

SOCIAL BEHAVIOUR CHANGE COMMUNICATION FOR HIV PREVENTION

**National STD / AIDS Control Programme
Ministry of Health, Nutrition
& Indigenous Medicine
and The United Nations Population Fund**



**NATIONAL
STD/AIDS
CONTROL
PROGRAMME**



GUIDE FOR PUBLIC HEALTH OFFICERS

Social Behaviour Change Communication for HIV Prevention Guide for Public Health Officers

**National STD/AIDS Control Programme
of the Ministry of Health,
Nutrition & Indigenous Medicine &
United Nations Population Fund**



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Original Forum

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19, St. Josephs' Road, Nugegoda, Sri Lanka
Tele: 285 2410 Fax: 282 2615
E-mail: ariyaw@gmail.com

Message from the Director General of Health services

The book Social Behavioural Change Communication for HIV prevention: Guide for public health officers, brings together recent developments in both practice and understanding of social Behavioural Change Communication to prevent HIV. The improvement of versatility and the sophistication of social behavioural change communication in prevention of HIV has been coming into common use worldwide, and its application is really necessary. The authors of the book have responded to the need very efficiently.

It is essential to understand the theories, concepts and applications of social behaviour change communication in order to perceive social behaviour change communication well. The aim of explaining them is successfully achieved by the authors, thus the health care workers who deal with prevention and control of HIV are the beneficiaries of this book.

The book on Social Behavioural Change Communication with new knowledge and additional illustrations is a great help for all the readers including health care workers, who are still very much on the learning curve in the understanding of social behavioural change communication.



Dr. Palitha Mahipala
Director General of Health services
Ministry of Health,
Nutrition & Indigenous Medicine

Message from the Deputy Director General Public Health Services

I extend my heartiest congratulations for the publication of Social Behaviour Change Communication for HIV prevention: Guide for public health officers. Social Behaviour Change Communication is a process of working with individuals, communities and societies. The book is bright and new in a way of presenting, with explanations and examples which essentially help to develop communication skills and strategies among health care workers and programme planners.

The book provides a guide to public health officers to promote positive behaviours in HIV and prevention of HIV and to provide a supportive environment which will enable people to initiate and sustain positive behaviours.

Further, this book answers the issues for effective methods to foster individual, interpersonal, community action, and social change. It combines theoretical perspectives with practical guidance, examining what works, and providing transferable lessons for effective communication. As this book showcases innovative thoughts and approaches related to prevention and treatment of HIV, this book is an essential reading material for anyone working to foster real and lasting behavioural and social change related with HIV.



Dr. Sarath Amunugama
Deputy Director General Public Health Services - 1
Ministry of Health,
Nutrition & Indigenous Medicine

Preface

I applaud the publication of this wonderful book on Social Behaviour Change Communication for HIV prevention: Guide for public health officers. Publication of this book is of significant importance as, development of a tailor-made behaviour change strategy and an appropriate model to improve the HIV testing, is a recommendation generated from the Integrated Bio Behavioural Surveillance of 2014, and that requirement is highly fulfilled by this book.

Currently, Sri Lanka is experiencing a low level of Human Immunodeficiency Virus epidemic with a HIV prevalence of <1% in the general population. Further, the HIV prevalence rate in the 15-49 year age group was less than 0.1% at the end of 2014. It is essential to get partnership from all the stakeholders for maintaining this low HIV prevalence in Sri Lanka further.

These guidelines are aimed for use by all those who are involved in the HIV and AIDS programme, no matter how they define their core responsibilities. All of them, in one way or the other, have to communicate with individuals or groups of people, either as people who are at risk for HIV infection, or as clients who need particular forms of HIV and AIDS related services. Others may be professionals who plan for, and allocate resources into various forms of health and social services, or politicians and legislators who lay down the laws and regulations for the conduct of the economic and social arrangements, including those that seek to protect the human rights of People Living with HIV, key populations, vulnerable populations and the general population.

SOCIAL BEHAVIOUR CHANGE COMMUNICATION FOR HIV PREVENTION

Along with globalization, the understanding of social behaviour change communication has changed, and this change has been influenced by increased literacy and education level of people in the world. This book greatly attempts to raise the knowledge on social behaviour change communication in relation to understanding prevention of HIV. Although the book is meant for health care officers, anyone else who wants to understand the social behaviour change communication related to prevention of HIV can easily use this as a handbook. This book will certainly ensure the improvement of prevention, control and treatment of HIV activities drastically.

I highly acknowledge Dr Janaki Vidanapathirana, Consultant Community Physician and Dr Nirosha Dissanayake, Registrar in Community Medicine for their commendable contribution in writing this valuable book. Special thanks go to the team of the Multi-Sectoral unit of the NSACP for their commitment and support during this whole process. I would also like to take this opportunity to thank the UNFPA for the partnership that was provided.



Dr. Sisira Liyanage
Director of National STD/AIDS Control Programme
Ministry of Health,
Nutrition & Indigenous Medicine

Authors

Dr Janaki Vidanapathirana, Consultant Community Physician, National STD/AIDS Control Programme

Dr Nirosha Dissanayake, Registrar in Community Medicine, National STD/AIDS Control Programme

Contributors

Mr. Sirimal Peiris, Former Health Education Officer of Health Education Bureau, Ministry of Health

Dr. Buddika Senanayake, Act. Deputy Director, National STD/AIDS Control Programme

Dr Nimali Fernando Wijegoonewardene, Registrar in Community Medicine, National STD/AIDS Control Programme

Dr. Samindra Ranasinghe, Senior Registrar in Venereology, National STD/AIDS Control Programme

Mr. Upeksha Jayaratne, Assist. Coordinator, GFATM project, National STD/AIDS Control Programme

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Clerical Support

Nishadhi Tharuka - Management Assistant, National STD/AIDS Control Programme

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Abbreviations

ART	Anti Retro Viral Therapy
BB	Beach Boys
BCC	Behaviour Change Communication
DU	Drug Users
HIV	Human Immunodeficiency Virus
IEC	Information, Education & Communication
KPs	Key population
MSM	Men sex with Men
NSACP	National STD/AIDS Control Programme
PLHIV	People Living with HIV
SBCC	Social and Behavior Change Communication
STIs	Sexually Transmitted Infections
STD	Sexually Transmitted Diseases
SW	Sex Workers
VCT	Voluntary Counseling and Testing
WHO	World Health Organization

Social Behaviour Change Communication for HIV Prevention

Overview of HIV Infection

HIV refers to the Human Immunodeficiency Virus. There are two types of HIV: HIV-1 and HIV-2.

HIV-1 is responsible for the vast majority of HIV infections globally. Only certain fluids like blood, semen, pre-seminal fluid, rectal fluids, vaginal fluids, and breast milk from an HIV-infected person can transmit HIV. These fluids must come in contact with a mucous membrane or damaged tissue or be directly injected into the bloodstream (from a needle or syringe) for transmission to possibly occur. Mucous membranes can be found inside the rectum, vagina, opening of the penis (glans penis) , and the oral cavity.

HIV is spread mainly by having unprotected sex with someone who is infected with HIV. Anal sex is the highest-risk sexual behaviour and vaginal sex is the second highest-risk sexual behaviour. Anal sex has a greater risk of getting HIV because the lining of the rectum is

thin and may allow HIV to enter the body during anal sex. Having multiple sex partners or having other Sexually Transmitted Infections (STIs) can increase the risk of infection through sex. HIV can be passed from the infected mother to the child during pregnancy, birth, or breast feeding. The risk of receiving blood transfusions and blood products that are contaminated with HIV is extremely small because of rigorous testing of all donated blood for transfusion transmitted diseases by the National Blood Center, Sri Lanka. Sharing needles and syringes with an HIV infected person has a risk of transmission among intravenous drug users.

When an HIV negative person has an STI, he or she is at least two to five times likely to get HIV from unprotected sex with someone who has HIV, compared to an HIV negative person without a STI. There are two ways that having a STI can increase the likelihood of getting HIV. If the STIs causes irritation of the skin (eg: syphilis, herpes, or human papillomavirus), breaks or sores may make it easier for HIV to enter the body during sexual contact. Even STIs that cause no breaks or open sores (e.g., chlamydia, gonorrhea, trichomoniasis) can increase the risk by causing inflammation that increases the number of cells that can serve as targets for HIV. [1]

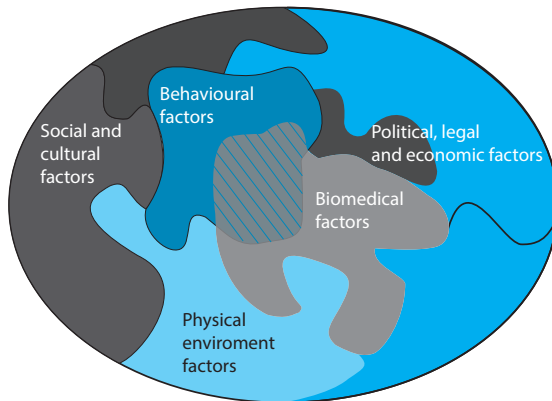
If the person is HIV positive and also infected with another STI, he or she is three to five times as likely as other HIV-infected people to spread HIV through sexual contact. This appears to happen because there is an increased concentration of HIV in the semen and genital fluids of HIV-positive people who are also infected with another STI. [1]

HIV prevention can be categorized under three approaches and prevention should be implemented in combination of all three methods:

- **Behavioural interventions** (Target to develop desirable behaviours and promote the existing desirable behaviours)
- **Biomedical Interventions** (Mix of clinical and medical approaches to reduce HIV transmission- ART treatment, Pre prophylaxis treatment, Post prophylaxis treatment)
- **Structural interventions** (Interventions change or influence social, political, or economic environments)

Combinations of all three approaches can be used to achieve maximum impact on reducing HIV transmission and acquisition. Combination of prevention programmes consider factors specific to each setting, e.g. levels of infrastructure, local culture and traditions, as well as populations most affected by HIV. Combination of prevention programmes can be implemented at the individual, community and population levels. [2]

Figure 1- Interacting Causes of HIV Risk and Vulnerability



This book provides social behaviour change communication to achieve UNAIDS Fast-Track targets of 90-90-90 by 2020. This will enable to achieve the targets of 90% of all people living with HIV to know their HIV status, 90% of people diagnosed with HIV to receive sustained antiretroviral therapy, and 90% of people receiving Anti Retroviral Therapy (ART) to have viral suppression.

Continuum of HIV Services

Continuum of HIV services refers to a comprehensive package of HIV prevention, diagnostic, treatment, care and support services provided for people at risk of, or living with HIV, and their families. Examples of these services include combination of HIV prevention including pre-exposure prophylaxis, HIV testing and linkage to care, management of opportunistic infections and other co-morbid conditions, initiating, maintaining and monitoring ART, switching to second-line and third-line ART, and palliative care. Continuum of HIV care refers to a comprehensive package of HIV services for people living with HIV (PLHIV). [3]

Public Health Approach

A public health approach addresses the health needs of a population or the collective health status of the people, rather than focusing primarily on individual case management. This approach aims to ensure the widest possible access to high quality services at the population level, based on simplified and standardized approaches, and to strike a balance between implementing the best-proven standard of care and what is feasible on a large scale in resource-limited settings. Key elements of a public health approach for HIV include behaviour change programmes, condom programming, HIV testing promotions, simplified drug formularies, fixed-dose

combinations for adults, adolescents and children. [3]

Key Populations

Key populations (KPs) are groups that have a disproportionate burden of HIV in many settings. They frequently face legal and social challenges that increase their vulnerability to HIV, including barriers to access HIV prevention and treatment. Key populations include: Men who have sex with Men (MSM), people who inject drugs, people in prisons and closed settings, Sex workers (SW) and transgender people. [4]

In addition to that, Sri Lanka recognizes Beach boys (BB) as a group of a key populations in Sri Lanka.

Sri Lanka provides a comprehensive sexual health care package for key populations. This ensures sexual health promotion among key populations. Some of the services are carried out in partnership with the non governmental organizations.

The comprehensive sexual health package for key population in Sri Lanka includes the following [5]:

- Identify and register female SW, MSM, Drug users (DU) and beach boys
- Conduct pocket meetings/support group meetings to provide basic information on HIV/STIs
- Provide information on HIV/STIs prevention services
- Provide information on HIV/STIs testing services
- Provide information about HIV/STIs treatment services
- Condom demonstration
- Condom distribution

Vulnerable Populations

Vulnerable populations are populations that are vulnerable to HIV in certain situations or contexts, such as adolescents (particularly adolescent girls in sub-Saharan Africa), orphans, people with disabilities, and migrant and mobile workers. They may also face social and legal barriers to accessing HIV prevention and treatment. These populations are not affected by HIV uniformly in all countries and epidemics. Each country should define the specific populations that are vulnerable and key to their epidemic and response, based on the epidemiological and social context. [4]

There may be different groups in your local area. Sri Lanka identified several vulnerable population groups, namely: Armed forces, tourist sector and both internal and external migrant populations. In your area, it may be urban slum youth or youth on the street etc.

Interventions for HIV prevention programmes are aimed to halt the transmission of HIV. They are implemented to either protect an individual and their community, or are rolled out as public health policies. Initially, HIV prevention methods focused primarily on preventing the sexual transmission of HIV through behaviour change. For a number of years, the ABC approach - “Abstinence, Be faithful and use a Condom” - was used in response to HIV. However, by the year 2000, it became evident that effective HIV prevention requires more than simply using method of ABC and that interventions need to take into account underlying socio-cultural, economic, political, legal and other contextual factors. Sri Lanka too has many punitive laws against key populations. Community mobilization is really important to revisit these laws in order to encourage for changing of these laws by advocacy.

HIV Situation in Sri Lanka

Sri Lanka is experiencing a low level of HIV epidemic, with the prevalence of less than 5% in any defined key affected population and less than 1% in the general population. Since the detection of the first patient with HIV in Sri Lanka in 1987, the National STD/AIDS Control Programme (NSACP) reports a cumulative number of 2241 HIV positives by the end of the third quarter of 2015, while the cumulative AIDS cases reported is 587. [6]

HIV prevalence rate in the 15-49 year age group was less than 0.1% at the end of 2014. The largest proportion of people with HIV are included in the age category of 25 to 49 years (75%). The age category of below 15 years, which is an equivalent to prenatally acquired HIV, has a cumulative figure of 3%. The data over the years indicate a slowly rising trend in the prevalence of HIV infection among persons having male to male and bi-sexual relationships. The predominant mode of HIV transmission still continues to be heterosexual, while no HIV cases have been reported due to blood transfusions since the year 2000. There was a case detected as prenatally acquired in 2014. There are no HIV cases reported due to blood transfusions since year 2000. The data shows that only one case was detected as prenatally acquired in 2014 and 1% of the reported cases had a history of injecting drug use in the same reporting period. The rate of HIV among the young (15-24 age group) shows a slow but a steady upward trend since 2003. Colombo, Gampaha and Puttalam districts show the highest HIV rates, with over 10 HIV cases per 100,000 population in a district. The data indicates that the number of reported HIV positives to the NSACP has doubled per quarter compared to the situation 6 years ago. [7]

The Integrated Bio Behavioural Survey which was carried out in 2014 showed that the percentage use of condoms at last sex with a client was 93% among female SW, and an equally high percentage of condom use (90%) was revealed with the non-paying partners. The percentage of Men Sex with Men reporting the use of a condom at last anal sex encounter with a male partner was 58%, and the percentage of injecting drug users reporting the use of a condom at last anal sex encounter with a male partner was 25%. The same study revealed that the condom use at last sex among beach boys was 67%. [8]

This book provides how to plan effective social behavioral interventions while supporting client friendly health services.

Guidance is provided on how to promote desired behaviours with effective behaviour change communication, in relation to HIV prevention.

Behaviour Change and Sexual Health

Behaviour plays an important role in a person's health. Behaviour is the way in which a person acts in response to a particular situation or stimulus. Human behaviour is a very complex area. In addition to the human behaviour, there are other factors which contribute to the health of the community (policy, environment etc). But, human behaviour also plays an important role in creating a healthy person, and subsequently a healthy community. Some of the human behaviours can have a major impact on community mortality and morbidity (eg: unprotected sexual behaviours can cause Sexually Transmitted Diseases (STD) including HIV infections and unwanted pregnancies). Many health interventions use Behaviour Change Communication (BCC) to change the behaviour in a positive way to improve the health of the community.

Sexuality is a central aspect of being human throughout life; it encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction. Sexuality is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviours, practices, roles and relationships. While sexuality can include all of these dimensions, not all of them are always experienced or expressed. Sexuality is influenced by the interaction of biological, psychological, social, economic, political, cultural, legal, historical, religious and spiritual factors.

Sexual health is fundamental to the physical and emotional health and well-being of individuals, couples and families, and to the social and economic development of communities and countries. Sexual health, when viewed affirmatively, encompasses the rights of all persons to have the knowledge and opportunity to pursue a safe and threat-free sexual life.

Sexual health is: ***“a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity”***. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled. [9]

Sexual behaviour deals with all things relating to sex, conception and satisfaction. It can also maintain social relationships and make bonds for life in populations.

Human sexual behaviour is any activity occurring in solitude, between two persons, or in a group, that induces sexual arousal.

There are two major determinants of human sexual behaviour: the inherited sexual response patterns that have evolved as a means of ensuring reproduction and that are a part of each individual's genetic inheritance, and the degree of restraint or other types of influence exerted on the individual by the society in the expression of his sexuality. Humans engage in a spectrum of sexual behaviours.

Sexual behaviours are very sensitive and private in each one's life. Sometimes, it is difficult to develop desirable behaviours to promote health. The needs of sexual health must be met for both men and women.

Sexual Health Rights

Sexual health is an essential component of the universal right to the highest attainable standard of physical and mental health, enshrined in the Universal Declaration of Human Rights and in other international human rights conventions, declarations, and consensus agreements. Sexual health rights include **[10]**:

- The rights to life, liberty, autonomy and security of the person
- The rights to equality and non-discrimination
- The right to be free from torture or cruel, inhumane or degrading treatment or punishment
- The right to privacy
- The rights to the highest attainable standard of health (including sexual health) and social security
- The right to marry and to find a family and enter into marriage with the free and full consent of the intending spouse, and to have equality in and at the dissolution of marriage
- The right to decide the number and spacing of one's children

- The rights to information, as well as education
- The rights to freedom of opinion and expression, and
- The right to an effective remedy for violations of fundamental rights.

Sexual rights protect all people's rights to fulfill and express their sexuality and enjoy sexual health, with due regard for the rights of others. **[10]**

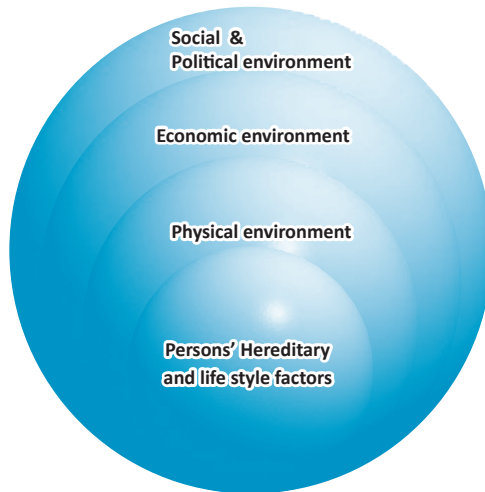
Main Determinants of Health

These can be categorized into:

- The social and economic environment,
- The physical environment, and
- The person's individual characteristics and behaviours.

The health of a person can influence in many different settings, for example, in homes, workplaces, schools, hospitals, youth centres, night clubs, and on the street. Health of a person is also affected by the human behaviour, which is influenced by several factors: knowledge, attitude, self image, perceived risk, norms, self efficacy, emotions, social influence and personal advocacy. The social influence can be policies, laws and guidelines of the country. **[11]**

Figure 2 - Main Determinants of Health



Behaviour Change Communication

Behaviour Change Communication or “BCC” is defined as **“a set of organized communication interventions and processes aimed at influencing social and community norms and promoting individual behavioural change or positive behaviour maintenance, for a better quality of life”**. [12]

Another definition of Behaviour Change Communication (BCC) is **“an approach used to support individuals’ ability to adopt and maintain a new positive behaviour”**. It aims at increasing knowledge, stimulating dialogue and could ensure that people are given accurate and timely information about HIV and AIDS in their preferred language or medium.

Behaviour Change Communication is a multi-level tool for promoting and sustaining risk reducing behaviour change in individuals and communities by distributing tailored health messages in a variety

of communication channels. Before they can reduce their risk and vulnerability to HIV, individuals and communities must understand the urgency of the epidemic. They must be given basic facts about HIV/STIs, taught a set of protective skills and offered access to appropriate services and products. They must also perceive their environment to be supportive of changing or maintaining safe behaviours. eg: No discrimination about a person's sexual behaviours or sexual orientations.

BCC is a process of working with individuals, communities and societies to develop communication strategies to promote positive behaviours, and to provide a supportive environment which will enable people to initiate and sustain positive behaviours to promote health.

Difference Between BCC and Health Education

The most important fact that needs to be realized is that providing people with information and educating them how they should behave ("teaching" them) is not enough to bring about a desired behaviour change.

Health education can be defined as **"any combination of learning experiences designed to help individuals and communities improve their health by increasing their knowledge or influencing their attitudes"**. [13] Although health education improved many aspects of communication, and evidence showed that it could increase knowledge and improve attitudes, it often did not result in behaviour change, because topics were largely limited to what health experts considered to be important and were conveyed from their perspective. Therefore, in many cases, changing of health outcomes were limited.

SOCIAL BEHAVIOUR CHANGE COMMUNICATION FOR HIV PREVENTION

Providing information to help people for making a personal decision is a necessary part of behaviour change. BCC recognizes that behaviour is not only a matter of having information and making a personal choice.

Behaviour change also requires a supportive environment. Recalling the interventions model, we learned that “Behaviour Change Communication” is influenced by development and health services provision” and that the individual is influenced by the community and the society. The community and the society provide the supportive environment necessary for behaviour change. **[14]**

Information, Education & Communication (IEC) is thus part of BCC, while BCC builds on IEC. Sustaining healthy behaviour is the most important part and the difficult process that usually require a continuing investment in BCC as a part of an overall health programme. One of the aims of BCC is to encourage individuals to take responsibility for their own health and to choose healthier lifestyles. In the process of BCC, it is important to consider about the rights of the client, and the intervention process should not be a forceful process.

BCC is an evidence and research based process of using communication to promote behaviours that lead to improvements in health outcomes. BCC efforts have focused on individual behaviour change because the most widely used theories emphasize the individual level. **[15]**

Shifting from Behaviour Change Communication to Social Behaviour Change Communication

BCC requiring support from multiple levels of influence resulted in an expansion of the approach to become Social Behaviour Change Communication (SBCC). It is a process of transforming the distribution of power within social and political levels. Behaviour change does not result from increasing knowledge alone. Behaviours can be influenced by various factors. Therefore, the range of behaviour change activities often extends beyond conventional communication, to link and coordinate communication activities with training, health system support, product and service improvements, social norm change and even new or improved policies.

The shift in terminology from BCC to SBCC is a recent milestone in health communication that reflects renewed emphasis on improving health outcomes through more healthful individual and group behaviours, as well as strengthening the social context, systems and processes. SBCC requires epidemiological evidence and client perspectives and needs to plan the programme successfully. [16]

Evolution of Behaviour Change



- Older approaches tried to persuade individuals to change their behaviours
- Newer approaches try to create an enabling environment to encourage healthy behaviours
- New approaches look for tipping points of change that need to address social change as much as individual behaviour change

Different Definitions for the Social Behaviour Change Communication

Social Behaviour Change Communication is the use of communication to change behaviours including service utilization, by positively influencing peoples' knowledge, attitudes and social norms. [17]

SBCC is the 'systematic application of interactive, theory based, and research-driven communication processes and strategies to address "tipping points" for change at the individual, community, and social levels'. [18]

SBCC looks at the role communication, in bringing about social change including policy, norm and individual behaviour change, by finding an effective tipping point for change. [19]

One of the principles of the social behaviour change approach is promoting positive behaviour change. Community engagement, ownership and empowerment at the community level are needed for the behaviour change approach, which focuses on activities that create and sustain an enabling environment for behaviour change. Community-centered behaviour change interventions promote the empowerment of the community including capacity building, and encourage partnership and implementation of local programmes. A community-oriented behaviour change approach identifies people

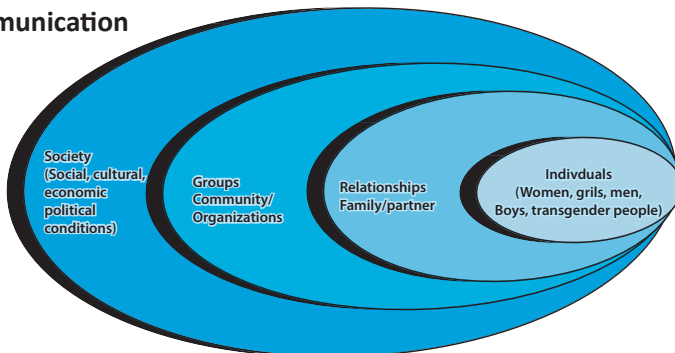
and communities as agents for their own change, placing information within the community for dialogue, debate and collective action, and using available resources to overcome barriers. Further, to get the effective desirable behaviour, it is important to develop new policies or change the existing policies in certain interventions, in order to get the desirable health outcomes.

A behaviour change approach is a process for planning and implementing a comprehensive, strategic set of interventions and activities to change behaviours at many levels to achieve a health objective.

Elements of SBCC consists of three cores:

- Communication using channels and themes that fit the target audience’s needs and preferences.
- Behaviour change through efforts to make specific health actions easier, feasible, and closer to an ideal, that will protect or improve health outcomes.
- Social change to achieve shifts in the definition of an issue, people’s participation and engagement, policies, and gender norms and relations. [19]

Figure 3 - A Social Ecological Framework of Social Behaviour Change Communication

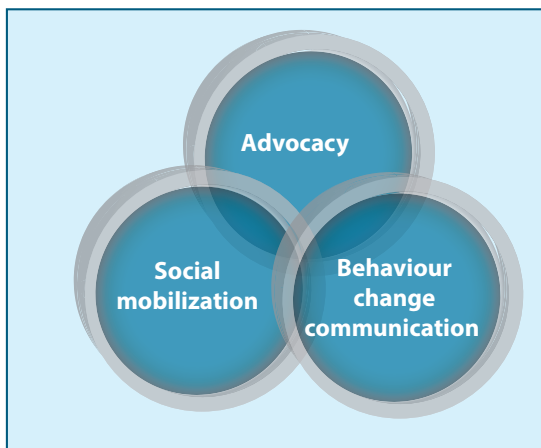


SOCIAL BEHAVIOUR CHANGE COMMUNICATION FOR HIV PREVENTION

Individual action is by immediate life conditions, including relationships, community, occupational groups, organizations, and by the broader society.

Effectiveness of Social Behaviour Change Communication depends on three successful strategies: advocacy, social mobilization and effective Behaviour Change Communication. Advocacy and social mobilization are essential for changing the policies, laws and necessary structural changes for a conducive environment. eg: conducive environment for key populations. Political commitment together with social mobilization is essential for changing the laws which affect key populations.

Figure 4 - Three Strategies of Social Behaviour Change Communication



Social and behaviour change communication is successful with supportive policies, laws and guidelines. It should include: community access for services, being able to keep and use of condoms without a problem, environment with zero stigma and discrimination,

availability of services and a supportive environment with gender equity and respect for human dignity.

Advocacy

Advocacy operates at the political, social and individual levels and works to mobilize resources and political and social commitment for social change and/or policy change.

Community Mobilization

Community mobilization is a capacity-building process through which the community, individuals, groups or organizations plan, carry out and evaluate activities on a participatory and sustained basis to improve their lives, either on their own initiative or stimulated by others. A successful community mobilization effort not only works to solve problems at the community level, but also aims to increase the capacity of a community to successfully identify and address its own needs.

Sometimes, community mobilization is described as social mobilization and social mobilization includes the more wider society.

Social mobilization

A process of bringing together all feasible and practical intersectoral social partners and allies to determine the felt-need and to raise awareness of demand for a particular development objective. It involved enlisting the participation of such actors, including institutions, groups, networks and communities, in identifying, raising, and managing human and material resources, thereby increasing and strengthening self-reliance and sustainability of achievements.**[18]**

Table 1 - Different Intervention Strategies Under Social Behaviour Change Communication in HIV Prevention and Control [2]

Biomedical Intervention strategies to Reduce Exposure, Transmission or Infection

- Male and female condoms
- ART for pre and post prophylaxis and prevention of mother to child transmission
- ART for people living with HIV
- Blood safety- Standarded precautions in health care settings
- Opioid substitution therapy and male circumcision(available in other countries)

Behavioural Intervention Strategies to Promote Individual Risk Reduction

- HIV testing and risk reduction counseling
- Behaviour change communication to promote partner reduction, stick to one faithful partner, condom use
- Social marketing for commodities
- Cash incentives for individual risk avoidance
- Interpersonal communication, including peer education and persuasion

Social and Cultural Intervention Strategies

- Community dialogue and mobilization to demand services
- Stigma reduction programmes
- Advocacy for social justice
- Education and curriculum reforms
- Quality control
- Support youth leadership

Political, Legal and Economical Strategies

- Human rights programming
- Review and revise workplace policies
- Strategic advocacy for legal reforms & regulations
- Policies eg- for access to condoms, sexual education
- Training and capacity building of Police and Judicial sector
- Prevention diplomacy with leaders at all levels
- Community microfinance

Laws Affecting Key Populations in Sri Lanka

There are a number of supportive policies, laws, plans, guidelines, strategies and programmes in Sri Lanka which oversee the structure of the Sexual and Reproductive Health issues in the country, in order to ensure the supportive and conducive environment for prevention of STIs/HIV. In addition, Sri Lanka is a signatory to several international conventions that uphold Sexual and Reproductive Health rights. All these documents support and provide a supportive environment for HIV prevention. [20]

There is no specific legal offence in sex work in private. However, many facets of sex work including homosexuality are prohibited under the three ordinances, namely; Vagrants Ordinance, Brothels Ordinance and 365A of the constitution. There are misinterpretations of the law, which makes KPs reluctant to keep condoms with them, to use in need. This will lead to unprotected sex among them. But, during the recent past, these unpleasant situations were overcome with continuous training programmes among the Police sector. It is high time to revisit and amend the respective legal framework in the country, to facilitate improving sexual health. [20]

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Countries may use laws, policies and other regulatory mechanisms to guarantee the promotion, protection and provision of sexual health information and services. As signatories to the different international and regional human rights treaties, countries should strive to fulfil their human rights obligations. They might do this by providing health care to everyone or by ensuring the right of people living with STIs or HIV to access information and services without discrimination. [21]

Sri Lanka needs to take the following steps to achieve Social Behaviour Change Communication for fighting HIV and for achieving 90-90-90 targets by 2020.

- Incorporation of a comprehensive sexual health curriculum to school education
- Removing of laws which are misleading, and improving access for health care services by key population

Focus of Social Behaviour Change Communication

Social behaviour change communication (SBCC) uses science and data as well as creative ideas to focus on:

- Changing or positively influencing social norms in support of long-term, sustainable behaviour change at the population level
- Fostering long-term, normative shifts in behaviour in support of increasing the practice of healthy behaviours
- Improving provider-client interactions in the health services
- Strengthening community responses to issues
- Influencing decision makers and family and peer networks
- Increasing demand for health services and products
- Increasing correct use of health services and products

- Influencing policy
- Encouraging an increased capacity for local planning and implementation of health improvement efforts

The planned interventions are especially useful in addressing lifestyle modifications for disease prevention, long-term disease management and addictions. Then people can adopt and sustain healthy behaviours and healthy lifestyles. When planning the programme, it is important to consider the following factors:

Factors to be Considered in Social Behaviour Change Communication

- Client-Provider Interaction
- Correct information including the benefits and availability of different forms of treatment or interventions
- Services should be available regardless of sex, colour, marital status and sexual orientation
- Decide freely whether to have and which option of the intervention
- Should be able to be assured of the safety of the intervention
- Should be assured that any personal information will remain confidential
- Clients' dignity should be maintained

Effective Social Behaviour Change Communication

- Increase the level of knowledge of HIV and AIDS
- Stimulate social and community dialogue
- Promote essential attitude and behaviour change
- Change social norms in groups
- Improve skills and increase self-assessment
- Reduce stigma and discrimination against people living with HIV and AIDS
- Create demand for information and services
- Advocate an effective response to the epidemic
- Promote services for prevention, care and support of vulnerable populations
- Promote advocacy/policy change

Know Your Epidemic

Before planning the SBCC intervention, it is important to identify the epidemic of HIV in the local area, and the country situation. Therefore it is important to identify the problem behaviour.

Before planning the SBCC intervention, it is important to identify the epidemic of the HIV in the country and the area. It includes understanding the size and nature of the epidemic, the populations most affected (population size estimations) and the main modes of transmission. It is also called “know your epidemic”.

When analyzing the epidemic, it is important to know the vulnerable and key populations. World Health Organization (WHO) has mentioned the analysis for HIV infection as follows:

Table 2 - Analysis of the Epidemic

Indicator	Details
HIV prevalence HIV incidence If available, population size estimates	Data should be disaggregated along the following dimensions wherever possible: age, sex, geographical area (province / district), key populations, vulnerable populations
Analysis of the modes of transmission	Mainly due to which method
Treatment access and patterns and levels of service utilization	Geographical area (province / district), key populations
Determinants of sexual behaviour and service uptake including social and ethnographic data on sexual practices, and broader socio cultural mechanisms that shape perceptions of risk and safety, including: knowledge (including newer knowledge on risk factors and services); attitudes, norms, demand, social, cultural and religious practices; and individual motivators and social and logistical barriers to service use.	Wealth quintile, education status, marital status and other socio demographic variables.

Analysis of the Identified Problem Behaviours (Results- chain of cause and effect for the problem)

It is important to identify the problem in the area in relation to the sexual health problems. Although the extent of the problem may be the same as the overall level, the root causes may be different from area to area. Therefore, it is important to identify the problem analysis. Problems can be due to one or several immediate causes. Each cause may be having several root causes. The causes are sometimes interrelated. This process is called “**Results- chain of cause and effect**”. After identifying the problem, it is important to develop the Behaviour Change Communication package.[12]

The problem may be different from one area to another.

*Problem- Risk taking behaviour among young boys in
“Nadungamuwa” city .*

Before developing the BCC package, you need to identify the causes by analyzing the problem through problem tree analysis (Cause effect problem tree). The problem can be divided in to two parts.

- Behavioural problem- **low condom use** - can be addressed through the BCC package through different effective communications.
- Non behavioural problem - **non availability of condoms** - non behavioural problems will not be addressed through BCC - non availability of condoms can be sorted out through advocacy and improvement of services.

Figure 5 - Schematic Elastrations of Problem Tree

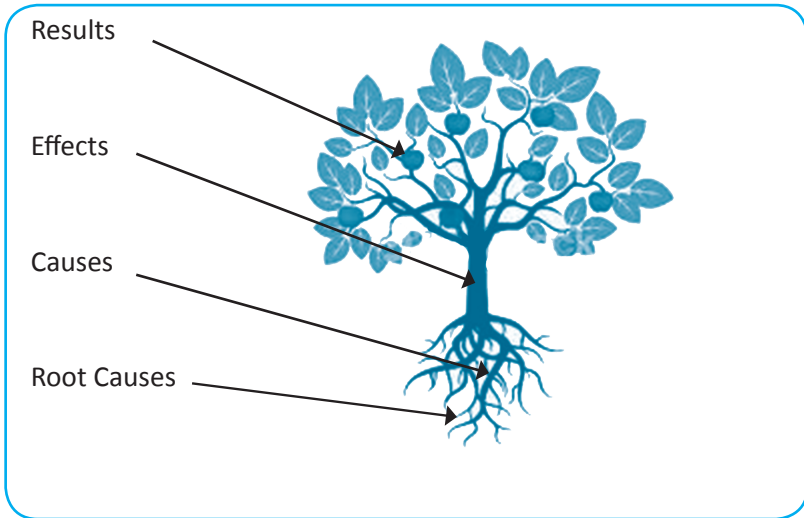


Table 3 - Analysis of Problem Behaviours

20 year old boy from Nadungamuwa area presented with confirmed HIV positive test results		
Cause	Reasons	
	Behaviour Related	Non - Behaviour Related
Immediate Causes	<ul style="list-style-type: none"> • Not using condoms consistently 	<ul style="list-style-type: none"> • Unprotected sex
underlying Causes	<ul style="list-style-type: none"> • Multiple partners • Unprotected Sex with sex workers • Did not buy condoms 	<ul style="list-style-type: none"> • Peer pressure • Difficult to negotiate with the partner • Lack of knowledge
	<ul style="list-style-type: none"> • Did not use condoms when he had condoms • Did not use condoms consistently and in a proper way 	<ul style="list-style-type: none"> • Non availability of condoms • Unconducive environment for access to condoms
Root Causes	<ul style="list-style-type: none"> • Cultural taboos and stigma • Wrong beliefs and perceptions 	<ul style="list-style-type: none"> • Lack of trained youth friendly services • Income • Education level

After analysis of “Results- chain of cause and effect” for the problem, next step is the behaviour analysis.

Behaviour Analysis

Behaviour analysis will help to identify what behaviours to promote and barriers to desired behaviours, and factors that encourage certain behaviours.

Table 4 - Questions to be Answered During the Behaviour Analysis:

Question
What is the problem behaviour that needs to be addressed?
Do females and males practice different behaviour patterns for the public health issue?
What are the consequences of the particular behaviour(s)?
What are the desired behaviour(s)?
What are the barriers for ideal or acceptable behaviour(s)?
What are the existing factors that can encourage ideal behaviours(s)?
What are the behaviours /practices that are to be promoted?
Who are the partners & allies we should engage?
What are the gender stereotypes and expectations surrounding the problem behaviours?

Table 5 - Identification of the Problems, Desired Behaviours, Barriers and Encouraging Factors for the Desired Behaviour

Problem behaviour	Consequences	Desired behaviour	Barriers to desired behaviour	Factors encouraging desired behaviour
Youth do not use condoms with multiple partners	<ul style="list-style-type: none"> • STIs including HIV infection • Complications of STIs 	<ul style="list-style-type: none"> • Using condoms every time in the correct way • Limit the number of partners 	<ul style="list-style-type: none"> • Ignorance • Unavailability of condoms • Unsupportive environment to buy condoms • Myths regarding condom use • Perceptions regarding sexual pleasure with condom use • Lack of negotiation skills to use condoms • Stigma for condom use 	<ul style="list-style-type: none"> • Youth friendly supportive local STD health staff • Peer led services • Availability of condoms • Accessibility of condoms • Social dialogue for condom use

Problem behaviour	Consequences	Desired behaviour	Barriers to desired behaviour	Factors encouraging desired behaviour
<p>Sex workers do not use condoms</p>	<ul style="list-style-type: none"> • STIs including HIV infection • Complications of STIs 	<ul style="list-style-type: none"> • Using condoms every time in the correct way with all clients 	<ul style="list-style-type: none"> • Ignorance-client does not agree to use condoms due to various reasons • myths regarding condom use 	<ul style="list-style-type: none"> • Supportive local STD health staff • Free condoms from STD clinics • Removing of punitive laws • Empowerment of sex workers
<p>Prisoners do not agree to take up VCT services</p>	<ul style="list-style-type: none"> • No timely treatment to improve quality of life and to prolong life 	<ul style="list-style-type: none"> • Acceptance of VCT services available in the prison set up 	<ul style="list-style-type: none"> • Ignorance • Unsupportive peers • Unsupportive services • Non maintenance of confidentiality 	<ul style="list-style-type: none"> • Supportive client friendly VCT services available in the prison setup • Good peer leader services in the prison set up • Advocacy and capacity building of prison staff to provide friendly services

Problem behaviour	Consequences	Desired behaviour	Barriers to desired behaviour	Factors encouraging desired behaviour
<p>MSMs do not use condoms</p>	<ul style="list-style-type: none"> • STIs including HIV infection • Complications of STIs 	<ul style="list-style-type: none"> • Using condoms every time in the correct way with all partners & separate condoms for each sexual activity • Lubricants for anal sex 	<ul style="list-style-type: none"> • Ignorance • Difficulty in keeping condoms at home • Partners do not agree to use condoms • Myths regarding condom use • Fear of keeping condoms • Punitive laws • Multiple casual partners 	<ul style="list-style-type: none"> • Supportive local STD health staff • Free condoms from STD clinics • Capacity building among Police officers • Removing punitive laws

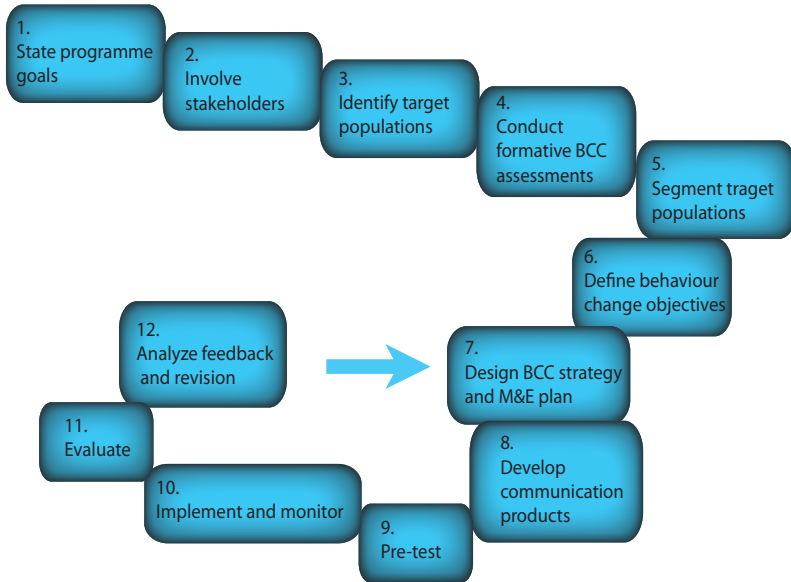
Problem behaviour	Consequences	Desired behaviour	Barriers to desired behaviour	Factors encouraging desired behaviour
General population discriminate HIV infected persons	<ul style="list-style-type: none"> • HIV infected persons will not come for health care services • Leads to disease progression 	<ul style="list-style-type: none"> • Empathy of general population towards HIV infected persons 	<ul style="list-style-type: none"> • Lack of knowledge • Myths • Stigma • Fear • Social norms 	<ul style="list-style-type: none"> • Literacy rate is high • Supportive local health staff • Religious support • Relevant laws and policies
Treatment adherence among positive young populations	<ul style="list-style-type: none"> • Drug resistance • Complications • Increased morbidity & mortality • Onward transmission 	<p>100% adherence to ART</p>	<ul style="list-style-type: none"> • Asymptomatic • Stigma among peers • Dislike for the term “life long treatment” • Ignorance • Different priorities 	<ul style="list-style-type: none"> • Proper counseling • Effective communication materials • Empowerment of treatment support groups

Problem behaviour	Consequences	Desired behaviour	Barriers to desired behaviour	Factors encouraging desired behaviour
<p>Loss to follow-up of positive people</p>	<ul style="list-style-type: none"> • Drug resistance • Complications • Poor prognosis • Onward transmission 	<ul style="list-style-type: none"> • Regular clinic follow-ups with 100% adherence to drugs and supportive interventions 	<ul style="list-style-type: none"> • Ignorance about the importance of clinic services provided 	<ul style="list-style-type: none"> • Friendly health care staff • Maintenance of confidentiality • Effective communications between clients and Health care staff
<p>Difficulties of Contract tracing</p>	<ul style="list-style-type: none"> • Increased transmission leading to a hidden epidemic 	<ul style="list-style-type: none"> • Bring the partners/contact details to the responsible people 	<ul style="list-style-type: none"> • Casual partners with no details • Fear of revealing the sero-status • Fear of violence • Attitude of healthcare providers 	<ul style="list-style-type: none"> • Separate trained staff for contact tracing • Guideline for contract tracing

Problem behaviour	Consequences	Desired behaviour	Barriers to desired behaviour	Factors encouraging desired behaviour
<p>Trans-gender people are less likely to come for SRH care</p>	<ul style="list-style-type: none"> • STIs including HIV infection • Complications of STIs 	<p>Access for SRH services</p>	<ul style="list-style-type: none"> • Lack of knowledge and lack of sensitivity among the community and the healthcare staff • Identity issues • Mental agony • Social barriers • Socially deprived 	<ul style="list-style-type: none"> • Transgender friendly health facilities • Improve the knowledge among health care providers

Development of Behaviour Change Communication programme

Figure 6 - Essential Steps to Develop a Behaviour Change Communication Strategy



Step 1 - Set up the Behaviour Change Communication Goals

BCC goals need to be developed in the context of overall national programme goals and specific behaviour change goals. It is important to identify the overall national goals. They may be very broad. BCC goal should be based on the problem and on the overall programme goals. BCC should be integrated with overall programme goals and specific objectives. The overall goal of most BCC programmes for HIV prevention is to promote behaviours/attitudes that prevent the

spread of HIV. eg:

National goal: Healthy Sexual life

Overall Programme goal: Healthy sexual life of young people in urban settings in the “Nadungamuwa” area.

Goal can be achieved through: Increased condom use, Increased appropriate STI care-seeking behaviour, Delaying sexual debut, Reducing the number of partners

Step 2 - Getting Involvement of Stakeholders for the BCC Programmes

Partnership is essential in this step. Support of the key stakeholders need to be involved early and in every step of the process of the BCC programme. Stakeholders include policymakers, opinion leaders, community leaders, religious leaders and members of the target populations, including People Living with HIV (PLHIV) . Also, more stakeholders can be decided depending on the area. Their active participation at appropriate stages of the BCC strategy development is essential from the planning stage.

Step 3 - Identify Target Populations

Identification of target groups is important and is one of the key factors that decides the effectiveness of the BCC programme. Target populations are defined as primary or secondary. Primary populations are the main groups whose HIV/AIDS-related behaviour of the programme is intended to influence the programme. Secondary populations are those groups that influence the ability of the primary population.

Target populations can be included as follows:

Table 6 - Primary and Secondary Target Groups

Target Group	Analysis of target groups
Primary	<p>Youth - belonging to key population Sex workers, Drug users, MSM, Beach Boys</p> <p>Vulnerable Youth - urban youth, migrant youth, plantation youth workers, IDUs, or uniformed services personnel</p> <p>Youth - low and no risk - General youth</p>
Secondary	<ul style="list-style-type: none"> • People providing services, such as health providers, private practitioners, pharmacists, counselors and social service workers • Policy makers, such as politicians • Leaders and authorities, formal and informal, including law-enforcement, social and religious leaders • Local communities and families

Step 4 - Conduct Formative BCC Assessments

Firstly, collect all the following available documents, national and local researches, case studies and available records.

National data - Epidemiological updates, behaviour surveillance surveys, IBBS, Sentinel surveys

Local data - available data relevant to the area (look at the local area / District analysis of national reports), in depth interviews of relevant key personnel

Local or District Data - Focus group discussions, key informant interviews, direct observation, participatory learning methods, rapid ethnographic assessments, mapping and in-depth interviews etc...

Once both these national and local data are synthesized, you can document the summary and come to the situation of behaviour analysis.

see page 24 on “Know your epidemic”

Step 5- Segment of target populations

A target population is a group of people who share the same demographic characteristics and behaviour patterns. Even among the youth group, it may be needed to segment them in to several groups.

It may be : Youth who are in the plantation sector, slums, rural sector, internally migrated and youth who practice risk behaviours

Once you do the BCC assessment, it is very easy to identify the segments of the target groups.

Demographic characteristics include age, place of residence (or work), place of birth, religion and ethnicity.

Target group Analysis

- Which target groups are most vulnerable.
- Which risk / vulnerability factors are most important.
- Which factors may be related to the impact of conflict and displacement.
- Which target groups and risk / vulnerability factors the community wants to address.
- What could be the motivators for behaviour change.
- What could be the barriers to behaviour change.
- What type of messages will be meaningful to each target group.
- Which communication media would best reach the target group.

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- Which services/resources are accessible to the target group.
- Which target groups and risk / vulnerability factors are feasible in terms of expertise, resources and time.

The following steps might be followed in deciding what the primary target populations should be.

- Which groups are the most at risk of being infected and infecting others?
- Which groups are the most likely to change their risk-taking behaviour?
- Which groups have the most common characteristics such as the same patterns of behaviour, age, language and culture?

Developing Messages

It is important to apply the following approaches while developing messages.

- The message is developed on the basis of detailed analysis of the surveillance conducted among the target population
- The message includes 3 components - problem raising - problem definition - problem solving
- The message gives positive change: it is important to give positive messages rather than negative messages
- The message promotes the target populations' implemented behaviour: e.g. a call addressing the delaying sexual relations is useful for youth aged 12-15 years, and quite incongruous for youth aged 18 years and above
- The messages are designed as comprehensive and distinct as possible, to avoid double interpretations made by the representatives of the target population.

Step 6- Define Behaviour Change Objectives

Before developing the behaviour change objectives, it is important to look at the programme/national behaviour change objectives.

- To increase safe sexual practices among youth through continuous condom use and reduction of partners
- To increase the incidence of healthcare-seeking behaviour among youth for STI treatment and HIV testing
- To improve compliance with drug treatment regimens among youth living with HIV
- To develop positive attitudes among the general population to prevent stigma and discrimination towards people living with HIV
- To reduce the incidence of discriminatory activity directed at key populations
- To increase the uptake of HIV tests among pregnant mothers
- To increase the uptake of HIV tests among youth
- To improve attitudes and behaviour among healthcare, social service and other service delivery workers who interact with PLHIV, key populations & vulnerable groups

When you develop effective BCC strategies, it is important to consider the achievement of intermediate and longer-term outcomes. Examples of BCC objectives are:

- Increased demand for information about HIV and AIDS
- Increased knowledge about HIV and AIDS
- Increased self-risk assessment
- Increased demand for information on STIs
- Increased demand for services

Step 7- Designing of BCC Strategy

The most effective and the best way of designing the BCC strategy should be based on getting the involvement of target groups, PLHIV and the stakeholders who are going to work with the relevant target groups.

BCC objectives should have :

- An overall **concept or theme** and **key messages**
- Identification of **channels** of dissemination (Which media we are going to use, peer leader communication and communication materials)
- **Identification of partners** for implementation (including capacity building plan)
- A **monitoring and evaluation** plan

Research findings should be used to develop the content of the messages, and should ensure that all HIV and AIDS messages do not conflict with the messages of other organizations. The quality and the client - friendliness of the messages should be maintained. Also the accuracy of the messages should be considered.

Information and Communication Technology

Information and communication technology is the fastest growing and evolving approach, with an increasing reach throughout the world. This approach includes digital media such as web sites, e-mails, Internet news feeds, chat rooms, virtual learning and E-learning, E-toolkits and message boards.

Mass Media

Mass media can reach large audiences cost-effectively through the formats of radio, television and newspapers. According to a

review, mass media campaigns that follow the principles of effective campaign design and are well-executed can have small to moderate effect size not only on health knowledge, beliefs, and attitudes, but on behaviours as well. Type of suitable media for different groups should be identified before deciding the channel.

Implementation Plan

The implementation plan details the “who, what, when and how much” of your communication strategy. The plan covers partner roles and responsibilities, activities, timeline, budget and management considerations.

Step 8- Monitoring and Evaluation Plan

Monitoring is regular collection and analysis of information on the basic components of programme implementation. Monitoring assumes a continuous observation of expenditure and results through a system specially developed for the collection and analysis of data.

Monitoring is the daily standard evaluation of functioning and on-going implementation of a programme or project, whereas, evaluation is a onetime assessment of the overall results and achievements.

Monitoring will help to answer this question: “Is the programme/project being implemented properly?”.

Evaluation will help to answer this question: “Is the proper programme/project being implemented?”.

Evaluation analyses the impacts and the results of interventions which include both process and outcome monitoring.

Periodic focus group discussions and in-depth interviews can help the BCC organizers keep track of the perceptions of the target population. [22]

Theories for the planning of your interventions

Theories can guide the design, implementation of evidence based programmes, and evaluations. Adequately addressing an issue may require more than one theory, and no single theory is suitable for all cases. [23]

Broadly speaking, social theories are analytical frameworks or paradigms used to examine social phenomena. The term ‘social theory’ encompasses ideas about ‘how societies change and develop, about methods of explaining social behaviour, about power and social structure, gender and ethnicity, modernity and civilisation, revolutions and utopias. [24]

In other words, a theory is a systematic and an organized explanation of events or situations. Theories are developed from a set of concepts (or “constructs”) that explain and predict events/situations, and provide explanations about the relationship between different variables.

Social Theories and Models

Social Behaviour Change Communication is based on several theories and models. The theories are categorized into three stages: individual level, interpersonal level and community level. Individual level of change is targeted to change the personal behaviours by the process of psychological change. Interpersonal level of change is targeted to change the social networks by the psycho-social change process. Community level of change is targeted to change the community development by the cultural and social change process. [25,26,27]

Interventions can be planned using these theories. In each intervention, more than one theory can be used.

Emphasis of Some Theories

Tabel 7 - Types of Theories

Theory	Emphasis
<i>Individual level</i>	
1. Health Belief Model	Planned behaviours, rational decision
2. Reasoned Action	Making processes
3. Stages of Change	Beliefs and Subjective norms
4. Fear Management	Interaction between cognition and emotion
<i>Interpersonal level</i>	
1. Social Learning	Social comparison, learning from role models, self-efficacy

Community Level

- | | |
|------------------------------|---|
| 1. Theory of Gender & Power | Social influence, personal networks |
| 2. Diffusions of Innovations | |
| 3. Ecological Model | behaviour is a function of the person and its environment |
-

Individual Level Theories

Health Belief Model

The Health Belief Model is a psychological model that attempts to explain and predict health behaviours by focusing on the attitudes and beliefs of individuals. It is based on the understanding that a person will take health-related actions, and it can be described as follows.

1. An individual feels that, a negative health condition can be avoided by applying a health related action, (i.e., use of condoms can prevent HIV).
2. An individual has a positive expectation that by taking a recommended action, a negative health condition will be avoided (i.e., using condoms will be effective in preventing HIV).
3. An individual believes that a recommended health action can be successfully taken (i.e., can use condoms comfortably and with confidence). **[24,25,28,29]**

People form behaviours based on perceptions:

- How severe is the illness?
- How likely could I get it?

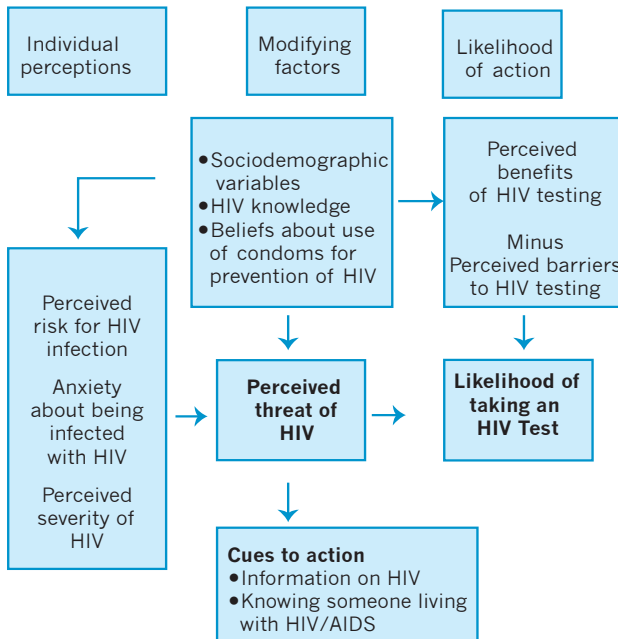
- What are the benefits of trying to prevent it and how effective is the new behaviour?
- What keeps me away from taking this action?

Applications

- Address personal risk perceptions and beliefs in severity of disease
- Identify key benefits and barriers to change and stimulate discussion
- Demonstrate potential positive results of change

The Health Belief Model is spelt out in terms of four constructs: perceived susceptibility, perceived severity, perceived benefits and perceived barriers.

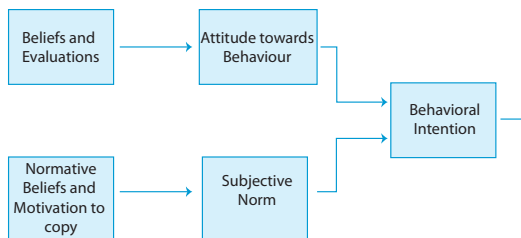
Figure 7 - Health Belief Model



Theory of Reasoned Action

The theory of reasoned action is a model used for prediction of behavioural intention and spanning predictions of attitude and behaviour. [30,31,32]

Figure 8 - Theory of Reasoned Action



People make decisions by:

- Weighing the advantages and disadvantages of behaviours before deciding to practice it. eg: Condom use

People base their intentions to act on two things:

- Their attitudes (whether performing the behaviour is a good thing or a bad thing)
- Their subjective norms (whether other people around you are performing it and think that you should do that, too)

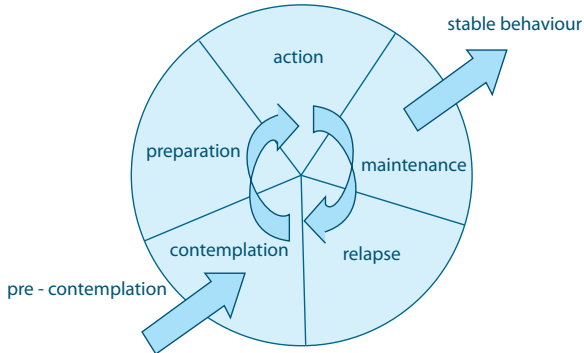
Applications

- Identify motivators and benefits for action
- Create messages that can affect attitudes
- Identify audiences that influence the group your are trying to reach

Stages of Change Model

Stages of change model is described in five stages as depicted below. [33]

Figure 9 - Stages of Change Model



1. Pre-contemplation

The individual is unaware that there is a behaviour which needs to be changed.

For example, if a person is addicted to drugs he does not know that the drug addiction is a problem and the pros and cons of it. He has no intention to change the use of drugs in the foreseeable future.

2. Contemplation

The individual acknowledges that there is a need for change, but is not yet ready or sure of wanting to make a change. For example, the drug addicted person acknowledges that drug addiction is a problem. He is ready to be open for information and education. He considers the change, but he is not quite ready to consider the pros and cons of giving up.

3. Preparation or Determination

The individual is getting ready to change. For example, the person has an intention to give up the habit of drug addiction. For that, the person begins to set goals and plans to stop the drug addiction, and develops strategies for it.

4. Action or Willpower

In this stage, the individual is making the change. Significant efforts are made to stop drug addiction.

5. Maintenance

The individual is maintaining the behaviour change. For example, the person continues to abstain from drugs. The person is able to more clearly identify situations and self-defeating behaviours that encourage relapse. He continues to work to prevent relapse.

6. Relapse

The individual is reverting to previous behaviours and moving away from the new behaviour. Relapses are common when people are trying to give up drugs. The individual starts using drugs again. Relapses occur when people who are in the action stage change their minds to slip back into the previous drug use stage.

It is important to note that people can move back and forward through these stages. This is seen as a learning opportunity. It is a chance to learn what strategies did not work and what part of the plan did not work.

Theory of Fear Management

Fear and threat appeals are used in the individual level of Social Behaviour Change communication. Fear can be engendered in the individual by making them aware of the perceived seriousness of the illness. Solutions how to be provided to the individuals to keep the value of the stimulation of the fear of the illness. The way of overcoming barriers by the others has to be shown. Fear method is not sustainable and it can be used for a shorter period like during an outbreak. Usually fear method is not applied for HIV prevention. [34]

People make decisions based on

- The threat (fear)
- Is the threat serious or severe?
- Can it happen to me?
- The efficacy (response)
- Does the response work?
- Can I do the response (self-efficacy)?
- What blocks me from responding (barriers)?

Applications

Find out about perceptions of fear and efficacy

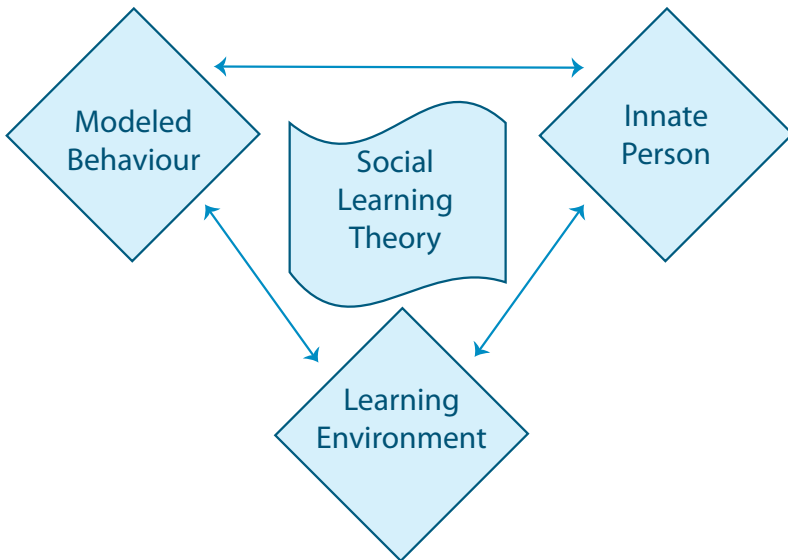
- Increase perceived seriousness of the illness
- Increase risk perception
- Increase knowledge on solutions
- Model response behaviours
- Show how others have overcome barriers

Interpersonal Level Theories

Social Learning Theory

In the social learning theory, three variables, namely, modeled behaviours, the person and the learning environment are influencing each other. [30,35]

Figure 10 - Social Learning Theory



People learn from one another by observing the actions of others and the apparent consequences of those actions. People check those consequences for their own lives and try out those by themselves.

People learn and decide how to act by

- Observing the actions of others
- Observing the apparent consequences of those actions

- Checking those consequences for their own lives
- Trying out those actions themselves

Applications

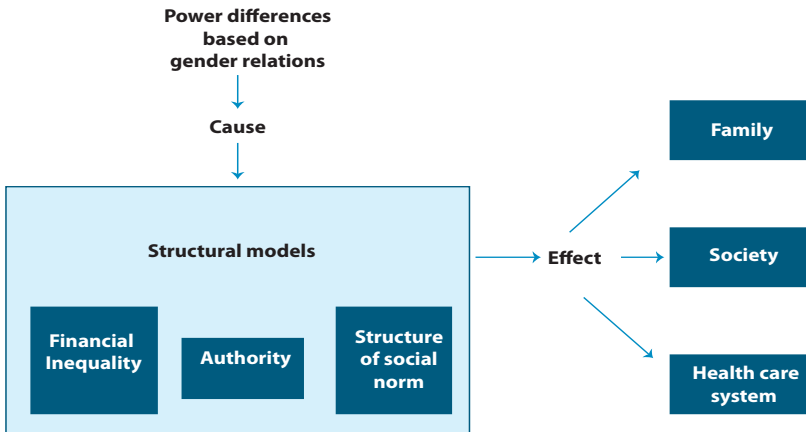
- Identify key role models in the community
- Provide opportunities for them to model or talk about their behaviours
- Showcase role models and their actions through radio, dramas, personal testimonials and community discussions

Community Level Theories

Theory of Gender and Power

People make decisions to change the behaviour based on wider social and environmental issues surrounding women, such as distribution of power and authority and gender specific norms outside of and within relationships. The theory of gender and power is applied to assess the impact of structural gender differences and social norms on interpersonal sexual relationships. It is important to Investigate how a woman's commitment to a relationship and lack of power can influence her risk. [36]

Figure 11 - Theory of Gender and Power



People make decisions based on:

- Wider social and environmental issues surrounding women such as:
 - Distribution of power and authority
 - Gender specific norms outside of and within relationships

Applications

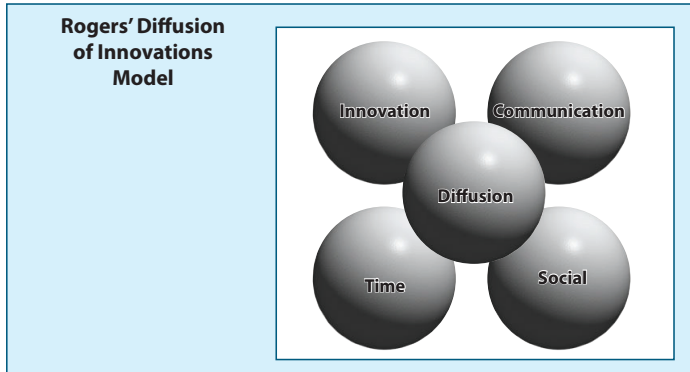
- Assess the impact of structural gender differences and social norms on interpersonal sexual relationships
- Investigate how a woman’s commitment to a relationship and lack of power can influence her risk reduction choices

Diffusion of Innovations

Innovations are spread through social networks over time. The speed at which an innovation spreads depends on what people think about the innovations and the people using it, and how well the social network works. This theory is applied to identify how the audience thinks of the innovation, identify the opinion leader in the network, identify the

messages that address concerns about the innovation and demonstrate what happens to others when they try the innovation.[37]

Figure 12 - Theory of Diffusion of Innovations



Innovations are spread through

- Social networks over time
- The speed at which an innovation spreads depends on what people think about the innovations and the people using it
- How well the social network works

Applications

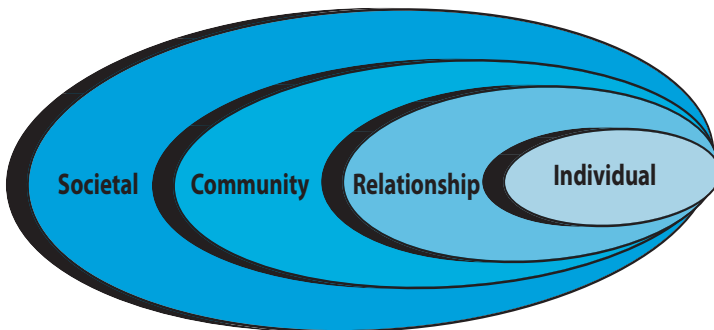
- Identify how the audience thinks of the innovation
- Identify the opinion leader in the network
- Identify messages that address concerns about the innovation
- Demonstrate what happens to others when they try the innovation

Ecological Theory

A four-level social-ecological model is used in the ecological theory. This model considers the complex interplay between individual, relationship, community, and societal factors. The first level identifies biological and personal factors including age, education, income,

substance use, and history of abuse of the individual. The second level examines how a person's closest social circle i.e. peers, partners and family members influence their behaviour and contribute to their range of experience. The third level explores the settings, such as schools, workplaces, and neighborhoods, in which social relationships occur, and seek to identify the characteristics of these settings. The fourth level looks at the broad societal factors including social and cultural norms and societal factors including the health, economic, educational and social policies that help to maintain economic or social inequalities between groups in the society.[38]

Figure 13 - Ecological Theory



Combination of prevention is essential to end the epidemic of HIV by 2030. The combination of prevention strategies should be implemented at different levels such as individual, relationship, community and societal, with a combination of biomedical, behavioural and structural interventions. This means that multiple interventions are likely to be required for the effective promotion of sustainable behaviours. Indeed, this constitutes the weight of opinion emanating from the evaluative evidence regarding interventions to affect behaviour.

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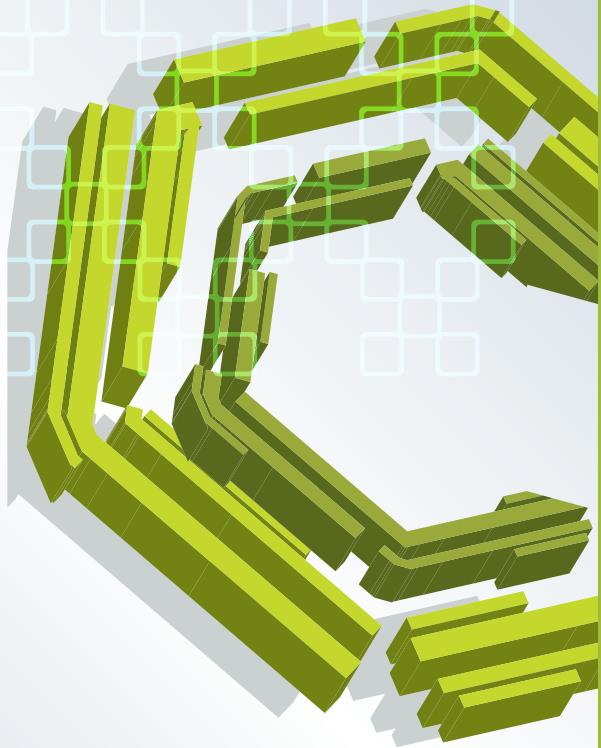
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Inquiries:
NATIONAL STD/AIDS CONTROL PROGRAMME
No. 29, De Saram Place, Colombo 10.
Tel: 011 2667163
Fax: 011 5336873, 2682859
E-mail: info@aidcontrol.gov.lk
Web: www.aidcontrol.gov.lk

Coordination:
MULTI-SECTORAL UNIT
NATIONAL STD/AIDS CONTROL PROGRAMME
Tel: 011 2687625
E-mail: multiunitsacp@yahoo.com

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