CHAPTER 14

BEHAVIOUR CHANGE COMMUNICATION FOR PUBLIC HEALTH PROGRAMMES

APURVAKUMAR PANDYA
ASSISTANT PROFESSOR AND CO-LEAD, CENTRE FOR QUALITY IMPROVEMENT AND PATIENT SAFETY, DEPARTMENT OF HEALTH POLICY, MANAGEMENT AND BEHAVIOURAL SCIENCE, INDIAN INSTITUTE OF PUBLIC HEALTH GANDHINAGAR, INDIA
MEDHA WADHWA
ASSISTANT PROFESSOR AND LEAD, CENTRE FOR QUALITY IMPROVEMENT AND PATIENT SAFETY, DEPARTMENT OF HEALTH POLICY, MANAGEMENT AND BEHAVIOURAL SCIENCE, INDIAN INSTITUTE OF PUBLIC HEALTH GANDHINAGAR, INDIA
MP CARIAPPA
TECHNICAL ADVISOR, TATA TRUSTS, PUNE, INDIA
SANJAY GUPTA
PROFESSOR, IIHMR UNIVERSITY, JAIPUR, RAJASTHAN, INDIA
NEETU PUROHIT
PROFESSOR, INSTITUTE OF HEALTH MANAGEMENT RESEARCH, IIHMR UNIVERSITY, JAIPUR, INDIA

Overview

This chapter delves into the critical role of behaviour change communication (BCC) in promoting public health. Personal choices, societal norms, and environmental factors influence human behaviour. Resistance is often the initial reaction to change, making it difficult to promote positive health behaviour changes. There are several reasons why people might resist

changing their behaviours. First, the message itself may be unclear or poorly communicated. People might not fully grasp the consequences of their actions or how the new behaviour would benefit them.

Additionally, individuals may not see themselves as susceptible to negative outcomes. Smokers, for instance, might know smoking causes cancer but not believe it will happen to them. Trust in the source of the message also plays a role. The information is less likely to be accepted if the messenger is seen as biased or untrustworthy. Another hurdle is the perceived trade-off between short-term gratification and long-term benefits. Unhealthy habits often provide immediate pleasure, while healthier choices require delayed gratification. Some "healthy" options, like buying organic produce, can be more expensive, creating another barrier. Finally, cultural beliefs or personal values can clash with recommended behaviours. In order to address these challenges, behaviour change communication is an effective tool.

Learning Objectives

After completing this chapter, you should be able to:

- Explain the concept of Behaviour Change Communication and its significance in public health programmes.
- Apply different behaviour change theories to design public health programmes.
- Determine behaviour change communication strategies, analyze target audience behaviours and develop audience-specific communication approaches for public health initiatives.
- Design, monitor and evaluate BCC programmes.

Behaviour Change Communication: Meaning and Strategies

Behaviour change communication (BCC) is a strategic approach that uses communication to nudge individuals and communities towards healthier choices in a local sociocultural context.

BCC is an interactive, researched and planned process to change social conditions and individual behaviours (Norman, P. 2005). BCC uses

evidence to address knowledge gaps and improve health behaviours. It tailors messages to specific audiences through interpersonal channels, mass media, and participatory methods.

BCC creates a more comprehensive approach to behaviour change, addressing not just knowledge and attitudes but also challenges social and gender norms, imparts skills, and creates an enabling environment.

Behaviour Change Communication is the strategic use of communication to develop interventions that:

- **Promote positive behaviours:** BCC encourages individuals and communities to adopt healthy and sustainable practices relevant to their contexts.
- **Create a supportive environment:** It goes beyond just messaging by fostering an environment that allows people to initiate and sustain these positive behaviours. This might involve policy changes, increased resource access, or community mobilization efforts.

Differentiating BCC from Information and Education

BCC occupies a distinct space within a broader communication landscape. It is crucial to distinguish BCC from information dissemination or education. Table 1 highlights differences in information, education, behaviour-change, and social behaviour-change communication.

Table 1: Differences between IEC, BCC and SBCC

Information	Information refers to the simple transmission of factual data.
Education	It involves structured instruction with the goal of knowledge acquisition.
Information, Education & Communication (IEC)	The IEC approach combines information and education but may not actively influence behaviour and measure behaviour change.
Behaviour Change Communication (BCC)	BCC is a strategic approach that uses communication to positively influence people's knowledge, attitudes, and practices. It involves creating an interactive process that engages individuals, groups, and

	communities in changing their risky health behaviours.
Social Behaviour Change Communication (SBCC)	SBCC is a specific type of BCC that focuses on influencing behaviours within a social context, considering group norms and social pressures. SBCC considers how messages are received and interpreted within a social context and how community leaders and peers can be leveraged to promote positive behaviour change.
Source: Prepared by Apurvakumar Pandya	

Characteristics of BCC

BCC is a communication strategy used to influence people's behaviour towards healthier choices. It is characterized as strategic, evidence-based, systematic, research-driven, audience segmentation, use of pre-tested communication materials, adaptation of multiple communication channels, goal-oriented, monitored, and evaluated.

Characteristics of BCC

BCC is

- **Strategic:** a well-planned approach, not random messaging.
- **Evidence-based:** relies on proven theories to understand what motivates behaviour change.
- **Systematic:** follows a clear process with distinct stages.
- **Research-driven:** starts with formative research to understand the target audience and their behaviours.
- **Segmented audience:** Messages are tailored to specific groups within the target population.
- **Pre-tested materials:** Communication materials and messages are tested before their implementation.
- **Multi-channel approach:** This approach utilizes various communication channels, such as one-to-one communication, group communication, social media, and mass media.

- **Goal-oriented:** It has defined objectives related to specific behavioural changes.
- **Monitored and evaluated:** Intervention progress is tracked and evaluated for effectiveness.

BCC plays a pivotal role in public health initiatives. BCC effectively tackles the root causes of behaviour change. It empowers individuals with the knowledge, skills, and motivation to make healthy choices, ultimately impacting population health outcomes.

Importance of BCC in Public Health

BCC plays a pivotal role in public health initiatives. BCC effectively tackles the root causes of behaviour change. It empowers individuals with the knowledge, skills, and motivation to make healthy choices, ultimately impacting population health outcomes (Rosenstock 2005).

Example of successful BCC intervention

India's polio eradication success story presents a valuable case study in BCC interventions. Communication strategies had to adapt as the program tackled a constantly evolving epidemic and diverse social contexts. By leveraging epidemiological, social, and behavioural data, India implemented proven strategies alongside innovative approaches to reach every child, especially in hard-to-reach areas. These interventions included setting a national agenda, building demand for the oral polio vaccine, increasing attendance at National Immunization Days, and mobilizing local partnerships to achieve universal coverage. Notably, the programme addressed pockets of vaccine hesitancy among caregivers in underserved areas with culturally sensitive approaches.

Overview of BCC Theories

BCC theories offer valuable frameworks for designing effective public health interventions to bring desired behaviour change. We present prominent theories and examples of their application in local sociocultural contexts. BCC theories can be classified into three categories: 1) Theories

focusing on an individual as a change agent for behaviour change; 2) Theories focusing on the community as a change agent for behaviour; and 3) Theories focusing on power structures and multiple levels of influence as a change agent for behaviour. Table 2 provides a classification of BCC theories, and Table 3 summarises BCC theories for your reference.

Table 2: Classification of critical BCC theories

Focus	Theories
Individual	Health belief model (Hochbaum, Rosenstock and others, 1950) Theory of planned behaviour (Icel Ajzen, 1991) Social cognitive theory (Albert Bandura, 1985) Stages of change model (James Prochaska, Carlo DiClemente, 1990)
Community	Diffusion of Innovation theory (Everett Rogers, 1962) Social influence theory (Berkman, 2000) Integrated Behavior Change Model (Hagger and Chatzisarantis 2014)
Power structures and different levels of influence	Theory of gender and power (Connell, 1987) Communication for Behavioural Impact (Everold Hosein, 1994) Socioecological Model (McLeroy, 1988)
Source: Prepared by Apurvakumar Pandya	

Table 3. Bird eye view of BCC theories

The Health Belief Model (HBM) - Hochbaum, Rosenstock et al. (1950s)
The HBM posits that individuals are more likely to adopt preventive health behaviours when they perceive themselves as susceptible to a disease, believe it to be severe, and perceive the benefits of the preventive action outweigh the barriers (Rosenstock et al., 1974). For example, a smoker might consider quitting if they perceive a high risk of developing lung cancer (susceptibility), believe it could be fatal (severity), and are convinced the benefits of quitting outweigh the challenges (benefits vs. barriers).

Theory of Planned Behavior (TPB) - Ajzen (1991)(Ajzen 1991)

The TPB builds upon the HBM by incorporating the influence of social norms and self-efficacy[4]. It suggests that individuals are more likely to engage in a behaviour if they hold positive attitudes, believe social norms support it, and feel confident in their ability to perform the behaviour (self-efficacy). For example, a TPB-based intervention in India aimed at increasing handwashing with soap. The campaign focused on the positive health benefits of handwashing (attitudes), highlighted the social expectation of handwashing before meals (social norms), and provided demonstrations to build self-efficacy in proper handwashing techniques (Janssen et al. 2009).

Social Cognitive Theory (SCT) – Bandura (1985)

SCT emphasizes the role of observational learning, social expectations, and self-regulation in behaviour change (Marks and Bandura 2002). It highlights the importance of role models and social cues in shaping behaviour. For example, an SCT-based intervention aimed at promoting malaria prevention in Uganda used community drama performances to showcase the benefits of using mosquito nets. Seeing neighbours using nets and observing the positive outcomes (observational learning) influenced others to adopt the behaviour (Horter et al. 2019).

Stages of Change Model (SOC) - Prochaska & DiClemente (1990)

SOC believes that individuals progress through stages of change (pre-contemplation, contemplation, preparation, action, maintenance) when adopting new behaviours(DiClemente and Hughes 1990)Interventions need to be tailored to the specific stage. For example, someone in the pre-contemplation stage might not be considering quitting smoking. When someone in the preparation stage might be actively planning to quit, a digital intervention focusing on raising awareness and systematic steps to help them develop and execute a quit plan could be beneficial (Pandya et al. 2023).

The Diffusion of Innovation Theory (DOI) – Rogers (1962)

DOI explains how new ideas and practices are adopted within a social system (Rogers 2004). It identifies factors influencing the adoption rate, such as the perceived relative advantage, compatibility with existing beliefs, complexity, and trialability of the innovation. For example, a DOI-

informed campaign in Ghana promoted using insecticide-treated bed nets (ITNs) for malaria prevention. The campaign emphasized the advantages of ITNs over traditional bed nets (relative advantage), addressed concerns about their compatibility with sleeping habits, and offered free trials of ITNs to increase adoption (Ahmed Agyapong et al 2024).

Social Influence Theory (SIT) - Berkman (2000)

SIT explains that social networks and social norms influence health behaviours (Zunzunegui et al. 2003). Social support, positive modelling, and community expectations can promote healthy choices. For example, individuals surrounded by friends who exercise regularly are more likely to adopt this behaviour themselves due to social influence and a desire to conform to group norms. Further, encouraging community leaders to promote physical activities can be more effective in reaching individuals and influencing their behaviour.

Integrated Behavior Change Model (IBCM) - Hagger & Chatzisarantis (2014) (Hagger and Chatzisarantis 2014)

IBCM is a comprehensive framework incorporating elements from various theories. The model considers direct influences on behaviour (intention) and indirect influences (attitudes, norms, and control), motivation, habit formation, and action planning as key factors for behaviour change. For example, IBCM can be used to design a smoking cessation programme that addresses all these factors. It might include educational sessions that change attitudes towards smoking, social support groups to address social norms, skills training to develop coping mechanisms, and action planning to set realistic quit goals and identify strategies to overcome challenges.

Theory for gender and power (TGP) – Connell (1987)

The Theory of Gender and Power delves into the complex relationship between gender, social structures, and power dynamics. The theory explains that gender is not simply a biological category (male/female) but a social construct that shapes how people interact, behave, and access resources. Furthermore, power, in terms of control over resources, decision-making, and cultural norms, also determines health behaviour (Wingood, G 2002). For example, the sexual division of labour (e.g. household work) and the division of power (e.g. lack of control over finances) might limit women and sexual minorities (LGBTQ+) to access healthcare services and afford healthcare costs. Accounting gender and

power dynamics in designing public health programmes can make healthcare accessible and equitable for men, women and gender minorities.
Communication for Behavioural Impact (COM-BI) –Everold Hosein (1994) COM-BI provides a practical framework for designing BCC interventions (Suhaili et al. 2004). It emphasizes identifying target audiences, behaviour change objectives, communication channels, and outcome indicators. For example, a COM-BI-based intervention in Vietnam aimed to improve maternal health practices. The intervention utilized community radio broadcasts (channels) to educate women on the benefits of prenatal care and skilled birth attendance (behaviour change objectives). It also involved training health workers to address any concerns raised by listeners (outcome indicators) (Nguyen et al. 2014).
Socioecological Model (SEM) – McLeroy, (1988) The socioecological framework was first suggested by Urie Bronfenbrenner and later redefined by McLeroy and colleagues (Scarneo et al. 2019). The SEM considers the interplay of factors across multiple levels: individual, interpersonal, community, organizational, and policy. The SEM addresses individual behaviour and the broader social and environmental context. This multi-level approach holds immense potential for promoting positive health outcomes and improving well-being in low-resource settings. For example, an SEM-based framework was developed to reduce sport-related deaths among adolescent participants.
Source: Prepared by Apurvakumar Pandya

Summary of BCC theories

Individual-focused theories have proposed an array of psychological factors that critically influence behaviour and behaviour change, such as perception of risk and vulnerability and the balance between anticipated positive and negative outcomes of performing a preventive behaviour. These theories are primarily individualistic, focusing on the individual as a change agent and ignoring other factors that influence behaviour. Community-focused theories consider the environment and community as change agents. It emphasizes dialogue with the community to build up a

critical perception of the social, cultural, political, and economic forces that structure reality and take action against oppressive forces. Theories focusing on power structures and different levels of influence emphasize addressing barriers at different levels (individual, family, community, systems and policy levels) using a combination of multiple communication channels (interpersonal communication, group and mass media). It also emphasises advocacy, organizational change, and addressing environmental constraints, including policy development or its effective implementation for creating a conducive environment for desired behaviour change.

Designing Effective BCC Programmes or Interventions

Designing an effective BCC programme is a multi-step process focusing on understanding the target audience and crafting communication strategies to achieve desired behavioural changes. A BCC programme is a comprehensive, long-term strategy designed to create an environment conducive to positive behaviour change, whereas a BCC intervention is a specific, targeted action or activity aimed at promoting behaviour change. Table 4 explains the difference between the BCC programme and BCC intervention.

Table 4. Characteristics of BCC programme and BCC intervention

Characteristics	BCC Programme	BCC Intervention
Scope	Broad, overarching framework with multiple interventions	Specific, targeted activities which may be part of the programme
Focus	Creating an enabling environment for behaviour change	Directly influencing individual or community behaviour
Timeframe	Long-term, sustained effort	Short to medium-term, specific activity

Source: Prepared by Apurvakumar Pandya

The key steps of designing BCC interventions are discussed as follows:

1. Situation assessment: Before diving in, we need to understand the field situation by understanding population demographics, current knowledge, attitudes, beliefs, and specific health behaviours, as well as

beliefs within the community that we want to address. Also, determine the goals of your health programme. Who are the key stakeholders – community leaders, healthcare workers, or others – and how can they be involved? You may consider relevant BCC theory/ies to consider to tackle the problem best. This can be accomplished through formative research using rapid surveys, focus group discussions, or interviews to understand s.

2. Identify target audience: Knowing your target audience is crucial. Consider segmenting the community into different groups, such as:

    - Patients: Individuals already diagnosed with the condition you are addressing.

    - People at-risk: Individuals with a higher chance of developing the condition.

    - Vulnerable or Marginalized individuals: Individuals or Groups of people facing social or economic barriers that may affect their health behaviours.

    - Healthy People: Healthy individuals who may benefit from preventive measures.

3. Determine behaviour change objectives: Using the SMART (specific, measurable, achievable, relevant, and time-bound) framework, identify target behaviour that needs to be changed. Identify barriers and facilitators that might influence the target audience's ability to adopt the desired behaviour.

4. Develop a BCC strategy: Select appropriate behaviour change communication strategies, such as community mobilization, advocacy, and communication approaches. Also, determine communication channels, such as interpersonal communication (face-to-face interaction), group interactions, or a mass media campaign.

5. Create and pre-test communication materials: Design clear, compelling messages that resonate with your target audience. Consider language, cultural relevance, and emotional appeal. Pre-test your communication materials to ensure the target audience understands them.

6. Implement and monitor: Put your plan into action! Track your progress towards achieving BCC objectives. Monitor the reach, engagement, and, most importantly, behaviour change over time.
7. Evaluate and adapt: Analyze the BCC intervention's effectiveness based on monitoring data. Use these insights to refine your messages, communication channels, or overall strategy for continuous improvement.

Remember, BCC interventions are most successful when they are:

- Theory-driven yet responsive to the community needs: BCC intervention should be informed by the established behaviour change theories; at the same time, it should be responsive to the community's needs. Therefore, situation assessment should be participatory

- Participatory: Involve the target audience in the design and implementation process.

- Culturally appropriate: Tailor messages and communication channels to resonate with the specific culture.

- Multi-level: Address individual, community, and societal factors influencing behaviour.

Strategies of Behaviour Change Communication

In achieving positive health outcomes, community mobilization, communication approaches, and advocacy are interwoven threads in the fabric of public health. These strategies empower communities, influence individual behaviours, and even drive policy changes by generating a 'felt need'. Let us learn about these strategies.

1. Community Mobilization

Community mobilization refers to the process of engaging and empowering community members to participate actively in health-related initiatives. It fosters a sense of ownership, collaboration, and collective action within the community. Effective community mobilization can lead to sustainable health improvements by leveraging local knowledge, resources, and social networks.

Key Elements of Community Mobilization

- **Participatory Approach**: Community mobilization thrives on inclusivity. It encourages community members to actively contribute to decision-making processes, program planning, and implementation. By involving diverse stakeholders, we tap into a wealth of perspectives and ideas.

- **Capacity Building**: Strengthening the skills and capacities of community members is essential. Training sessions, workshops, and skill-building programs empower individuals to take charge of their health and advocate for change.

- **Social Networks and Trust**: Building and nurturing social networks within the community fosters trust. These networks serve as conduits for information dissemination, peer support, and collective action.

- **Resource Mobilization**: Effective community mobilization requires access to resources—both financial and non-financial. Community members can pool resources, seek external funding, or collaborate with local organizations. Examples of community resource mobilization include seeking support from the leading community members, community health workers (CHWs), community-based Organizations (CBOs), or civil society organizations (CSOs).

2. Communication approaches

Communication approaches aim to modify individual behaviours sustainably by delivering targeted messages that influence attitudes, beliefs, and social norms. Effective communication approaches use evidence-based strategies to promote positive health behaviours.

Key Elements of Communication Approaches

(a)**Assess**: Before determining the communication approach, assess the target audience, their needs, barriers, and existing practices. Use insights from formative research for message framing and channel selection.

(b)**Message Framing**: Messages should resonate with the audience, complete and endeavour to use positive framing (emphasizing benefits) or negative framing (highlighting risks) based on the context. It is essential to tailor messages to the locally relevant cultural nuances.

(c) **Channels**: Choose appropriate channels for message dissemination, such as interpersonal communication (one-on-one communication session or group session), mass media (TV, radio, posters, slogans, wall paintings, hoardings, etc.), social media (digital campaign, digital posts, digital learning resources, etc), and community events (folk events, movie shows, street plays, etc.) in various combinations.

(d)**Feedback Mechanisms**: Getting feedback on implementing communication approaches is important. Regular assessments help refine messages and adapt strategies. The PDSA (Plan-Do-Study-Act) cycle is best suited to be adopted for the implementation of communication approaches.

3. Advocacy

Advocacy focuses on influencing policies, systems, and structures to improve health outcomes. It involves raising awareness among decision-makers, building partnerships with relevant organizations, and advocating for policies that support healthy behaviours. It bridges the gap between community needs and policy decisions. Effective advocacy requires strategic planning, collaboration, and persistence.

Key Elements of Advocacy

(a) **Policy Analysis**: Understand existing policies and identify gaps. Advocate for evidence-based policy changes that align with community needs.

(b)**Coalitions and Alliances**: Join forces with like-minded organizations, policymakers, and influencers. Collective voices carry more weight.

(c)**Media Engagement**: Use media platforms to raise awareness, share success stories, and highlight pressing locally relevant health issues. This involves writing for newspapers, local TV, magazines, etc.

(d)**Policy Implementation**: Advocacy does not end with mere policy change. It extends to implementation and monitoring the impact of policy change on the population. Therefore, it is a continuous and ever-evolving process.

Monitoring and Evaluation of BCC programmes

The objective of any behaviour change programme is behaviour change by influencing the targeted audience's knowledge, attitude, and intention. The monitoring and evaluation, therefore, attempt to measure changes at all stages of behaviour change communication. Monitoring and evaluation (M&E) informs whether the communication effort subsequently or eventually culminates in the desired behaviour change or progresses and reaches some point towards a behaviour change.

M&E could be defined as a continuous management function that assesses progress in achieving expected results, spots bottlenecks in implementation, and highlights any unintended effects (positive or negative) from the communication programme or intervention and its activities.

Monitoring is a continuous, day-to-day management process of checking, analyzing, and giving feedback about programme activity and resource allocation plans. Monitoring BCC programmes involves routine data collection and analysis to check progress from the programme implementation and beneficiary perspectives. For this, the specific

indicators of change need to be identified and measured to ensure that they are giving the expected results. These indicators should be in alignment with the objectives of the BCC programme.

As per the system's framework, these indicators are specified for input, process, output, outcome, and impact variables. Input, process, and output indicators fall under the domain of monitoring, and outcome and impact are evaluation indicators. Measurement requires assessing the changes specified in the programme objectives. Process refers to what happens as the programme is implemented. Impact refers to programme outcomes. Table 5 below illustrates this concept with an example of COVID-19.

Table 5. Example of Communication Programme Objective: Preventing COVID-19 Infection

<table>
<tr><td>Input</td><td>• Availability of masks and sanitizers</td><td rowspan="3">• Physical and financial availability
· Comprehension of the message
· Barriers and Facilitators
• Reach and Appropriateness of time and media</td></tr>
<tr><td>Process</td><td>• Providing information on the ways COVID spreads and the role of masks and hand hygiene in prevention
• Providing information on the role of social distancing in preventing the spread of COVID-19</td></tr>
<tr><td>Output</td><td>• Several media channels were used to provide information
• Frequency of providing information
• Number of people reached via communication channel</td></tr>
<tr><td>Outcome</td><td>• The proportion of people who become knowledgeable about ways of preventing COVID
• The proportion of people following all three ways to prevent COVID-19 infection</td><td rowspan="2">• Attributes of existing knowledge and behaviour
• Reasons for lack of/incomplete knowledge
• Reasons for positive/negative attitude towards following preventive measures</td></tr>
<tr><td>Impact</td><td>• COVID infections averted
• COVID-related deaths averted</td></tr>
<tr><td colspan="3">Source: Prepared by Neetu Purohit</td></tr>
</table>

In behaviour change communication programmes, process indicators are highly valued as they have the potential to determine the success or failure of the intervention greatly. Hence, in addition to monitoring the designed programme output, the immediate reactions of the community or beneficiaries (audience) should also be tracked continually to provide feedback as quickly as possible.

It is not easy to monitor the programme's influence or impact on the audience; therefore, programme outputs are monitored instead. Output is the immediate result of the programme activities. For example, the programme output in terms of the number of meetings conducted or the number of brochures printed.

Without regular monitoring, there is ample scope for non-recognition of inadvertent errors and incorrect messaging, which never gets corrected and could immensely harm the programme objectives. Further, monitoring techniques need to be appropriate to the media involved. For example, radio and television broadcasts must be carefully followed to check whether public service announcements, especially paid advertisements, are aired as scheduled and that broadcast quality is acceptable.

The basic purpose of monitoring is to permit rapid modifications if they are needed to make the BCC programme more effective. For monitoring the programme, the "right" information is the key and not the "more" information. Collecting too much information for monitoring purposes rather clogs a monitoring system as excessive information keeps pouring in and slows down the analysis, not only obscuring conclusion but also defeating the very purpose of data monitoring wherein timeliness is crucial.

Examples of Monitoring of the BCC Programme

In the initial years (1990s) of the HIV/AIDS programme in India, the BCC intervention included wall paintings on HIV/AIDS, which tried to convey the severity of HIV/AIDS. One of the key messages was "AIDS is incurable" (*AIDS La-ilaz Hai*). The motive was well-intentioned, but the fear it conveyed probably led to a feeling of hopelessness. Based on the monitoring of outputs, the message was modified to "Protection is the only cure for AIDS" (*AIDS- Bachav Hi Eilaj Hai*). The modification addressed hopelessness and provided cues for taking ownership of one's health by practising safe behaviour.

Source: Based on Personal Communication with People Living with HIV in 2003-2004 by Neetu Purohit.

In Uganda, radio programme listeners noted their reactions after each episode of a weekly radio drama series and discussed them monthly with programme managers. As a result, producers responded to these comments/feedback by building future episodes around a popular character who was drawing a strong following, toning down characters not perceived to be impressive, simplifying the language used by the health provider and paying more attention to the continuity between episodes. It was due to regular monitoring that an incorrect suggestion about the availability of injectable contraceptives for men in the radio programme was spotted immediately. The error was corrected in a subsequent programme. After that, the Family Planning Association of Uganda (FPAU) became more vigilant about reviewing scripts before recording episodes.

Source: JHU/PCS, 1994, compiled by Neetu Purohit

In recent years, the term "participatory monitoring' has gained momentum. Since strategic communication emphasizes the involvement of all stakeholders, the engagement of beneficiaries for monitoring purposes is promoted. The importance of this concept lies in the fact that it brings in ownership of the behaviour change intervention by the beneficiaries- who are also part of the community and increases the possibility of sustainability lest the implementing agency withdraws due to any reason.

Monitoring is a continuous process of any BCC programme. However, it is not enough as it focuses on outputs. For the success of the BCC programme, outcome and impact are crucial. Therefore, evaluation is essential. Evaluation is the systematic application of scientific procedures to assess social interventions' conceptualization, design, implementation, impact, and cost-effectiveness (Bertrand & Kincaid, 1996). The evaluation aims to measure the process, outcomes, and impact of the BCC programme on the objectives. Evaluation also provides insights into the future of a programme for both implementers and donors in terms of sustainability, scalability, and policy implications. Evaluation, therefore, differs from monitoring in terms of timing and focus and level of details of outcomes and impact of the programme.

Example of evaluation of BCC programme

An impact assessment of street plays on Family Planning in Jharkhand, India, found that while monitoring the immediate reaction of people who witnessed street plays conveyed that the message via play was well-understood by the people and motivated them to use contraceptives, in the evaluation too, it was found relevant and while there was high recall value for the street play, its message and its characters, difference of only 4 per cent was found between people of experimental and control villages for use of contraceptives.

On investigation, it was found that one of the reasons was the lack of expected involvement of health service providers- who would provide contraceptives. Since the health services providers were not recognized as one of the key stakeholders in the bigger picture of health communication, the opportunity to convert the sensitized community into adopters of contraceptives was missed, and this failure was spotted only in the evaluation when the attempt was made to go beyond the process indicators and assess the outcome.

Source: Compiled by Neetu Purohit

Depending on the purpose of the evaluation, it can be conducted during the programme period or at the end of the programme period. It involves data collection at discrete points in time, e.g., before the programme implementation, during the implementation, and at the end of the implementation. Both monitoring and evaluation have an important role in the BCC programme.

Ethical Considerations in Behaviour Change Communication (BCC)

Behaviour Change Communication (BCC) is a powerful tool for promoting positive health behaviours and improving well-being. However, with this power comes the responsibility to use BCC ethically. Adherence to ethical principles ensures that the target audience is not exploited or manipulated and measures are taken to prevent and control unintended consequences.

Core Ethical Principles in BCC

We discuss ethical principles for public health practice that are essential to consider while designing, implementing, monitoring, and evaluating BCC interventions (Unger et al. 2020; WHO 2018).

- **The Principle of Autonomy:** BCC intervention must respect and protect the rights and dignity of participants. Individuals have the right to make their own choices about their health behaviours. BCC should empower individuals with knowledge and skills to make informed decisions, not coerce them into adopting specific behaviours.

- **The Principle of Beneficence:** This principle emphasizes doing good. BCC interventions aim to improve population health. They should also make a positive contribution to people's health but avoid causing unintended consequences or infringing on individual rights. For example, mandatory vaccinations can protect the community but raise ethical concerns about bodily autonomy.

- **The Principle of Non-maleficence:** This principle emphasizes avoiding harm. BCC interventions must not cause harm to the participants in particular or to people in general. They should be designed to minimize potential harm. This includes avoiding messages that could create stigma, discrimination, or anxiety. Piloting and evaluating interventions are crucial to identifying and addressing potential risks.

The Principle of Justice: This principle emphasizes fairness and equity in health promotion interventions' design, implementation, and impact. It ensures that BCC's benefits reach all intended populations while minimizing any potential risks or burdens and excluding any vulnerable or

marginalized groups. By adhering to ethical principles, we can ensure that BCC interventions are respectful and contribute to positive health outcomes for all.

Some practical considerations based on ethical principles

Based on the four ethical principles discussed, we have summarized key practical considerations while designing, implementing, monitoring and evaluating BCC interventions.[18,1]

Be truthful, fair and balanced: BCC messages should be evidence-based, designed and implemented fairly and avoid making exaggerated claims or using misleading information. Building trust with the community (target audience) is essential for long-term impact.

Focus on justice and equity: BCC interventions should be designed and implemented considering the diverse needs and vulnerabilities of different populations. This includes ensuring the message and programme resources are accessible to all intended audiences. Addressing these factors alongside behaviour change can create a more equitable environment for improving health outcomes.

Ensure confidentiality and protect privacy: Personal information should be maintained confidentially throughout the intervention. This includes obtaining explicit consent for data collection and storage and ensuring anonymization where appropriate. BCC initiatives must respect the privacy of participants.

Take informed consent: Individuals have the right to understand the nature and purpose of a BCC intervention before participating. This includes providing clear information about the potential risks and benefits, data collection methods, and how the information will be used.

Do not use offensive language: Be mindful of cultural sensitivities and avoid language or humour that could be hurtful or disrespectful. Consider the audience's background and beliefs to ensure the message is inclusive.

Some practical considerations based on ethical principles (cont.)

Ensure cultural sensitivity: BCC strategies and messages should be culturally sensitive and avoid perpetuating stereotypes or biases. Tailoring communication to specific cultural contexts is crucial for ensuring inclusivity and effectiveness.

Do more good than harm: The ultimate goal of BCC intervention is to create a positive impact. Be thoughtful about the potential consequences of activities within BCC intervention. Strive to promote well-being and avoid harmful consequences, including spreading misinformation or modelling inappropriate behaviour.

Favour-free choice: Let people feel empowered to make their own decisions. Provide information and guidance, but respect individual autonomy. Do not impose any decisions. The goal is to encourage healthy choices, not to dictate or impose any choice or decision.

Evaluate effectiveness: BCC interventions should be evaluated to assess their effectiveness and potential unintended consequences. Findings should be reported transparently, allowing for course correction and improvement in future BCC efforts.

Conclusion

BCC plays an essential role in creating awareness and developing health service providers' and beneficiaries' attitudes and skills. In this chapter, you read about the meaning, characteristics, importance, and BCC theories. It has delineated BCC strategies and the process of designing effective BCC interventions. The chapter describes the guidelines for successfully implementing and monitoring BCC intervention. This chapter also covers the ethical considerations for designing, implementing, monitoring, and evaluating BCC interventions.

Reflective Questions

1. You are tasked with developing a BCC campaign to promote HIV prevention among young adults in urban India. How would you apply BCC theories to design an effective intervention that addresses the specific needs and behaviours of this target group?

2. You are working on a BCC program to improve maternal and child health outcomes in a rural community. What BCC strategies would you use to address barriers to accessing antenatal care and immunization services in this context?

3. You are responsible for developing a BCC campaign to promote healthy lifestyles and prevent diabetes in the middle-aged population.

    - How would you tailor your BCC messages to address this age group's specific needs and concerns?

    - How would you measure the impact of the BCC campaign on diabetes risk factors and health outcomes?

4. What ethical considerations should be considered when designing and implementing BCC interventions for vulnerable populations like pregnant women and children?

References

Ahmed Agyapong et al. 2024. "Performance Outcome of Entrepreneurial Behavior of SMEs in a Developing Economy: The Role of International Mindset | Request PDF." *ResearchGate*, October. https://doi.org/10.1108/JSMA-07-2020-0173.

Ajzen, Icek. 1991. "The Theory of Planned Behavior." *Organizational Behavior and Human Decision Processes*, Theories of Cognitive Self-Regulation, 50 (2): 179–211. https://doi.org/10.1016/0749-5978(91)90020-T.

DiClemente, C. C., and S. O. Hughes. 1990. "Stages of Change Profiles in Outpatient Alcoholism Treatment." *Journal of Substance Abuse* 2 (2): 217–35. https://doi.org/10.1016/s0899-3289(05)80057-4.

Hagger, Martin S., and Nikos L. D. Chatzisarantis. 2014. "An Integrated Behavior Change Model for Physical Activity." *Exercise and Sport Sciences Reviews* 42 (2): 62–69. https://doi.org/10.1249/JES.0000000000000008.

Horter, Shona, Sarah Bernays, Zanele Thabede, Velibanti Dlamini, Bernhard Kerschberger, Munyaradzi Pasipamire, Barbara Rusch, and Alison Wringe. 2019. "'I Don't Want Them to Know': How Stigma Creates Dilemmas for Engagement with Treat-All HIV Care for People Living with HIV in Eswatini." *African Journal of AIDS Research: AJAR* 18 (1): 27–37. https://doi.org/10.2989/16085906.2018.1552163.

Janssen, Patricia A., Lee Saxell, Lesley A. Page, Michael C. Klein, Robert M. Liston, and Shoo K. Lee. 2009. "Outcomes of Planned Home Birth with Registered Midwife versus Planned Hospital Birth with Midwife or Physician." *CMAJ: Canadian Medical Association Journal = Journal de l'Association Medicale Canadienne* 181 (6–7): 377–83. https://doi.org/10.1503/cmaj.081869.

Marks, David, and Albert Bandura. 2002. "Social Foundations of Thought and Action." In , 94–106. 1 Oliver's Yard, 55 City Road, London EC1Y 1SP United Kingdom: SAGE Publications Ltd. https://doi.org/10.4135/9781446221129.n6.

Nguyen, Laurent Son, Denise Frauendorfer, Marianne Schmid Mast, and Daniel Gatica-Perez. 2014. "Hire Me: Computational Inference of Hirability in Employment Interviews Based on Nonverbal Behavior." *IEEE Transactions on Multimedia* 16 (4): 1018–31. https://doi.org/10.1109/TMM.2014.2307169.

Norman, P., Conner, M. 2005. "Predicting Health Behaviour: Research and Practice with Social Cognition Models." *Open University Press, Maidenhead.*

Pandya, Apurvakumar, Mythri K S, Shweta Mishra, and Kriti Bajaj. 2023. "Effectiveness of the QuitSure Smartphone App for Smoking Cessation: Findings of a Prospective Single Arm Trial." *JMIR Formative Research* 7 (December):e51658. https://doi.org/10.2196/51658.

Rogers, Everett M. 2004. "A Prospective and Retrospective Look at the Diffusion Model." *Journal of Health Communication* 9 Suppl 1:13–19. https://doi.org/10.1080/10810730490271449.

Rosenstock, Irwin M. 2005. "Why People Use Health Services." *The Milbank Quarterly* 83 (4): 10.1111/j.1468-0009.2005.00425.x. https://doi.org/10.1111/j.1468-0009.2005.00425.x.

Scarneo, Samantha E., Zachary Y. Kerr, Emily Kroshus, Johna K. Register-Mihalik, Yuri Hosokawa, Rebecca L. Stearns, Lindsay J. DiStefano, and Douglas J. Casa. 2019. "The Socioecological Framework: A Multifaceted Approach to Preventing Sport-Related Deaths in High School Sports." *Journal of Athletic Training* 54 (4): 356–60. https://doi.org/10.4085/1062-6050-173-18.

Suhaili, M., E. Hosein, Z. Mokhtar, Nyamah Ali, and K. Palmer. 2004. "Applying Communication-for-Behavioural-Impact (COMBI) in the Prevention and Control of Dengue in Johor Bahru, Johore, Malaysia." In . https://www.semanticscholar.org/paper/Applying-Communication-for-Behavioural-Impact-in-of-Suhaili-Hosein/22e46032c10000bb96144934aa9658030b52df9a.

Unger, Jean-Pierre, Ingrid Morales, Pierre De Paepe, and Michel Roland. 2020. "In Defence of a Single Body of Clinical and Public Health, Medical Ethics." *BMC Health Services Research* 20 (2): 1070. https://doi.org/10.1186/s12913-020-05887-y.

WHO. 2018. "WHO Guidance on Ethics for Health Promotion." https://www.who.int/health-topics/ethics-and-health.

Wingood, G, DiClemente, R. 2002. "The Theory of Gender and Power. Emerging Theories in Health Promotion Practice and Research: Strategies for Improving Public Health." In . chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/ https://tms.iau.ir/file/download/page/1575186246-emerging-theories-in-health-promotion-practice-and-research-.pdf.

Zunzunegui, María-Victoria, Beatriz E. Alvarado, Teodoro Del Ser, and Angel Otero. 2003. "Social Networks, Social Integration, and Social Engagement Determine Cognitive Decline in Community-Dwelling Spanish Older Adults." *The Journals of Gerontology Series B: Psychological Sciences and Social Sciences* 58 (2): S93–100.