corresponding indicators, target and activities for the year. (b) The CP Outcome, Outcome Indicators, Output and Output Indicators are taken from the UNFPA Viet Nam CPAP (see Table 7 and Table 8)

Table 9. Example of the use of a standard UNFPA Annual Work Plan Form

Step 5: EVALUATION

Evaluation measure the results achieved by the BCC interventions

Evaluation is an important and critical component of any intervention programme. Having set the behaviour outcomes, outputs and their corresponding indicators as well as the behaviour change strategies for how to achieve them, it is imperative to find out whether we have achieved the results or not, at the end of the programme or project.

Evaluation of BCC interventions can be divided into two stages; a ***monitoring*** stage and an ***evaluation*** stage. During implementation of the BCC interventions, activities need to be monitored to see if they are going on the right track so that mid-course corrections can be made, if necessary. Typical data and indicators for monitoring activities are process indicators such as the number of communication media materials produced and disseminated (posters, flip charts, TV/radio spots, etc) or the number of training workshops conducted (TOT, peer education, etc.). Thus, the CPAP Monitoring and Evaluation Calendar should include M&E schedules for BCC interventions.

It is important to understand that **monitoring** and **evaluation** are two different but complimenting activities

Monitoring visits are an important part of this (for reporting on such visits we should use the "Field Monitoring Visit Report"). This type of monitoring is the responsibility of UNFPA, executing and implementing staff themselves. For example, during monitoring visits to a RH clinic, it is important to check if all communication materials and tools for the use of trainers, peer promoters, counsellors, clinical staff, beneficiaries, etc. are available in sufficient quantities and are properly displayed with easy access for the relevant groups. It is also important that signs marketing the services of clinics are well displayed and easily identifiable. Check also whether BCC intervention activities are implemented according to plan.

Clearly stated outcome indicators are important for evaluating programmes

Data for measuring results at the CP outcome level is generated through the use of surveys during an end-line ***evaluation*** of the programme or project. However, unless the outcome indicators are clearly laid down at the design stage, researchers will tend to gather process indicators only and report these as outcomes. This is incomplete and is largely what actually happens with a number of UNFPA evaluation studies. For example, it is not sufficient to report that X numbers of TOT workshops were held but to evaluate the result of these workshops at the behaviour outcome level. Did they contribute to the behaviour change of the intended population – say, pregnant women – in respect to their going to the health clinics for prenatal check-ups and deliveries or deliveries assisted by trained midwives if they were conducted at home?

Types of Indicators for BCC interventions

"Indicators" – as the term implies – are to show the status or position to be reached/achieved at the particular level of outcome, output or activity. Measurement of changes in a situation (i.e. the result) due to BCC interventions is done against these indicators.

Communication process indicators measure inputs and activities

Indicators can generally be divided into two types; process indicators and output indicators. ***Communication process indicators*** measure the inputs (e.g. cash and human resources) and activities to help achieve desirable results (e.g. number of workshops conducted, the number of IEC materials produced and/or distributed). As per the principles of the results-chain we discussed in an earlier section, these inputs and activities should/will yield some measurable results or outputs.

Communication output indicators measure consequences of inputs and activities

On the other hand, ***BCC output indicators*** provide us with information regarding the consequence of the inputs and activities – e.g. 100% of youth populations (15 – 24 years) in village X are aware/knowledgeable of the three means of HIV transmission. This could be due to the health promotion activity as a result of the training received by the village health worker.

Communication outcome indicators measure long-term impact/result of the inputs and activities

The health worker's training and activity, along with many others who had similar training and assignment for health promotion will/should contribute to the change in behaviour outcome. Hence, a ***BCC outcome indicator*** could be, for example, "increased rate of child deliveries by trained health staff X% to Y%" by the end of a certain period.

Some readers may be familiar with the commonly used principles of setting ***"SMART"*** indicators:

The SMART way to set indicators:

Specific
Measurable
Achievable
Reliable
Time-bound

- **Specific –** relates to the issue that must be addressed (e.g. adolescent pregnancy, HIV infections).
- **Measurable –** relates to the numerical or qualitative difference in value/status of the issue that can be measured at the beginning and at the end of the programme/project to indicate result (e.g. new infection rates for HIV in State X was 4.3 per cent in 2003 and 3.5 per cent in 2005).
- **Achievable –** relates to the setting of target numbers, quantities or percentages that can reasonably be achieved (e.g. reducing new HIV incidence rate by 1.0 – 2.0 per cent as against 50 per cent in a high risk district or geographic region).
- **Realistic –** relates to the outcome of activities (e.g. can HIV infection rates be reduced to 0.5 per cent from 3.5 per cent in one year? or can HIV be eradicated from the area?)
- **Time-bound –** there should be a target date for achieving the desired result(s).

UNFPA uses the **DOPA** criteria to set indicators. DOPA is a simple tool to guide us in the indicator selection.

What are DOPA criteria?

They are standards used to assess that the indicators are:

Direct : - closely measure the intended change.

Objective : - unambiguous about what is being measured; and which data to be collected.

- clear operational definition that is independent of the person conducting the measurement.

Practical : - reasonable in terms of data collection cost, frequency, and timeliness for decision-making purposes.

Adequate : - the minimum number of indicators necessary to ensure that progress towards the output is sufficiently captured.

Source: Monitoring & Evaluation Tool Kit for Programme Managers, UNFPA DOS – Tool Kit No. 6, August 2002.

BCC interventions can result in changes in individuals' *knowledge, attitudes, skills, behaviours,* and even *political commitments.* Here are some examples of BCC outcome and output results and their indicators:

Examples of how to state BCC results and indicators

- Number of intended audience (e.g., men, women, adolescents, sex workers, truck drivers, young men, men having sex with men) reporting having used a condom (correctly) during their last sexual intercourse increased from X% (baseline) to Y% (endline).
- Number of people among targeted population using modern FP methods increased from X % (baseline) to Y % (endline).
- Number of intended audience seeking VCT on HIV in the last 6 months increased from X % (baseline) to Y % (endline).
- Number of men accompanying their wives to the FP clinics in the last 6 months increased from X % (baseline) to Y % (end-line) for prenatal and antenatal care.

ANNEXES

Annex-1 The Causality Analysis Matrix (CAM)

The Causal Analysis Matrix (CAM) is a diagnostic tool that helps to determine the "who, what and why" that lead to a public health outcome or result. It illustrates the results-chain discussed on page 14 & 15. They can be behaviour and non-behaviour related.

The health outcome of an individual is the result of an immediate cause that could be behaviour related. This behaviour is in turn due to a underlying causes such as external influences (e.g. lack of knowledge, awareness, skills, etc.) that could have changed the individual's health behaviour. The underlying causes could be due to some deep root(ed) causes including social, cultural and religious norms as well as economic, topographical and political situation.

As an example, the death (i.e. health outcome) of a mother due to childbirth could be caused by her health behaviour during her pregnancy (immediate cause) – not getting prenatal check and delivery by an untrained midwife. This action could be due to someone or something exerting an influence on her health behaviour such as her lack of knowledge or unsupportive husband and family members (underlying cause). The seemingly uncaring environment could be due to some basic or root causes (societal, political, administrative) formed from many years or generations of doing or not doing the same thing.

In the example given, we use the CAM to analyze different levels of causes that are behaviour and non-behaviour related resulting in the deaths of new mothers.

1. Begin with writing down a statement for the ***Result*** in the health outcome box. In our example, it is **"Death of woman due to childbirth/ delivery"**

2. There are two columns for analyzing the effects. One for behaviour related causes and the other for non-behaviour related causes. Work through the causal tree of one column first before moving to the other column. That is, if you begin to list the behaviour causes, work down the column to trace the immediate, underlying and root causes.

3. Questions that may help to determine the ***Immediate Cause*** can be:
   a. "What or Whose behaviour(s) led to the resultant health outcome?"
   b. "What was the actual cause for the health outcome that is non-behaviour related?"

4. Questions that may help to determine the ***Underlying Causes*** can be:
    a. "Why did this happen?" (for both behaviour and non-behaviour causes)
    b. "Who or What influenced the primary subject's health seeking behaviour(s)?"
    c. "Why is this problem happening here or in this area?"

5. Questions that may help to determine the ***Root Causes*** can be:
    a. "What is the community's influence on the behaviour of the primary individual?"
    b. "What deep rooted factors including religious and cultural practices, local customs and environment contributed to this problem?"

Example of a Causality Analysis Matrix on high Maternal Mortality

Result: Deaths of women due to childbirth/delivery (Insert the final health outcome here)		
Causes	**EFFECTS**	
	Behaviour Related	**Non-behaviour Related**
Immediate (e.g. status)	Q: "What/Whose behaviour(s) led to the Outcome/Result?" [i.e. deaths of the pregnant women] A: "Unsafe delivery by untrained midwife"	Q: "What was the actual cause for the Outcome/Result that is non-behaviour related?" [i.e. death of the pregnant woman] A: "Complication in delivery" A: "Post delivery tetanus infection"
Underlying (e.g. access, practices, services)	Q: "Why did this happen?" Q: "Who influenced the pregnant women's behaviour(s)?" A: "Women having children "too many, too soon and too early" A: "Poor pre-natal care"	Q: "Why is this problem happening here or in this area?" A: "Lack of trained health staff" A: "Lack of EmOC facility" A: "Poor referral system"
Root (e.g. society, policies, resources, geography)	Q: "What is the community's role/influence relating to the behaviour of the primary individual?" A: "Cultural and religious practices don't encourage pregnant women to leave the house" A: "Child marriage is customary"	Q: "What deep rooted factors contribute to this problem?" A: "Poverty" A: "High illiteracy rate" A: "Topography (mountainous country / lack of roads) making access to RH services difficult"

Annex-1A Exercise – Drawing up Causality Analysis Matrix (CAM)

Exercise: Use the worksheet below to draw up a Causal Analysis Matrix (CAM) for HIV infection among young people when the outcome and manifestation are known. Some sample questions are already provided. Feel free to add more questions. Remember that the Root Cause results in the Underlying Cause which in turn results in the Immediate Cause that is manifested by the "symptoms" which in turn result in the health outcome. They can be behaviour and non-behaviour related.

Result: 3,500 people are infected with HIV in the country of which 1,800 have become full blown AIDS patients. 500 died of AIDS last year		
Causes	**EFFECTS**	
	Behaviours Problem	**Non-behavioural Problems**
Immediate (e.g. status)	Q:"What/Whose behaviour(s) led to the health outcome or Result?" A:	Q: "What immediate factors contributed to the health outcome of individuals that is non-behaviour related?" A:
Underlying (e.g. access, practices, services)	Q: "Why did this happen and who is it affecting?" Q: "What or who has or can influence the health related behaviour(s)?" A:	Q: "Why is this problem happening here or in this (geographic) area?" A:
Root (e.g. society, policies, resources, geography)	Q: "How does the community contribute to the health outcome / Result?" A:	Q: "What deep rooted factors contribute to this problem?" A:

Annex-2 The Behaviour Analysis Matrix (BAM)

The Behaviour Analysis Matrix (BAM) is a diagnostic tool that helps to determine the problems behaviour(s), the desired behaviour(s), the barrier and facilitating factors to the behaviour(s) and their consequences that lead to the public health outcome. It visualizes the behaviour analysis discussed on page 14.

Problem behaviour	Consequence	Desired behaviour	Barriers to Desired behaviour	Factors encouraging desired behaviour
Here, list and / or identify the behaviour problem of each "target" or group	Here, list the consequences of the specific behaviour(s) of each "target" or group	Here, list what would be the desirable or positive behaviour(s) of the "target" or group	Here, list what could be the barriers for the desirable behaviour(s)	Here, list all the factors that can influence and encourage performing the desired behaviour(s)
Sample questions for each cell				
Who is the primary "target" and what is the problem whose behaviour?	What will happen if the person/group continues with the behaviour?	Ideally, what should the behaviour(s) be?	Who/What is preventing the person/group from "doing the right thing"?	Who/What can influence the behaviours?
Examples of answers to above questions				
Pregnant women don't seek pre-natal care from trained health staff	Risk of delivery complication resulting in maternal death	Pregnant women attend regular pre-natal check-up at local health centre	- Ignorance - Unsupportive husbands - Negative traditional beliefs and customs	- Supportive local leaders - Supportive neighbours - Presence of trained health staff in village

Annex-2A Exercise – Drawing up a Behaviour Analysis Matrix (BAM)

Exercise: Use the worksheet below to draw up a Behaviour Analysis Matrix (BAM) for HIV infection among young people drawing from the CAM worksheet of Annex-2A. See the examples of questions and answers provided in Annex-2. It is suggested that you write down the list of questions for each column before you begin to fill the cells. Move across horizontally, problem behaviour by problem behaviour.

Problem behaviour	Consequence	Desired behaviour	Barriers to Desired behaviour	Factors encouraging desired behaviour
Here, list and / or identify each problem behaviour of the "target" or group	Here, list the consequences of the specific behaviour(s) of each "target" or group	Here, list what would be the desirable or positive behaviour(s) of the "target" or group	Here, list what could be the barriers for the desirable behaviour(s)	Here, list all the factors that can influence and encourage performing the desired behaviour(s)
Problem behaviour #1				
Problem behaviour #2				
Problem behaviour #3				

Annex-3 The Stakeholders Analysis Matrix (SAM)

The Stakeholders Analysis Matrix (SAM) is a diagnostic tool that helps to determine who the primary and secondary stakeholders are who have an interest in the behaviour of the intended audience (IA.) The SAM will also help analyze what role each stakeholder has the IA's behaviour(s).

Below is an example of the SAM for pregnant women not availing pre-natal care.

Problem Behaviours	Intended Audience	Primary/Secondary (P/S) Stakeholders	Role in BCC intervention strategy
(Import the behaviour problem identified in the BAM) Pregnant women not seeking pre-natal care from trained health staff and not having their infants delivered by a trained health worker	**(Import the list of IA from AAM & ComAM as appropriate)** - women of child bearing age (PA)	Pregnant women (P)	Targeted directly to influence pre-natal care and delivery
		Husbands and mother-in-laws (P)	Directly influences pregnant women's behaviours
		Family members, brothers/sisters (S)	Can influence PA to seek pre-natal care and delivery in health centre
		Friends (S)	Can have strong peer influence and apply peer pressure
		Schools (P)	Can be entry point for introducing and sustaining BCC intervention programmes on RH
		Social Workers (S)	Can provide support and guidance for RH programmes
		Community / religious leaders (S)	Can have strong influence on RH programmes by supporting them
		Min of Health (P)	Responsible for RH policy and can institute and support BCC programmes through the health services
		Min of Education (P)	Responsible for ARH/RH policy in the education sector and can institute BCC programmes on ARH/RH through education institutions
		Community Based Organizations (CBOs)	Support and/or implement BCC programmes on ARH/RH

Annex-3A Exercise – Drawing up the Stakeholders Analysis Matrix (SAM)

Exercise: Use the worksheet below to draw up a Stakeholders Analysis Matrix (SAM) for HIV infection among young people drawing from the CAM, BAM, AAM and ComAM worksheets of Annex-2A, Annex-3A, Annex-4A and Annex-5A. Each set of problem behaviour maybe of interest to different stakeholders. Hence it is important the analyze them separately as suggested by the colour separations.

Problem Behaviours	Intended Audience	Primary/Secondary (P/S) Stakeholders	Role in BCC intervention strategy
Behaviour #1 **(Import the behaviour problem identified in the BAM)**	**(Import the list of IA from AAM & ComAM as appropriate)**		
Behaviour #2 **(Import the behaviour problem identified in the BAM)**	**(Import the list of IA from AAM & ComAM as appropriate)**		

Annex-4 The Audience Analysis Matrix (AAM)

The Audience Analysis Matrix (AAM) is a diagnostic tool that helps to determine who the intended audiences are to be targeted in a BCC intervention related to the problem behaviour(s) identified in the BAT. There should be a primary audience (PA) and a secondary audience (SA). The secondary audiences may be divided into categories such as those who are close to the PA. They can and do provide immediate support to the PA and to those whom we need to mobilize and advocate with for different kinds of supports.

Problem behaviour	Intended Audiences (IA)			
	Primary Audience (PA)	Secondary Audience (SA)		
		For immediate support	For Social Mobilization	For Advocacy
Here, import the problem behaviour(s) identified in the BAT	Here, identify who is to be the primary audience	Here, identify who are the secondary audiences that can influence the PA	Here, identify those from among the community who can provide support	Here, identify those whom convince to provide support to the programme
Sample intended audiences for each cell				
Pregnant women not seeking pre-natal care from trained health staff	All Women of child bearing age	Close family members (husband, mother, sister, etc.)	- Religious leaders - School Teachers - Social Workers - CBOs	- Local leaders - Religious leaders
Preference of home delivery	- Pregnant women	Mother-in-law; husband, sister-in-law	Community & CBOs	Friendly and supportive health staff

Annex-4A Exercise – Drawing up an Audience Analysis Matrix (AAM)

Exercise: Use the worksheet below to draw up an Audience Analysis Matrix (AAM) for HIV infection among young people drawing from the CAM and BAM worksheets of Annex-2A and Annex-3A. See the examples provided in Annex-3. It is suggested that you move across horizontally, problem behaviour by problem behaviour to identify all the intended audiences.

Problem behaviour	Intended Audiences (IA)			
	Primary Audience (PA)	Secondary Audience (SA)		
		For immediate support	For Social Mobilization	For Advocacy
Here, import the problem behaviour(s) identified in the BAT	Here, identify who is to be the primary audience	Here, identify who are the secondary audiences that can influence the PA	Here, identify those from among the community who can provide support	Here, identify those whom we need to convince to provide support to the programme
Problem behaviour #1				
Problem behaviour #2				
Problem behaviour #3				

Annex-5 The Communication Channel Analysis Matrix (CCAM)

The Communication Chanel Analysis Matrix (CCAM) is a diagnostic tool that helps to determine and analyze the channels through/with whom, how or from where the intended audiences get their information and knowledge and to communicate. This is different from traditional IEC *materials/media analysis.* Communication is a two way process. There must be a sender and a receiver who in turn respond and send back a message to the original sender who now becomes a receiver. Each of the intended audience identified in the AAM should be listed in the left-hand IA column. Like other matrix, work through horizontally to complete the matrix.

Communication Channels Analysis					
Intended Audience (IA)	**Group affiliation (social, religious, economic) of the IA**	**Where does the IA spend a lot of time?**	**Who does IA consult with on health issues / problems?**	**Who can influence the IA?**	**Media accessible to the IA**
Import PA from the AAM here	List the social group(s) that the IA belongs to	List all the places where IA spend time considerable time	List all the people that IA consults in order of importance	List all those who exert influence of IA	List ONLY the media that IA has access to
Sample lists of communication channels					
Pregnant women as PA	Women's Union; Farmers' Assoc; Religious groups; CBOs;	Home; Market; Waiting at health clinics	Sisters; Friends; Peers; Elders; religious leaders	Mother-in-law; Husband; Married female relatives; Religious person	Radio; Community speaker broadcast; TV, IEC materials from health centre
Husband As SA	Workers' Union; Football club;	Factory; Tea shop; Club;	Best friend; Colleagues; Elders;	Best friend; Monk/Priest/ Imam;	Radio; TV; Newspaper; Magazines;

Annex-5A Exercise – Drawing up the Communication Channel Analysis Matrix (CCAM)

Exercise: Use the worksheet below to draw up a Communication Channel Analysis Matrix (CCAM) for HIV infection among young people drawing from the CAM, BAM and AAM worksheets of Annex-2A, Annex-3A and Annex-4A. See the examples provided in Annex-4. It is suggested that you move across horizontally, IA by IA. Use a single horizontal column for each IA.

Communication Channels Analysis					
Intended Audience (IA)	**Group affiliation (social, religious, economic) of the IA**	**Where does the IA spend a lot of time?**	**Who does IA consult with on health issues / problems?**	**Who can influence the IA?**	**Media accessible to the IA**
Import PA from the AAM here	List the social group(s) that the IA belongs to	List all the places where IA spend time considerable time	List all the people that IA consults in order of importance	List all those who exert influence of IA	List ONLY the media that IA has access to
Sample lists of communication channels					
Primary Audience (PA)					
SA #1 (close to the PA)					
SA #2 (for social mobilization)					
SA # 3 (for Advocacy)					

Annex-6 Country Programme Communication Strategic Framework

Whether you are planning a communication strategy for the purpose of **advocacy, social mobilization** or for **behaviour change,** the principle is the same.

CP Outcome:	**Outcome Indicators:**
CP Outputs :	**Output Indicators:**

Areas For Intervention : (e.g. Young People and Adolescent Reproductive Health)

Communication Strategy	**Intended Audience**		**Key Existing Knowledge, Attitudes & Behaviours**	**Key Communication Messages**	**Communication Channels**
Behaviour Change Communication Interventions	Primary	(list the **MAIN /** primary person to be addressed here	(list **existing** knowledge, attitudes & behaviours that will affect the outputs / outcomes in order of priority)	▪ keep in mind the message format, message approach – and the tone used for delivering messages	(Do **NOT** list all and every kind of channels. List **ONLY** those
	Secondary	(list other people of immediate importance to the primary audience here)		▪ message design depend on the type of media it is sent through. ▪ do not clutter posters with too much text.	that will be the most appropriate and effective for the intended audience. Keep in mind the
Social Mobilization	(list all those who can support and influence **both** the primary & secondary audiences)		(list **existing** knowledge, attitudes & behaviours that will affect the outputs / outcomes in order of priority)		**purpose** of the communication whether it is for BCC, social mobilization or advocacy. Select the channel only after doing
Advocacy	(list all those who are in position to make decisions that affect the implementation of programme that impacts on outcome)		(list **existing** knowledge, attitudes & behaviours that will affect the outputs / outcomes in order of priority)		a communication channel analysis.

Annex-7 Suggestions for Further Readings

The following can be downloaded from the UNFPA website: **http://www.unfpa.org/publications/index.cfm**

Soap Operas for Social Change to Prevent HIV/AIDS: ***A Training Guide for Journalists and Media Personnel (2005).*** This guide is designed to be used by journalists and media personnel to plan and execute the production and broadcast of entertainment-education serial dramas for HIV prevention.

Preventing HIV/AIDS among Adolescents through Integrated Communication Programming (2003). Preventing HIV/AIDS among adolescents is a challenging task that touches upon several controversial policy and cultural issues. Nevertheless, it is an absolutely crucial task, as more and more young people are being infected with the deadly virus each day. As several countries have shown, effective prevention programming includes integrating advocacy, behaviour change communication and educational strategies with other policy and service components. This handbook focuses on HIV prevention through *integrated communication programming* that blends advocacy, behaviour change communication and education interventions.

Strengthened Partnerships among Local FM and Community Radio Networks and RH Agencies on HIV/AIDS (2003): *Background Paper: A Review of the Effectiveness of Local FM Radio in Promoting Reproductive Health, HIV/AIDS Prevention and Gender Equity.* This interactive CD-ROM presents all materials developed for and discussed during two pilot regional training workshops in Africa and Asia in 2003. (It is downloadable as a .pdf file.) During the workshops, managers learned how to use entertainment-education methodologies to produce radio serial dramas that are culturally sensitive and research-based. The aim is to use this popular medium more effectively to reduce risky behaviour and prevent HIV/AIDS. The workshops were organized by UNFPA and the Population Media Center (PMC).

Communication/Behavior Change Tools Number 2: (2002) : *Effectively Using Hotlines for BCC in Population and RH.* Communication/Behavior Change Tools Number 2: Effectively Using Hotlines for BCC in Population and RH. This programming brief provides definition, aims of hotlines for behaviour change in population and reproductive health and highlights the

key programming elements to consider. It also documents a few UNFPA experiences in integrating hotlines in its programmes. Hotlines are innovative behaviour change tools to maximize information, counselling and services that can be applied to a variety of UNFPA thematic initiatives such as Humanitarian Response, elimination of gender violence, reduction of maternal mortality, HIV/ AIDS, Sexuality education, legal advice and literacy.

Communication/Behaviour Change Tools Number 1: (2002) : *Entertainment-Education.* To make a positive difference on attitudes and behaviour on reproductive health and gender issues, quality entertainment-education programmes involve careful planning, monitoring and evaluation. Especially key to success is the timely use of socio-cultural research and evaluation at various stages of the programme planning sequence. The note defines entertainment-education (EE), addresses its relevance to UNFPA thematic priorities, discusses key programming elements, describes experiences-to-date, lists key lessons learned, and points to a number of useful resources (references and web-based resources).

Communication for Development Round Table Report (2001): *Focus on HIV/AIDS and Evaluation.* This new publication summarizes discussions from the Eighth Roundtable on Communication for Development Roundtable (Managua, 2001) on strategies to meet the urgent challenge of HIV/AIDS. It highlights communications that address the needs of young people, use of community media, and community mobilization to tackle gender-based violence and discrimination. It also presents communications models and applications from the field, along with lessons learned. A CD-ROM companion features all presentations and related documentation.

The following can be downloaded from UNFPA Myanmar website: **http:Myanmar.unfpa.org**

- **Behaviour Change Communication Master Plan for Reproductive Health (2003)**
- **The Community-Operated RH/BCC Project in Myanmar: Documentation of Model Project Outcomes and National Level Assessment Report (2003)**

The following can be downloaded from UNFPA Viet Nam website: **http:Vietnam.unfpa.org**

- **Behaviour Change Communication Strategy To Improve Reproductive Health For Adolescents And Youth 2004 – 2006**
- **Advocacy Strategy For Adolescent Sexual And Reproductive Health for RHIYA Program in Viet Nam 2005- 2006**

The following can be downloaded from the Family Health International (FHI) website: **http://www.fhi.org/en/HIVAIDS/pub/guide/BCC+Handbooks/index.htm**

- **BCC Handbook: How to Conduct Effective Pretests.**
- **BCC Handbook: How to Create an Effective Communication Project**
- **BCC Handbook: Assessment and Monitoring of BCC Interventions**
- **BCC Handbook: How to Create an Effective Peer Education Project**
- **BCC Handbook: Behavior Change Through Mass Communication**
- **BCC Handbook: STD Treatment and Prevention**
- **BCC Handbook: Policy and Advocacy in HIV-AIDS Prevention**
- **BCC Handbook: Partnership with the Media**
- **Behavior Change Communication (BCC) for HIV/AIDS: A Strategic Framework**

The following can be downloaded from the Communication Initiatives website: **http://www.comminit.com/materials/ma2006/materials-2772.html**

Behavior Change Perspectives and Communication Guidelines on Six Child Survival Interventions. (2005). Publisher: Academy for Educational Development, Johns Hopkins Bloomberg School of Public Health.

This document was designed for those who want to incorporate behaviour change and communication strategies in their child survival programmes, as well as those who already plan and carry out such activities. The document examines critical behavioural determinants for major audiences in different children's health areas. It discusses what has already been learned about "what works," innovations that have been tried at smaller scales, and perspectives about gaps and promising areas for new communication strategies.

Behavior Change Communication for Improved Infant Feeding: Training of Trainers for Negotiating Sustainable Behavior Change (2004). Publisher: The LINKAGES Project (Available at: **http://www.comminit.com/materials/ma2006/materials-2770.html)**

This training module has been designed as course to train community health workers and trainers of community health workers to deliver training on behaviour change communication related to infant feeding. It emphasizes behaviour change communication skills and infant feeding technical content. The approach is geared toward practical responses to problem solving and questions related to infant feeding.

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