

**BEHAVIOR CHANGE COMMUNICATION (BCC)
FOR HIV/AIDS**

A STRATEGIC FRAMEWORK



This work was supported by the United States Agency for International Development (USAID) as part of Family Health International's Implementing AIDS Prevention and Care (IMPACT) Project (Cooperative Agreement HRN-A-00-97-00017-00) and does not necessarily reflect the views of USAID or FHI.

FHI implements the USAID IMPACT Project in partnership with the Institute of Tropical Medicine Management Sciences for Health ♦ Population Services International ♦ Program for Appropriate Technology in Health ♦ and the University of North Carolina at Chapel Hill

© September 2002
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GLOSSARY

BEHAVIOR CHANGE INTERVENTION (BCI): A combination of activities/interventions tailored to the needs of a specific group and developed with that group to help reduce risk behaviors and vulnerability to HIV by creating an enabling environment for individual and collective change.

BEHAVIOR CHANGE COMMUNICATION (BCC): An interactive process with communities (as integrated with an overall program) to develop tailored messages and approaches using a variety of communication channels to develop positive behaviors; promote and sustain individual, community and societal behavior change; and maintain appropriate behaviors.

FORMATIVE BCC ASSESSMENT: Research conducted before the start of a project to help staff establish target population profiles to be used in developing messages.

GATEKEEPER: A person outside a target audience who has both influence and control over access to that audience.

GOAL: The hoped-for result of a program or project.

INTRAVENOUS DRUG USER (IDU): A person who injects drugs (and thereby raises his or her risk of HIV infection).

INFORMATION, EDUCATION AND COMMUNICATION (IEC): Development of communication strategies and support materials, based on formative research and targeted at influencing behaviors among specific groups.

OBJECTIVE: A specific, measurable and time-bound result.

OPINION LEADER: A person who has great influence over members of a target audience.

PLHA: Person/s living with HIV/AIDS.

STRATEGIC PLANNING: A disciplined effort to generate fundamental decisions and actions that will shape and guide the direction of a project or program. Strategic planning is flexible, often iterative and long-range, covering a period of three to five years. It includes setting the project's/program's goals, strategies and objectives.

STRATEGY: A coordinated and comprehensive plan for guiding multiple actions or activities that are aimed at achieving a project's goal and objectives.

STAKEHOLDER: A person or group with an interest in the outcome of an intervention.

SEX WORKER (SW): A person who sells sex in exchange for money, commodities, or services.

TARGET POPULATION: A group within a population who share similar characteristics and behaviors, and upon whom BCC activities are focused.

TRADITIONAL MEDIA: Channels of communication that are usually culture- or community-specific.

I. INTRODUCTION

Behavior change communication (BCC) is an interactive process with communities (as integrated with an overall program) to develop tailored messages and approaches using a variety of communication channels to develop positive behaviors; promote and sustain individual, community and societal behavior change; and maintain appropriate behaviors.

In the context of the AIDS epidemic, BCC is an essential part of a comprehensive program that includes both services (medical, social, psychological and spiritual) and commodities (e.g., condoms, needles and syringes). Before individuals and communities can reduce their level of risk or change their behaviors, they must first understand basic facts about HIV and AIDS, adopt key attitudes, learn a set of skills and be given access to appropriate products and services. They must also perceive their environment as supporting behavior change and the maintenance of safe behaviors, as well as supportive of seeking appropriate treatment for prevention, care and support.

In most parts of the world, HIV is primarily a sexually transmitted infection (STI). Development of a supportive environment requires national and community-wide discussion of relationships, sex and sexuality, risk, risk settings, risk behaviors and cultural practices that may increase the likelihood of HIV transmission. A supportive environment is also one that deals, at the national and community levels, with stigma, fear and discrimination, as well as with policy and law. The same issues apply in parts of the world where unsafe injection of illegal drugs is the chief source of new infections.

The AIDS epidemic forces societies to confront cultural ideals and practices that can contribute to HIV transmission. Effective BCC is vital to setting the tone for compassionate and responsible interventions. It can also produce insight into the broader socioeconomic impacts of the epidemic and mobilize the political, social and economic responses needed to mount an effective program.

FHI's pragmatic BCC approach, based on sound practice and experience, focuses on building local, regional and national capacity to develop integrated BCC that leads to positive action by stimulating society-wide discussions. BCC is both an essential component of each program area and the glue between the various areas. However, society-wide change is slow; changes achieved through BCC will not occur overnight.

This document outlines FHI's BCC strategy for HIV/AIDS. It has been developed for use by donors, partners, collaborators and potential collaborators.

II. THE ROLE OF BEHAVIOR CHANGE COMMUNICATION

BCC is an integral component of a comprehensive HIV/AIDS prevention, care and support program. It has a number of different but interrelated roles. Effective BCC can:

- **Increase knowledge.** BCC can ensure that people are given the basic facts about HIV and AIDS in a language or visual medium (or any other medium that they can understand and relate to).
- **Stimulate community dialogue.** BCC can encourage community and national discussions on the basic facts of HIV/AIDS and the underlying factors that contribute to the epidemic, such as risk behaviors and risk settings, environments and cultural practices related to sex and sexuality, and marginalized practices (such as drug use) that create these conditions. It can also stimulate discussion of healthcare-seeking behaviors for prevention, care and support.

- **Promote essential attitude change.** BCC can lead to appropriate attitudinal changes about, for example, perceived personal risk of HIV infection, belief in the right to and responsibility for safe practices and health supporting services, compassionate and non-judgmental provision of services, greater open-mindedness concerning gender roles and increasing the basic rights of those vulnerable to and affected by HIV and AIDS.
- **Reduce stigma and discrimination.** Communication about HIV prevention and AIDS mitigation should address stigma and discrimination and attempt to influence social responses to them (see box).
- **Create a demand for information and services.** BCC can spur individuals and communities to demand information on HIV/AIDS and appropriate services.
- **Advocate.** BCC can lead policymakers and opinion leaders toward effective approaches to the epidemic.
- **Promote services for prevention, care and support.** BCC can promote services for STIs, intravenous drug users (IDUs), orphans and vulnerable children (OVCs); voluntary counseling and testing (VCT) for mother-to-child transmission (MTCT); support groups for PLHA; clinical care for opportunistic infections; and social and economic support. BCC is also an integral component of these services.
- **Improve skills and sense of self-efficacy.** BCC programs can focus on teaching or reinforcing new skills and behaviors, such as condom use, negotiating safer sex and safe injecting practices. It can contribute to development of a sense of confidence in making and acting on decisions.

STIGMA

Stigma is a mark of shame or discredit on a person or group. Stigma can manifest itself in a variety of ways, from ignoring the needs of a person or group to psychologically or physically harming those who are stigmatized. Stigma is often felt by PLHA, men who have sex with men (MSM), sex workers (SWs), IDUs, migrant populations and others.

The importance of addressing stigma in the context of BCC campaigns has programmatic implications that transcend questions of compassion and humane treatment. Failure to address stigma jeopardizes BCC programs in critical ways:

Prevention. BCC programs that fail to address stigma allow some people to ignore the messages of HIV prevention. Stigma can cause people to perceive individuals with or at risk for HIV as *the other* (“*them*”), reinforcing their feeling that HIV “couldn’t happen to me.” Failure to address stigma can also deter individuals from seeking out VCT and proper medical care, including MTCT prevention services. Stigma is also sometimes attached to carrying condoms. Stigma can work against prevention programs; for example, an outreach or peer education program for MSM, IDUs, or SWs can be damaged by “round-ups” and detention of beneficiaries.

Quality of care. Stigma can perpetuate harmful practices, such as discrimination against or poor treatment of PLHA, IDUs, MSM, or SWs. A BCC campaign to increase demand at a health facility would be hurt if poor quality of care were encountered there by PLHA.

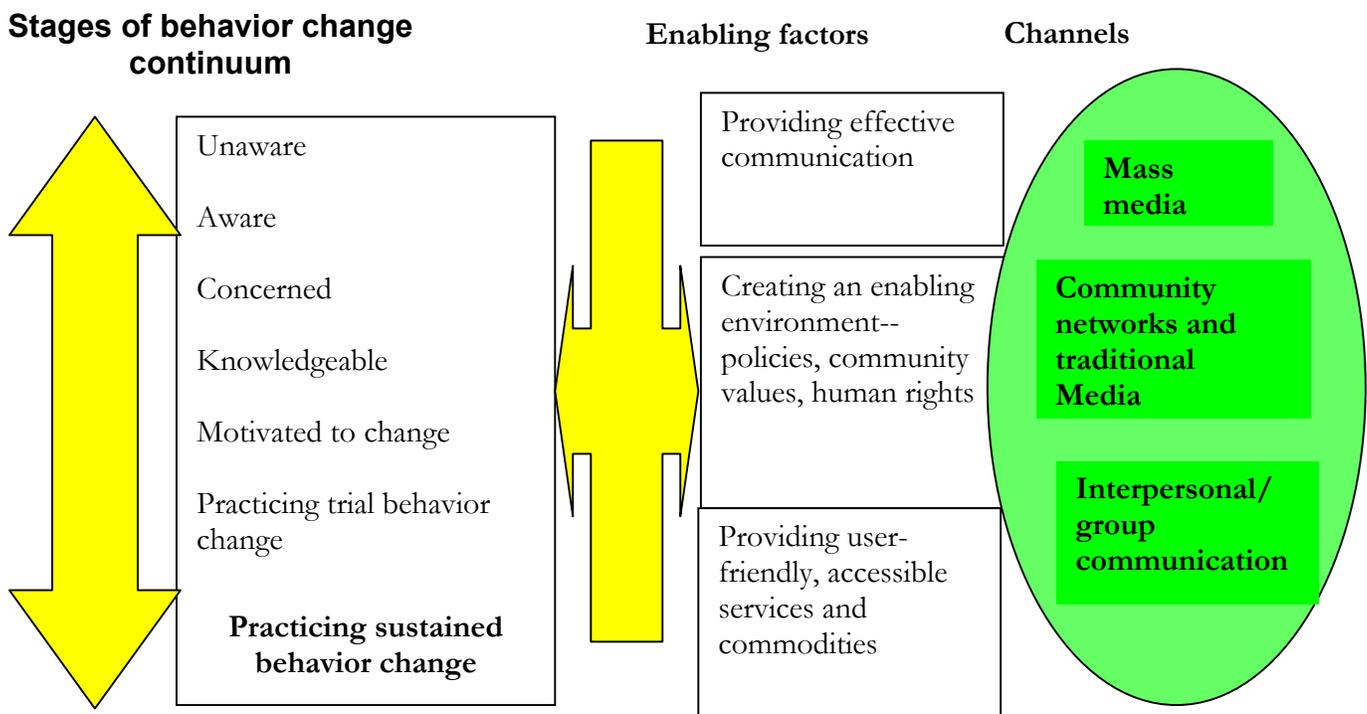
Policy. Programs that fail to address stigma help perpetuate discriminatory laws and practices and, in some cases, result in failure to enforce laws against them. Such programs also miss an opportunity to influence policy direction.

BCC programs that address stigma can work with and employ people from traditionally stigmatized groups, such as PLHA, SWs and MSM, as advocates for policy change. Such individuals can also serve as dedicated caregivers, social workers, peer educators and role models for change.

III. THE PROCESS OF BEHAVIOR CHANGE: A FRAMEWORK FOR BCC DESIGN

BCC has its roots in behavior change theories that have evolved over the past several decades. These theories are valuable foundations for developing comprehensive communication strategies and programs. FHI’s BCC practitioners draw upon various models and theories to design effective programs and activities. These include the Diffusion of Innovations model (Everett Rogers), the Stages of Change model (Prochaska, DiClemente and Norcross), the Self-Efficacy model (Bandura) and the Behavior Change Continuum (World Bank). FHI BCC practitioners use a combination of theories and practical steps that are based on field realities, rather than relying on any single theory or model. The following figure is based on the prevailing models and theories, and is one framework that guides FHI’s BCC design.

Figure 1. A framework for BCC design



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

Different channels have been shown to be more effective at different stages of the continuum and for achieving different goals. Communication through mass media can ensure that correct information reaches a specific population and can model positive attitudes, but when an individual or community is motivated to attempt new behaviors, policies and the larger social environment become more important. When audiences become ready to change, the activities, services, or products being promoted must be available to them.

IV. BCC GOALS

Behavior change communication goals need to be developed in the context of overall program goals and specific behavior change goals. The following highlights the place of BCC goals within an overall program.

Program goal: Reduce HIV prevalence among young people in urban settings in X country.

Behavior change goals:

- Increase condom use
- Increase appropriate STI care-seeking behavior
- Delay sexual debut
- Reduce number of partners

BCC goals:

- Increase perception of risk or change attitudes toward use of condoms
- Increase demand for services
- Create demand for information on HIV and AIDS
- Create demand for appropriate STI services
- Interest policymakers in investing in youth-friendly VCT services (services must be in place)
- Promote acceptance among communities of youth sexuality and the value of reproductive health services for youth (services must be in place)

BCC goals are related to specific issues identified when assessing the situation, knowledge, attitudes and skills that may need to be changed to work toward behavior change and program goals.

V. GUIDING PRINCIPLES

- **BCC should be integrated with program goals from the start.** BCC is an essential element of HIV prevention, care and support programs, providing critical linkages to other program components, including policy initiatives.
- **Formative BCC assessments** must be conducted to improve understanding of the needs of target populations, as well as of the barriers to and supports for behavior change that their members face (along with other populations, such as stakeholders, service providers and community).
- **The target population should participate** in all phases of BCC development and in much of implementation.
- **Stakeholders** need to be involved from the design stage.
- Having a **variety of linked communication channels** is more effective than relying on one specific one.
- **Pre-testing** is essential for developing effective BCC materials.
- **Planning for monitoring and evaluation** should be part of the design of any BCC program.

- **BCC strategies should be positive and action-oriented.**
- **PLHA should be involved** in BCC planning and implementation.

VI. FHI'S APPROACH

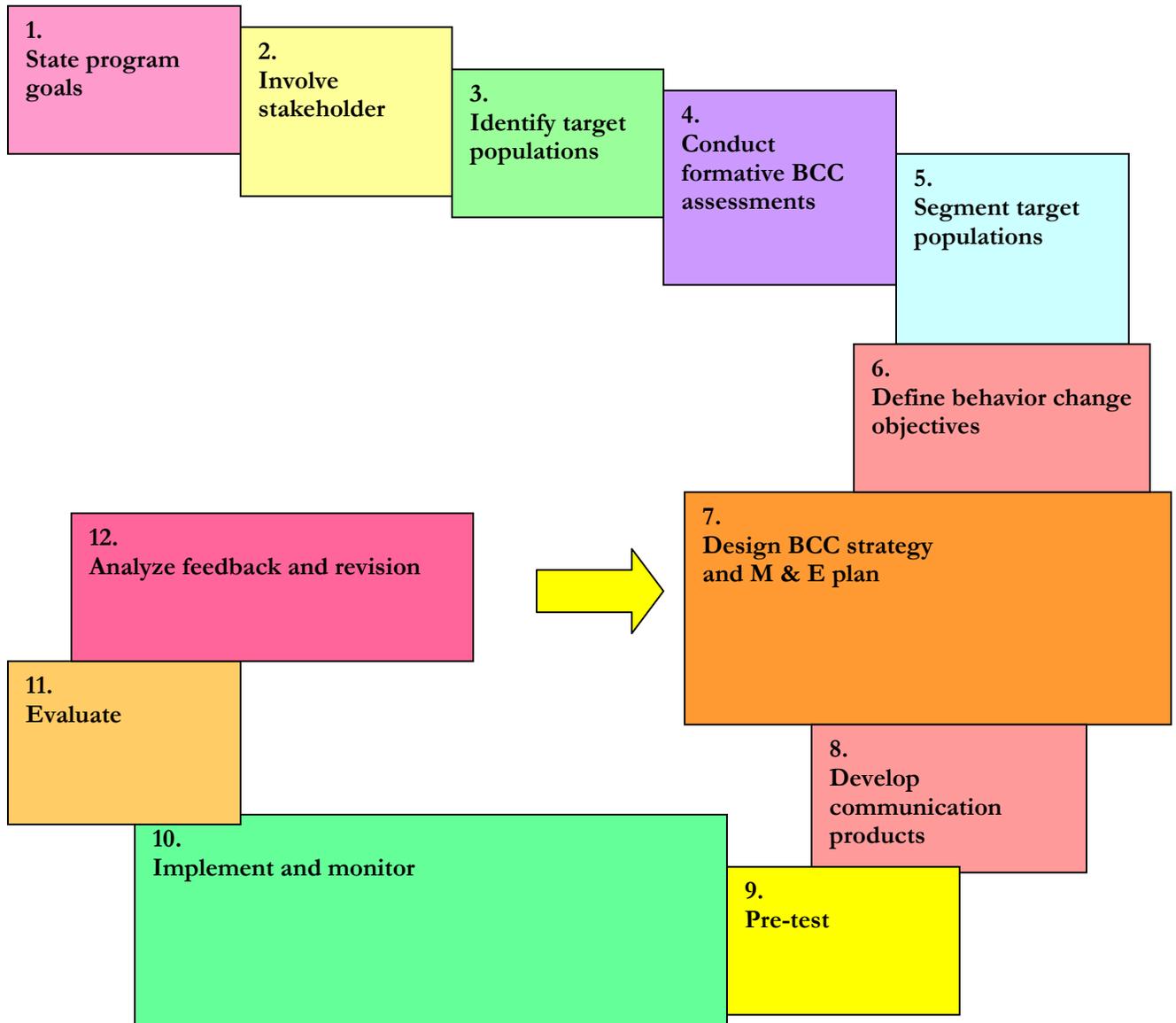
BCC is both an essential component of an HIV/AIDS program and a support element in the program's service, mitigation and policy components. FHI develops BCC in the context of a prevention, care and support program. **FHI advocates moving beyond individual communication products to an integrated use of many different interventions, products and channels, woven together into a comprehensive strategy.** A BCC strategy based on sound formative BCC assessment can ensure that communication effectively influences community discussions and social norms and plays an important role in services and individual and community behavior, once services and commodities are in place.

FHI works to contribute to national program goals and collaborate with other national, regional and international partners to achieve greater impact. Linkages with other BCC in-country initiatives and programs are essential to ensure the effectiveness of FHI's BCC initiatives.

VII. BCC STRATEGY DEVELOPMENT AND PLANNING

To put this approach into action, FHI promotes a practical, step-by-step methodology for developing and implementing a BCC strategy. The following steps are meant as a general guide, rather than as a blueprint. Where local situations vary, the strategy should be adapted accordingly. (It should be noted that some of these steps may take place simultaneously. For example, monitoring the involvement of stakeholders will happen throughout all steps of strategy development.)

Figure 2. Steps in developing a behavior change communication strategy



State program goals

FHI's program goals are designed in coordination with national HIV and AIDS strategies. Clearly identifying overall program goals is the first step in developing a BCC strategy. Specific FHI program goals are established after reviewing existing data, epidemiological information and in-depth program situation assessments.

Involve stakeholders

Key stakeholders need to be involved early on in every step of the process of developing HIV/AIDS programs and their BCC components. Stakeholders include policymakers, opinion leaders, community leaders, religious leaders and members of target populations, including PLHA. Their active participation at appropriate stages of BCC strategy development is essential. A stakeholders' meeting should be held at the planning stage to obtain guidance and commitments to the process and to develop coordination mechanisms.

Identify target populations

To develop communication, it is important to identify the target populations as clearly as possible. Target populations are defined as primary or secondary. Primary populations are the main groups whose HIV/AIDS-related behavior the program is intended to influence. Secondary populations are those groups that influence the ability of the primary population to adopt or maintain appropriate behaviors. For example, an HIV program may seek to increase condom use among sex workers and clients (primary populations). But to achieve this objective, it may be necessary to change the behavior or gain the support of brothel owners and police (secondary populations).

Target populations include:

- **Individuals at high risk or vulnerability**, such as sex workers, their clients, youth, migrant workers, IDUs, or uniformed services personnel
- **People providing services**, such as health workers, private practitioners, pharmacists, counselors and social service workers
- **Policymakers**, such as politicians
- **Leaders and authorities, formal and informal**, including law-enforcement, social and religious leaders
- **Local communities and families**

Conduct formative BCC assessments

A formative BCC assessment should start by seeking out all available studies, including data from in-depth assessments or rapid ethnographic assessments, behavioral surveillance surveys and other related studies. After synthesizing this information, a formative BCC assessment protocol can be developed. The formative BCC assessment should collect information on:

- Risk situations, showing in detail how decisions are made in different situations, including what influences the decisions and settings for risk
- Why individuals and groups practice the behaviors they do, and why they might be motivated to change (or unable to change) to the desired behaviors
- Perceptions of risk and risk behaviors
- Influences on behavior, such as barriers or benefits
- Insights of opinion leaders
- Patterns of service use and opinions about these services

- Perceptions of stigma and discrimination
- Future hopes, fears and goals
- Media and entertainment habits
- Health care-seeking behaviors
- Positive deviants, or those most willing to model change
- Media resources

Formative BCC assessments make use of qualitative methods, such as focus group discussions, key informant interviews, direct observation, participatory learning methods, rapid ethnographic assessments, mapping and in-depth interviews. Where possible, the organizations that are directly engaged with the population, such as community-based and non-governmental groups, should participate in the formative BCC assessment with assistance from appropriate research institutions.

Segment target populations

Based on the formative BCC assessment, target populations can then be segmented. For example, sex workers can be grouped more specifically according to work location (street, home, brothel), income level, ethnicity, or language.

Population segments are often defined by psychosocial and demographic characteristics. Psychosocial characteristics include the knowledge, attitudes and practices typically demonstrated by a given group or audience; or by their role in society, their formal and informal responsibilities and their level of authority. Demographic characteristics include age, place of residence (or work), place of birth, religion and ethnicity. In addition, structural factors and settings (e.g., in the workplace, risk settings, border settings) should also be considered. For example, if sex workers and truck drivers are the target population, border crossings and truck stops constitute risk settings.

Define behavior change objectives

Whether the target population is a particular group or the general public, it is important first to refer to the HIV/AIDS program behavior change objectives. What changes in behavior does the program intend to achieve? While behavior changes may not have been specified in project documents, they can be inferred from project goals. Following are some common behavior change objectives:

- Increased safer sexual practices (more frequent condom use, fewer partners)
- Increased incidence of healthcare-seeking behavior for STIs, TB and VCT (for example, calls or visits to facilities)
- Increased use of universal precautions to improve blood safety
- Increased blood donations (where appropriate)
- Improved compliance with drug treatment regimens
- Adherence by medical practitioners to treatment guidelines
- Increased use of new or disinfected syringes and needles by IDUs
- Decline in stigma associated with HIV/AIDS
- Reduced incidence of discriminatory activity directed at PLHA and other identified high- risk groups
- Improved attitudes and behavior among healthcare, social service and other service delivery workers who interact with PLHA, SWs, IDUs and other marginalized groups

- Increased involvement of opinion leaders and policymakers, private sector managers and community members
- Increased involvement in self-help and homecare initiatives

Design BCC strategy and Monitoring and Evaluation (M&E) Plan

A BCC strategy is best designed in a participatory fashion, including members of target populations, organizations planning to work with them and stakeholders. Designing a BCC strategy is more than a matter of developing messages and media materials for dissemination. It is necessary to find the right mix of approaches to involve target populations—that is, to get their attention—and to promote and enable action. A well-designed BCC strategy should include:

- Clearly defined **BCC objectives**
- An overall **concept or theme** and **key messages**
- Identification of **channels** of dissemination
- **Identification of partners** for implementation (including capacity-building plan)
- A **monitoring and evaluation** plan

Taking each target population's needs and situation into consideration, along with the initiatives that answer those needs, a theme and key messages must be developed to provide a framework around which focused communication activities can be planned. Ideally, well-tested messages developed with the participation of target populations are disseminated through a variety of channels—mass media, interpersonal communication, traditional media, community-based activities and advocacy—to ensure that aspects of the information received by the target populations reinforce each other. With proper planning, BCC program implementers can build on existing quality communication and benefit from existing opportunities. Mutually reinforcing messages lend legitimacy to one another and stimulate community discussion and dialogue.

Interpersonal communicators, such as peer educators, outreach workers, counselors and other service providers, need to be prepared and well informed of both the findings of formative research and the key messages, so that their work will support that of the campaign and vice versa. For example, to make use of research findings and the content of messages, they will need to know any internal and external barriers and enabling factors. They should be prepared to promote services and products and to deliver communication messages. They will need to know of and be prepared to build on other communication activities. For example, they will have to ensure that audiences are aware of various mass communication activities and promote the discussion of messages. If mutually reinforcing messages are to be delivered and community discussion stimulated, this preparation is essential.

It is also important to ensure that HIV and AIDS messages not conflict with the messages of other organizations. For example, in many countries, public health authorities promote condoms, but religious organizations promote fidelity and oppose condom use. It may be necessary to find ways to work around conflicting messages from other sources. It is essential to prepare community-based communication and training service workers to deal with potential conflicts.

Define BCC objectives

Observable changes in behavior, as specified in the behavior change objectives, are a final program outcome. Such changes are generally preceded by intermediate changes. Such changes include:

- **Knowledge change:** an increase in knowledge among targeted youth of modes of transmission
- **Attitude change:** an increase in perception of personal risk or a change in authorities' attitudes toward promoting condoms to youth
- **Environmental change:** a decrease in harassment of sex workers by police or an increase in acceptance of messages about condom use on television

Although some of these changes are not directly related to behavior change, they can function as necessary environmental antecedents or as shifts that reflect an increasingly supportive environment.

An effective BCC strategy needs to be developed to guide achievement of intermediate and longer-term outcomes. Examples of BCC objectives are:

- Increased demand for information about HIV and AIDS. (Youth will ask for information about HIV and AIDS.)
- Increased knowledge about HIV and AIDS. (Youth will have correct knowledge of modes of transmission of HIV and AIDS.)
- Increased self-risk assessment. (Truck drivers will say that if they do not use condoms they feel at increased risk of contracting HIV.)
- Increased demand for information on STIs. (Miners will ask for more information on STIs.)
- Increased demand for services. (Sex workers will demand VCT services.)

Develop themes and messages

It is important to develop an overall theme that will appeal to and attract target populations. The theme should stem from the BCC formative assessment and further consultation. The theme will provide overall guidance for the development of messages, all of which will therefore be consistent with the theme.

The theme should be positive. It is now commonly understood that fear campaigns and campaigns blaming particular groups are ineffective. Most experts agree that fear tends to focus an audience's attention on what *not* to do, or what to avoid. Approaches are more effective when they promote positive messages that state clearly what audiences *can* and *should* do.

Themes should also avoid blaming or stigmatizing. Messages that blame a particular group can backfire, especially in AIDS programs, by diverting audiences' attention from their own needed behavior changes. Such messages can also encourage discrimination, stigma and even physical harm to PLHA and other vulnerable groups. Stigma and denial can in turn cause people to avoid services that may benefit them.

The theme should call attention to the campaign and link its various elements together, functioning as a sort of umbrella. It should be catchy and devised in such a way that all target populations can relate to it and identify with it. People who see different messages for different audiences should be able to link any of these diverse elements with the theme of the campaign.

Effective prevention and care messages should diplomatically "push the envelope," if necessary, and, to avoid conflict, take into account the country's traditions, culture, norms and values.

A message consists of carefully crafted information that is targeted at specific population groups. It should be designed to meet BCC objectives and to stimulate discussion and action. Messages are the most critical element in developing a BCC strategy—and they are the area where most strategies fail.

Using standard methodology, FHI works through a series of steps to develop the overall theme and key messages.

Step 1. Develop a profile of the target population from formative BCC assessment.

Step 2. Identify desired behavior change.

Step 3. Understand and take into account the varying situations that could affect action and decision-making.

Step 4. Identify the information or data that you want understood by the target population.

Step 5. Develop key benefit statements that take the hopes and aspirations of the target population into account: “If I do X (use condoms, get information, seek out treatment), I will benefit by Y” (remaining fertile, being seen as responsible, protecting my family, saving money, looking smart and sophisticated, attracting the opposite sex, etc.) Whatever the benefit, it will have to outweigh any disadvantages or “costs” the audiences might feel.

Step 6. Develop messages from key benefit statements. Messages should be simple, attractive and make clear the benefits of what is being promoted, through words or images.

Messages that promote products, such as condoms, must include information on where to get those products and how to use them. If a message promotes skill development or specific services, then the services that are being promoted must actually exist.

People may also need messages that help them feel they can succeed. This may be accomplished through messages that model success and positive outcomes.

Choose channels

A channel is the way a message is disseminated. It is important to know which channels can most effectively reach particular target populations. Identifying the range of available channels should be part of every formative BCC assessment.

Messages can be delivered through mass media—for example, television or radio spots; articles in periodicals; or material in brochures, posters, flip charts, picture codes or comics—or in-person, by health workers, peer educators, counselors, or other trained personnel. Additional means of delivery include musical or dramatic performances and community events. Messages can be reinforced with “gimmicks” such as key chains or stickers.

It is important to think about how particular channels can help achieve particular goals. Each medium has its own advantages and disadvantages, so that each may be best suited to a particular circumstance. For example, research has shown that mass media can raise awareness of specific facts, because the mass media are assumed to carry a certain authority and reliability. Mass media can also model behaviors and positive attitudes in the person of respected members of the target community. Later on in the process, however, target populations appear less interested in media authority than they are in the opinions and behaviors of people to whom they feel close. Interpersonal communication becomes primary, while the mass media play a supporting role.

If mass media are used, it is important to know which radio stations and TV programs are popular with the target population. It may not be cost-effective to use a less expensive AM news station if the message is intended for youth who primarily listen to FM music stations.

Peer education (or peer facilitation) is a cornerstone of all interventions with target populations. In *Peer Education, Concepts, Uses and Challenges* (UNAIDS 1999), a literature review was reported to have found that peer education has an overwhelmingly positive impact on STI or HIV incidence and risk behaviors. Peer educators can help reach specific groups, model safe behaviors, stimulate community discussions and provide referrals to appropriate services.

In resource-constrained settings, it is especially important to look for opportunities to link various channels, taking advantage of a maximum number of opportunities. If there is a national campaign, for instance, interpersonal messages should be linked to messages in the mass media. If the chief medium chosen is radio talk shows for youth, issues related to youth and HIV/AIDS should be scheduled as discussion topics. Links should also be created to messages that promote condoms through a social-marketing campaign.

Develop monitoring and evaluation plan

A plan for monitoring and evaluation needs to be drawn up during the initial stage of BCC strategy design. The information to be gathered for BCC should be linked to the program's overall monitoring system.

Monitoring is part of the ongoing management of communication activities, and it usually focuses on the process of implementation. The following should be closely monitored:

- **Reach:** Are adequate numbers of the audience being reached over time?
- **Coordination:** Are messages adequately coordinated with service and supply delivery and with other communication activities? Are communication activities taking place on schedule, at the planned frequency?
- **Scope:** Is communication effectively integrated with the necessary range of audiences, issues and services?
- **Quality:** What is the quality of communication (messages, media and channels)?
- **Feedback:** Are the changing needs of target populations being captured?

To monitor the course of a BCC strategy properly, it is necessary to establish effective information-gathering systems. These include reports, site visits and reviews of materials. Reporting tools and protocols must be standardized to ensure consistency.

Periodic focus-group discussions and in-depth interviews can also help BCC programmers assess the perceptions of target populations. Peer educators can collect responses from target populations to help identify changes that may have to be made in the environment or aspects of communication and services that may need to be addressed.

The evaluation of outcomes (actual, measurable changes in behavior and environment) is generally more complex and may be beyond the resources and abilities of many country-level programs, and certainly of projects. Good monitoring data enables programs to demonstrate the degree to which they have contributed to changes as measured by national surveillance systems, such as the Behavioral Surveillance Survey (BSS). Questions related to communication intervention can be added to such a survey to assess the activities' reach.

Choose partners

In developing a BCC strategy, it is important to identify key partners who can help design and implement its components. Partners may include NGOs, government counterparts, media outlets, graphic designers, local traditional entertainers, members of target populations and other program implementers. It is essential to plan for capacity-building of partners (*see below*).

Develop communication products

Development of specific communication support materials should be based on decisions made about channels and activities. They can include:

- Print materials for peer educators, such as flip charts and picture codes
- Print materials to support health workers on specific care issues
- Television spots for general broadcast
- Promotional materials about the project, for advocacy
- Scripts for theater and street theater
- Radio or television soap opera scripts

Conduct pre-testing

Pre-testing is key to ensuring that themes, messages and activities reach the intended target populations. It is important to pre-test at every stage with all audiences for whom the communication is intended, both primary and secondary. Pre-testing should be done of themes, messages, prototype materials, training packages, support tools and BCC formative assessment instruments.

Pre-testing of media, messages and themes should evaluate:

- Comprehension
- Attraction
- Persuasion
- Acceptability
- Audience members' degree of identification

Several versions should be pre-tested and audience reactions compared.

Although not as important as pre-testing with members of the target population, pre-testing and discussions should also be done with stakeholders, since their views may differ from those of the target population. This is not always possible, but with an eye toward minimizing controversy, programmers should attempt it, since disagreement with stakeholders can derail or compromise a program.

Implement and monitor

In the **implementation** phase, all elements of the strategy go into operation. An especially important element is management. All partners, programmers and channels of the BCC strategy must be closely coordinated. There must be links among critical program elements, such as supply and demand. If populations discover that VCT services being promoted by BCC messages and materials are unavailable, the programs will suffer. Timing and coordination are key to managing a program effectively. Because the BCC strategy is linked to other parts of the prevention and care effort, BCC specialists must work as members of a broader team and coordinate their activities. Coordinators of each component of the team should keep others informed of their progress and activities. Ongoing communication with partners about areas outside of prevention and care

should also take place. Team members should track what gatekeepers, stakeholders and influential parties say and do and, where appropriate, modify the campaign accordingly.

Working with these partners, programs must design formal mechanisms to ensure coordination and manage any conflicts or problems that might arise. Examples of such mechanisms are regularly scheduled meetings for the purpose of sharing monitoring information or reviewing and updating work plans. Identifying a focal point within each organization can help ensure that communication is timely and appropriate.

It is also necessary during the implementation phase to review the preceding steps in the BCC process to ascertain whether the program has been addressing the target audiences' previously identified problems and needs. This can also help identify whether behavior change and communication goals are being achieved, and whether channels are being used as wisely as possible.

It is essential to budget adequately for all steps needed to develop a BCC campaign and program.

It is important that monitoring be carried out as planned. Often monitoring receives inadequate attention, both in terms of collecting information and, still more often, in making sure it gets fed back in usable form to people who need it for decision-making and field implementation. Specific personnel must be designated to make sure that the monitoring plan is developed with input from the people who will use it; to make sure that everyone involved knows the expected outcomes and has the appropriate tools and skills; and to make sure that there is budget and time enough to carry the plan out.

Evaluate

Evaluation refers to the assessment of a project's implementation and its success in achieving predetermined objectives of behavior change. BCC interventions should be evaluated against their stated objectives and in reference to a baseline that may be qualitative or quantitative (or both). For large-scale interventions, baseline quantitative research may be repeated to demonstrate changes in knowledge, attitudes and reported behaviors relative to communication and project-level behavior change objectives. Change can also be assessed through qualitative research into target-group responses to interventions. Qualitative evaluation involves examining data that are designed to illustrate changes in audience behavior.

Elicit feedback and modify the program

As programs evolve, target populations acquire new knowledge and behaviors, and communication needs may change. The needs of target populations must be periodically reassessed to understand where they stand along the behavior change continuum. As epidemics develop, the types of information and communication needed by target populations evolve from basic HIV/AIDS information to discussions related to stigma, care and support and sustaining safe practices. Monitoring and evaluation studies should lead directly to modifications of the overall program, as well as of the BCC strategies, messages and approaches.

Day-to-day monitoring will provide information for making adjustments in short-term work planning. Periodic program reviews can be designed to take a more in-depth look at program progress and larger-scale adjustments or redesign. Involving stakeholders, target audiences and partners as much as possible will provide a better look at what is happening; help make appropriate decisions; and make sure that the people affected by any decisions will be fully aware of them.

VIII. CHALLENGES

This document addresses the ideal steps for developing BCC programs. It is important to keep in mind that the process does not occur in a vacuum. Country programs are constantly dealing with the reality of day-to-day work with local governments, communities, implementing partners and environments that may or may not be amenable to the process of BCC and the issues of an HIV/AIDS program.

Challenges to BCC programmers include:

- **BCC vs. IEC.** In practice, IEC has often resulted in the production of discrete communication materials. The use of the term *BCC* is part of an effort to establish communication as strategic and integrated into entire programs.
- Integrating BCC into all programs. **BCC is a component of all successful interventions and must be included in their original design. However, in reality this doesn't always happen. It is essential to identify opportunities for improving the quality of communication components.**
- **Limited training resources.** Limited capacity and availability of trained, in-country resource people, including advertising agencies and media outlets, can hamper the effective implementation of BCC programs.
- Political and physical environments. **In some countries, geography and populational diversity can complicate the development of BCC programs. This is especially the case where vast distances must be covered, or multiple languages and cultural traditions included, in a single country program.**
- **Sustainability.** To be effective, BCC strategies and components must evolve constantly to meet the changing needs of target populations. This requires the continuous input of human and financial resources.
- **Expanding the response.** To have a real impact on the epidemic, responses must be expanded in quality, scope of activities and geographic coverage. Expanding comprehensive BCC strategies is a continuing challenge.
- **Budgets.** The steps necessary to develop a comprehensive BCC strategy are often not adequately budgeted. For example, a budget will be prepared for the production of materials but not for the process necessary to develop the appropriate content. Capacity-building needs are ongoing and resource-intensive and this must be taken into consideration. Donors and managers need to understand the costs and benefits associated with BCC activities.
- **Linkages and coordination.** FHI often works with partners. For BCC to be effective, their messages and information should be coordinated. Building and maintaining linkages and coordination is an ongoing challenge.

IX. MANAGEMENT OF BCC AND BUDGET

The BCC component of a project needs good management support to ensure correct sequencing of activities; collaboration and coordination; identification of appropriate resources; and budgeting.

X. CAPACITY-BUILDING

Planning for ongoing communication capacity-building is essential in implementing a BCC strategy, whether in regard to formative BCC assessment, design, communication product development, pre-testing, monitoring, or evaluation. Capacity-building is also extremely important for personnel (peer educators, outreach workers, counselors and community workers) whose primary responsibility is communicating with target populations. Making sure that peer educators know about the timing, objectives and content of messages through other channels, as well as providing those personnel with adequate communication skills and support materials, will enable them to reinforce key messages and stimulate discussion. These individuals should also be prepared to help people acquire essential new skills and prepare personal plans for action.

Communication training is also necessary for political, religious, social and cultural leaders and authorities. Staff members of implementing agencies who will need to “sell” their programs to communities and authorities will need new skills as well as support materials. Self-help groups and human rights advocacy groups also need communication skills, particularly if they take on a significant role in building a supportive environment and decreasing stigma. Other parties whose primary responsibility is service delivery will have a communication role and need training in it as well; this includes clinical care providers, VCT staff and social welfare staff.

Materials are meant to be *used*. Without good communication skills, the best materials are likely to fail and messages are likely to get lost.

Training media professionals should also be part of the plan. Some of the broadest and most cost-effective reach can be accomplished by making use of a well-oriented cadre of media personnel. (After all, they will be producing media whether or not they are part of a program.) Conversely, untrained media personnel can perpetuate myths, create stigma and harm the lives of PLHA and their families, however unintentionally.

Finding adequate capacity-building resources can also be a challenge. It is important to build the capacity of implementing partners and of local, national, regional and international human resources. Strategies for increasing capacity in the area of BCC include:

- **Quality strategic planning and design** at the beginning of programs
- Developing **standardized tools**, including training modules, guidelines and protocols (being developed by FHI)
- Setting up national, regional and international **training programs**
- Developing a cadre of local, national, regional and international **consultants** who can provide quality technical support
- **Working with networks of PLHA to develop their ability to communicate effectively.**

XI. LINKAGES AND PARTNERSHIPS

FHI/IMPACT is working closely with Program for Appropriate Technology in Health (PATH) and Population Services International (PSI) to develop and implement BCC strategies in numerous countries. FHI also works with many local organizations and institutions.

XII. CONCLUSION

BCC should be linked to the overall goals and strategies of HIV/AIDS prevention, care and support programs. Individuals who plan and implement HIV/AIDS programs should develop strategic approaches that view BCC not as a collection of different and isolated communication tactics but as a framework of linked approaches that function as part of an ongoing, interactive process.

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