Research Methods in Health Promotion

Prof. (Dr.) Madhumita Dobe
Chairperson,
Foundation for Actions and Innovations Towards Health Promotion

Week 09

Lecture 41: BCC and SBCC (Part I)

In our lectures on research methods in health promotion, we will now deal with two very important topics behavior change communication and social and behavior change communication very oft used oft applied, but let us see what it is in its proper sense. The concepts covered include what is behavior change communication, what then is the difference between what we have been using all through the IEC and the BCC which we are now talking about, identifying the emphasis behaviors for research and planning for implementation of BCC interventions or behavior change communication interventions. What then is behavior change communication? The very three words used in this is self-explanatory. It is a process of working with individuals or with communities or with societies and what do we do at the end of this work, what is the aim of behavior change communication? The process will develop communication strategies to promote positive behaviors appropriate to their settings. So, basically the aim is to promote positive behaviors, it might be related to health, might be related to other issues, but we choose strategies to implement them in order to promote positive behaviors. And here is where a very important aspect comes in, provide a supportive environment which will enable people to initiate and sustain positive behaviors.

Positive behaviors do not only happen by providing knowledge or by just by knowing, in that case as we always say that we have doctors who are smoking, we have nutritionists who are overweight, but they do have all the knowledge about the related risks, perhaps they require something more. They require a supportive environment just like the community, just by knowing they will not be able to bring about changes in their behaviors unless they have a supportive environment in terms of services, availability, access and affordability of buying into those positive behaviors. So, what is the difference between behavior change communication and information education and communication or IEC which we have been using all this while? For many they are all in the same, but it is not so. Our experience has shown that providing people with information and telling them how they should behave that is basically what we always try to do, we try to teach people that is not enough to bring about behavior change.

While of course, this is an important part providing information to help people to make a personal decision, the informed choice that is necessary, that is a very integral part of behavior change, but BCC recognizes that behavior is not only about having information and making a personal choice, it requires a supportive environment. So, the information part is there, we need to communicate effectively to provide the information to the community. So, information is important and what is education then? Education is a systematically planned process of conveying this information. So, it is not ad hoc, it is not suddenly this morning we decide to

go and do an awareness program to teach something to the community, those things will obviously fail to make a sustainable impact. But if it is systematically planned, the communication of appropriate information to the community is an integral part of behavior change communication, but behavior change communication has an additional component of supportive environment.

So, IEC is part of BCC and BCC builds on IEC, but the environmental part is an important determinant or influencer of actually adopting the changed behavior. So, that part has been taken care of now with BCC. So, let us look at some of the emphasis behaviors. Before we think of changing behaviors, we have to decide on which behaviors do I need to change. For all of us planning to do some BCC activities or interventions, we need to first identify which behaviors we are wanting to change.

I have given here a list of some emphasis behaviors in maternal and child health, might be related to reproductive health practices. Women of reproductive age need to practice family planning and seek antenatal care when they are pregnant. So, this might be one type of behaviors which I work on or could be like for all women of reproductive age delay the first pregnancy, practice birth spacing and limit family size. This can be another set of behaviors which I want to emphasize in my intervention. Third can be for all pregnant women seek antenatal care at least two times, now it can be at least four times during pregnancy.

This is prepared on the global level, but in India we will say at least four times during pregnancy. For all pregnant women take iron tablets, for Ani Mehmukh Bharat this is one emphasis behavior which we need to look into. For infant and young child feeding practices, the behavior of mothers to give age appropriate food and fluid that is one set of behaviors. So, for each issue we can and should first identify certain behaviors on which we will put our emphasis on. Similarly, exclusive breastfeeding for 6 months, then again 6 from 6 months appropriate complementary feeding and continuing breastfeeding till 24 months.

Immunization practices like infants with full course of vaccinations, women of child bearing age with tetanus vaccinations, then again measles immunization, immunization even when the child is sick and then pregnant women and women of child bearing age will also we have already spoken about tetanus, Toxide, HPV vaccination also can come in this category. So, now having chosen and having chosen a set of behaviors we then again have to prioritize, we cannot change everything at a go. So, we need to prioritize, we can consult the community all this while we have been talking about it that the community or the target audience needs to be taken into consultation to decide on the priorities. They can rank it with various methods of participatory tools and technique applications, we can find out what they feel and what we feel and come to a compromise as to what we will do. Next we need to plan for implementation of BCC interventions.

We are often doing it, but exactly it should also follow a definite steps and procedure and protocol. For example, during situational analysis of sanitation conducted in a Lahanga village in Orisha, it was found that majority that is 87 percent of the community who also have low literacy levels go for open defecation that is the behavioral diagnosis. So, the problem behavior is open defecation again amongst people who also have low literacy levels. Now many of them did not have any knowledge about the harmful effects of open defecation. So, this was lack of knowledge, the lack of knowledge was in the aspect of not knowing about the harmful effects of open defecation.

What was the other issue? Only 13 percent of households have access to toilet facility. So, this was the defect in the environment. Even if you wanted to give them if you gave them knowledge and they wanted to change their habits they do not have access, but only 10 percent of the families residing in these households had all family members. So, of these 13 percent who had toilet facilities of these only 10 percent had all family members using the toilet due to prevalent social norms which accepted males and children defecating in the open. So, again that was what we call in our educational diagnosis the reinforcing factors what is there in the society, what is accepted in the society does not appear to be a problematic issue at all.

So, and they had the fear that the pit would fill up fast again that is a problem because if the pit fills up fast you have to replace it that involves money. So, most of the households children feces were thrown in the paths or open areas outside the household premises because they feel that it is easier to make small children defecate in the open. Majority of the community again 93 percent felt that open defecation is a shameful act. So, you see they know, but people are not they said that they were not able to afford constructing a sanitary laterally. So, you see even despite having the knowledge sometimes even having the attitude that it is a shameful act we should not be doing it, but there are other factors which are preventing people from adopting this healthy behavior.

Behavioral change communication must address all these. Majority of the community members said that due to financial problems they could not construct sanitary laterings and most of them were not aware about the procedure you know sometimes there are government programs and these help which is afforded or accorded by the pantayats, but people do not even know about it. So, they are not aware about the procedures to avail the financial aids provided by the government to build sanitary latering. So, again that was an enabling factor. Most of the community members had knowledge about swachh bharat abhijan.

So, not that they did not know about it, but these were the deterrence. So, again trying to recapitulate and reiterate what I have been saying is that change of behavior is not brought about despite or in spite of having knowledge. So, we now have to do something. So, that these issues the barriers the factors in the environments can be taken care of the social environment the other environments of services and facilities that has to be taken care of. So, first to do this we make a list of the gaps.

So, what have we found? Majority still practice open defecation because of we just take example of the knowledge first. What are the knowledge gaps? The gaps are there is lack of knowledge about how open defecation contributes to transmission of diseases, lack of knowledge about how these diseases particularly affect the health and well being of children leading to under nutrition, lack of knowledge about incentives provided by the government to build sanitary later in. So, if I just pick up the knowledge gaps in the beginning these are the three major knowledge gaps which have been observed. For paucity of time I have not taken up the other issues of reinforcing factors enabling factors etcetera, but each can be addressed in the same manner we just have to follow the same pattern. Secondly having found out the gaps for all plans and programs we need to fix up objectives smart objectives they should be specific, they should be measurable, they should have a time etcetera.

So, now let us look at framing these objectives. So, the first one was knowledge, knowledge of course, has a smaller time span we can do it within a smaller time span changing a practice takes more time changing knowledge takes less time. So, by next three months at least 90 percent of the villagers shall know how open defecation contributes to transmission of diseases this addresses the first gap this objective. The second gap by next three months at least 90 percent of the villagers shall know how open defecation affects the health and well being of children leading to under nutrition because that was again another gap. The third gap by next two months because this is easier you can easily convey what incentives are provided by the government to build the sanitary laterings right.

So, this is what we have fixed up as objectives for our intervention. So, next part in the plan we will actually implement it and then plan for evaluation. So, before we come to further discussion I will just deal with the evaluation in the beginning because this will happen both during the process happen in the end and happen after our program ends as well. So, planning for evaluation of these BCC interventions includes both process evaluation the process during implementation has to be kept on supervised being supervised being monitored being evaluated. So, whether what has been planned is actually done what needs to be planned for each of these gaps sorry for each of these gaps actually we need to plan the entire communication process what we are doing here for knowledge is providing information.

So, what information we will provide we will not look for the standard messages again because they are already there and they are not addressing these gaps. So, we will have to formulate messages new messages about how open defecation is contributing to transmission of diseases. Remember we spoke about this audience being low literate. So, for a low literate audience you need to have more pictures. So, posters with pictures less words easily read easily interpreted.

So, these should be prepared and tested with these new messages right. We also need to plan who would convey these messages which are the opportunities will it be VHNDs will it be

every opportunity where these people interact in the health facilities will it be during household visits. So, these sorts of things need to be decided upon previously beforehand and then at the end conducted during this period of time which we have decided is 3 months 2 months etcetera. Now keep on evaluating it the formative evaluation is important because not always things are planned taking every ground situation or ground reality in mind. When you actually go and do it you might find that the worker is busy with any other program at that time they are filling up some other register they have to do some other survey.

So, it has not worked in that way. So, then you need to modify you need to again correct it and do it in a some in a different manner. So, that is why formative or process evaluation of BCC interventions is very very important. Second is summative evaluation for both outcome and impact. Now impact is actually whether we really this knowledge generation has brought about any change in behavioral or environmental factors which we are wanting to change like say after 12 months of intervention 50 percent of the villagers have given up open defecation that is the impact you had based on the knowledge or perhaps based on other interventions also which you did during this period.

Outcome evaluation sees whether the intervention really worked to bring about the outcomes identified in the objectives. We have made some smart objectives like after 3 months of intervention 90 percent will know how to how open defecation contributes to transmission of diseases. So, after our baseline we conduct another survey to see whether at all this knowledge has improved to the desired level which we had planned before. So, outcome we can do immediately after our intervention that is after 3 months. Some of the outcomes and impact may not be apparent for a long time some things take time to change like lifestyle changes made by young people to prevent non communicable diseases not as easy as stopping open defecation building a sanitary latrine and starting to going to the toilet inside the house.

This will require much more complex issues much more motivation much more commitment to change. So, for instance usually these changes daily physical exercise, healthy or dietary practices, giving up tobacco, giving up alcohol these will not reveal the health benefits until people are well into middle age. So, when we do not see tangible benefits right then it is not like clinical cure you give a medicine and you get the effect immediately. So, it has to be patiently done it has it will take time. So, plan accordingly depending upon the issue the impact has to be seen the outcome has to be seen and that has to be remembered while planning.

I have given some examples of what people did for behavior change interventions. The first one is mobilizing demand for titanic stock so it in Pakistan. Now at a time in Pakistan 80 percent of the births were taking place at home and without skilled attendance. In 1999 only about half of women of childbearing age were immunized against tetanus. In that year 22000 newborns died from titanus.

So, this was an emphasis behavior they had to take tetanus stock so it. What were the barriers and what they thought about reducing the barriers? The government was initially providing TT vaccination through antenatal services. However it was clear that the approach was not meeting the needs of the women in that largely traditional culture. Pardha is there people do not come out very easily at least at that point of time. The ministry of health UNICEF WHO JICA and SNL they developed a campaign approach that involved home visits by lady health workers who were more acceptable to the women than male vaccinators.

They had male vaccinators as well but people did not take the vaccine from them. So, the program still faced a number of barriers. One of the primary ones was suspicions about a connection that this vaccine is actually meant for birth control. Particularly because the campaign targeted unmarried women and married women both who were not pregnant as well as those who were. So, people started asking questions if this is good for the newborn child or during pregnancy why are unmarried and married non pregnant also being addressed.

So, and the second issue was the multiple audiences. A multi level campaign strategy focused on creating national awareness and acceptance for vaccination at the community level. So, the barriers as you are well aware is not only about lack of knowledge it is about misperceptions miscommunication etcetera. Focal audiences were fathers and husbands because they were the decision makers, mothers in law community and the religious leaders and teachers. So, your target audiences while planning have to be selected accordingly.

Just prior to the campaign in each district local mosques promoted acceptance of the vaccinators. Vaccinators were motivated with a short docudrama which was also aired on the national TV and the results ultimately were very good. More than 80 percent of the 5 million women in the target group received 3 doses of the vaccine. So, you can see it was not just knowledge dissemination, it was motivation, it was stimulation of a lot of discussion among different levels, it was targeted towards not only the primary audience of women it was also amongst the decision makers and the influencers of women's practices.

So, that is how they went about doing it. This is another example birth preparation. So, delivery skilled attendant and referral facility this is something which they looked into in Nepal. The family also needs a plan for transportation which means saving money and receiving support from the community to identify a vehicle. So, what they did this was found to vary greatly, this behavior was found to vary greatly from program to program. In Nepal 11 percent of these women were delivering entirely by themselves, 89 percent were delivering at home and 78 percent were without skilled attendants.

A major focus therefore, in that country was to plan for a hygienic delivery. Safe delivery kits were provided, but in the survey which they did 80 percent were not familiar with them and only 8 percent had used one. So, they undertook a social marketing campaign again a different

communication strategy to promote use of the delivery kits. Preparing in Palestine in some countries planning for an emergency is considered bad luck you know they do not talk about this because they say if you talk about it will happen.

So, this is a major barrier. In the West Bank however, mothers were encouraged to view emergencies as the norm. Women often deliver en route to a facility because of roadblocks, border delays, always the areas in conflict. Positive deviance research was done and it uncovered the fact that women who do some advance planning are better able to protect their infants. So, mothers were encouraged to stay with well located friends or relatives as birth approaches. So, that the distance to the facility can be shortened.

The program has also created materials to help women discuss with her families what to do in case of emergency. So, that is how you can use communication different strategies different information as per needs of the needs and context. This was another example the challenges of feeding messages. A USAID program in Gambia addressed the problem of wasting following chronic diarrhea in the rainy season. So, what did they find when they did the research? It found feeding messages much more difficult to convey than messages about rehydration.

Feeding means feeding during illness. So, people were accepting the messages about rehydration, but not really paying any attention to feeding during illness. So, you see what again is emphasized is please do not think about the standard posters and messages which are available. This gives you an opportunity to look into what are the gaps and your information the messages which you disseminate should be based on those gaps. So, non literate mothers who had no access to ORS were able to learn and give the recipe for a home mixed water sugar salt solution, but did not accept the nutritional changes during a child's illness. And after the first year 66 percent of rural women interviewed could recite the formula of SSS or what is ORS in there in Gambia and 47 percent reported using it, but only 21 percent had adopted the give solid foods during after diarrhea message.

So, something was going wrong something was not allowing this adoption. So, what did they do? They revised the messages. In the second year the communication program made feeding messages more specific and differentiated between feeding during illness and during recuperation. So, the new messages acknowledge that it is difficult to feed solid food when the children have no appetite. They focused on giving frequent feeds, small amounts of frequent feed.

They emphasized on energy rich dishes added the few simple ingredients to the increase the calories and protein and solid foods were given as a source of power and weight gain. So, it is how you position your messages. So, they also developed a slogan when your baby is recovering from diarrhea give him solid foods to restore his power. So, new result was that

the number of children not fed solids or liquids dropped from 31 percent to only 10 to 16 percent.

So, you see that these are examples of how we can do it. Similarly, there are messages which can be derived about malaria. Similarly, they did gaps they modified messages and that has given good responses. Then the similar thing was found for ARI. Language is vital in those messages that was the gap which they found the language the way in which it was spoken. So, these are some examples which you can go through later, but health behavior practice we have to actually remember that not all health programs and initiatives become clearly equally successful.

Those which are more successful are based on a clear understanding of targeted health behavior. So, we have been talking about it emphasize on the behaviors you want to change target them and look into the environmental contexts in which they occur because that is a critical thing and in the program planning process. So, if we really look into it behavior change communication is a process. Remember it is a process it is not a one point thing.

It is a process of working with different groups. It can be with individuals, it can be with communities, it can be with societies. It involves developing strategies or approaches and that again depends upon what we find in our formative research. So, we need to find out we need to find out the gaps and from that the strategy the messages and others have to be planned not only for giving information, but also to provide supportive environment. Information is an integral part of BCC, but BCC also has to provide supportive environments in some way or the other. It is again reiterated that before embarking into such interventions identify the emphasis behaviors through formative research and identify the gaps frame objectives accordingly plan interventions accordingly.

So, these are some of the references, but I would say read them do them the more you do it the better skilled you become and you would find wonderful results if you do it as per rules and as per procedures. Thank you very much.