



Republic of Zambia
Ministry of Health

Community Behaviour Change Communication Framework

2011 – 2015

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DISCLAIMER

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List of Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal care
ART	Antiretroviral therapy
BCC	Behaviour change communication
CATF	Community AIDS Task Force
CDC	Center for Disease and Control Prevention
CIDRZ	Center for Infectious Disease Research in Zambia
CH	Community Health
CHAZ	Churches Health Association of Zambia
NHPO	National Health Promotion Office
CSH	Communication Support for Health
DACA	District AIDS Coordinating Advisor
EHA	Essential Health Action
FP	Family planning
HCAC	Health Center Advisory Committee
HIV	Human immunodeficiency virus
HPFP	Health Promotion Focal Person
HPU	Health Promotion Unit
IEC	Information, education and communication
IECTWG	Information, Education and Communication Technical Working Group
IPT	Intermittent preventive treatment for malaria in pregnancy
IRS	Indoor Residual Spraying
ITN	Insecticide treated mosquito net
JICA	Japan International Cooperation Agency
MAMaZ	Mobilising Access to Maternal Health Services in Zambia
MACEPA	Malaria Control and Evaluation Partnership in Africa
M&E	Monitoring & Evaluation
MOH	Ministry of Health
NAC	National AIDs Council
NFNC	National Food and Nutrition Commission
NGO	Non-Governmental Organization
NHC	Neighborhood Health Committee
PACA	Provincial AIDS Coordinating Advisor
PMTCT	Prevention of mother-to-child transmission of HIV
SBCC	Social and Behaviour Change Communication
SFH	Society For family Health
SHPO	Senior Health Promotion Officer
SMAGs	Safe Motherhood Action Groups
TB	Tuberculosis
TBA	Traditional birth Attendants
TWG	Technical Working Group
ZCCP	Zambia Center for Communication Program
ZISSP	Zambia Integrated Systems Strengthening Program

Executive Summary

The Community BCC Framework is intended to guide MOH personnel and partner organisations to coordinate the implementation of decentralised, integrated, community-based BCC efforts in Zambia with the aim of improving health outcomes in the areas of HIV/AIDS, family planning, maternal and neonatal health, child health, nutrition and malaria. Further, it intends to provide guidance on how BCC planning can be decentralized within the Ministry of Health at the district, health facility and community levels.

The Community BCC framework is based on a review of existing research, health communication strategies and communication assessments. The framework is guided by the Johns Hopkins University Center for Communication Programs “PATHWAYS” model. This framework was developed in collaboration with other partners working on BCC at the community level to ensure harmonization and synergy of efforts. It is hoped that the involvement of stakeholders in the development of the framework will ensure harmonization and coordination of BCC efforts to reduce duplication, use available resources more effectively and ensure interventions have the greatest impact. MOH Health Promotion Officers, District Health Promotion Focal Persons and health communication representatives from organisations implementing health communication efforts in Zambia developed this framework.

The framework seeks to address the following gaps in community BCC services.

- Lack of coordinated BCC efforts
- Lack of decentralized BCC planning at district and community level
- Lack of harmonization and synergy of efforts among stakeholders

The Government of Zambia has developed health communication strategies to promote Essential Health Actions (EHA) designed to improve maternal, neonatal and child health, malaria control, HIV/AIDS prevention care and treatment, and nutrition. Unfortunately, these strategies have not been implemented by most communities in Zambia.

The Community BCC Framework outlines how the existing health system can implement health communication strategies at community level to improve access to health information, uptake of health services and practices, and improved health indicators among rural and peri-urban Zambians.

The framework aims to build capacity of Health Promotions Officers (HPO), Districts Promotions Focal Persons (DPFP), Health Center Advisory Committee (HCAC), Neighborhood Health Committee (NHC) and the establishment of the Social Behaviour Change Communication Committee (SBCCC).

Recommendations

Recommendations are provided within the document on how to operationalize the BCC strategy. Within the first year, priority has been given to capacity building efforts including orientating of Health Promotions Officers and implementing partners on the Basics of the BCC framework. Further it is recommended that the district level Social Behavior Change Communication coordinating committees need to be established.

1.0 Introduction & Background

The Community Behaviour Change Communication (BCC) Framework reflects the outputs of a four-day workshop held in Chisamba in November, 2011, under the direction of the Ministry of Health (MOH) and the Zambia Integrated Systems Strengthening Project (ZISSP). MOH Health Promotion Officers, District Health Promotion Focal Persons and health communication representatives from implementing partners in Zambia developed this framework based on a review of research, existing health communication strategies and communication assessments.

In this document, the terms health promotion, health communication, and behavior change communication are used interchangeably to mean the strategic use of communication to promote positive health outcomes, based on proven theories and models of behavior change. Regardless of the term used, it involves a process of analysis and design, followed by development and testing of materials and approaches; implementation and monitoring; and evaluation and re-planning. To be effective, BCC actively engages and also equips with the skills needed to make the change, influence, and also strengthens the capacity of actors in socio-political, service delivery, community and household.

This framework is intended to guide MOH personnel and partner organisations to coordinate the implementation of decentralised, integrated, community-based BCC efforts in Zambia in order to improve health outcomes in the areas of HIV/AIDS, family planning, maternal and neonatal health, child health, nutrition and malaria. The framework seeks to address the following gaps in community BCC services – (1) Lack of coordinated BCC efforts (2) Lack of decentralized BCC planning at district and community level (3) Inadequate harmonization of efforts among stakeholders.

The BCC framework provides a common approach that everyone working at the district and community levels can use, in that, it would provide a road map on “how to” translate National Strategy to local level and to harmonize efforts. It will also act as a tool to establish a Social Behaviour Change Communication Coordinating Committee at district and community level. It will further guide implementing partners in cascading national level information to the community while reflecting district level realities. It is envisioned that the framework will be used as an instrument to identify gaps and further provide steps to evaluating Social Behavior Change Communication (S/BCC) at district and community level.

2.0 Health Situation in Zambia

Current evidence suggests that Zambia has recorded considerable gains in health outcomes since 1990. Among others: under-five mortality rate dropped by 38 percent between 1992 and 2007 with an average annual reduction of 2.3 percent; and maternal mortality also decreased by 31 percent between 1996 and 2007 with an average annual reduction of 2.6 percent (MoH/CSO,

2007). Despite these achievements, health indicators are still poor with under-five mortality rate of 119 per 1,000 live births, and maternal mortality ratio of 591 per 100,000 live births (MOH and World Bank, 2010)

Malnutrition underlies up to 52 percent of all deaths among under- five year olds in Zambia. Stunting among under-five year old children stands at 45 percent, while 5 percentages are acutely malnourished (wasted), and 15 percent are underweight.

Malaria is still a key driver of morbidity and mortality in Zambia. In 2009, 3.2 million cases of malaria (confirmed and unconfirmed) were reported countrywide, contributing to approximately 4,000 deaths. While the annual malaria incidence dropped from an estimated 252 to 246 per 1,000 people between 2008 and 2009, malaria continues to account for over 40 percent of all health facility visitations in Zambia and the disease poses a severe social and economic burden on communities living in endemic areas.

National adult (15 - 49 year olds) HIV prevalence was estimated at 16 percent in 2002 (MoH/CSO, 2007), but recent estimates suggest a gradual reduction to a prevalence of 14.3 percent as of 2007. Females (16.1 percent) are more likely to be HIV positive than males (12.3 percent) due to biological, economic and social factors. Urban-rural differentials exist and urban areas have higher prevalence (20 percent) than rural areas (10 percent) (MOH, 2011).

The contraceptive prevalence in Zambia is admittedly low at 30 percent while 70 percent of women are not currently using any contraceptive despite high knowledge levels of 97 percent for women and 99 percent for men. According to the 2007 Zambia Demographic & Health Survey (ZDHS), current use of any contraceptive method among women increased from 12 percent in 1992 to 30 percent in 2007. Further, the contraceptive prevalence rate for modern contraceptives methods increased from 7 percent in 1992 to 25 percent in 2007. Currently Zambia has a Total Fertility Rate (TFR) of 6.2 births, meaning that on average, at the end of a woman's childbearing years, a Zambian woman will have given birth to 6.2 children. This marks a slightest increase from a TFR of 5.6 children in 2001/2002. Zambia has the second highest TFR in sub Saharan Africa, after Uganda with a TFR of 6.7.

Zambia's rural areas have much higher TFR than urban areas (7.5 and 4.3 respectively). Age specific fertility also shows the same pattern when delineated along rural-urban parameters. The ZDHS states that "the largest variations are in age groups 20-24 and 25-29 in which the rates among rural women exceed 300 births per thousand women, compared with urban rates of 201 and 190 births per thousand women respectively" (ZDHS, 2007).

While knowledge of Family Planning (FP) has not yet translated into increased use of contraceptives, the ZDHS identifies three main reasons for this. The first is that currently married women are not using a contraceptive method or do not intend to use one in the future. The biggest reason women

do not intend to use a method in the future is fertility-related, at 55 percent. The second largest category is women who do not intend to use a contraceptive for method-related reasons (26 percent) and the third category comprises of women who are not willing to use a contraceptive because of the respondent's or other people's opposition to the use of contraception (11 percent).

As in most developing countries, rural residents, and those who are less educated and of lower socioeconomic status are disadvantaged in terms of access to health information and services. With the exception of HIV prevalence, rural residents also have poorer health indicators than urban residents (Yingying, 2010).

3.0 Current status of health promotion and BCC in Zambia

Health promotion is coordinated through Health Promotion Unit (HPU) at the Ministry of Health. The Health Promotion Unit at MOH is responsible for coordinating the implementation of health promotion through health education, information, and communication programs and putting in place mechanisms for inter-sectorial collaboration and community participation and empowerment. It has the mandate to provide direction and guidance in the areas of health promotion. It is also responsible for developing health promotion policies, (currently, Zambia has no Health Promotion Policy in place but has recently developed health promotion guidelines) national health promotion strategies, capacity building for implementation of health promotion, development of guidelines and standards for health promotion, research, monitoring and evaluation of health promotion in the country. At Provincial level, the function of health promotion falls under the Senior Health Promotion Officer while at the district level the Health Promotion Focal Point Person is tasked to oversee this function.

3.1 Health Promotion Functions and structure in Zambia

The Health Promotion Unit is an integral constituent of the Ministry of Health, mainly responsible for the production and dissemination of materials and information to promote awareness to the public on the various interventions the Ministry embarks on as it delivers health services. The Unit therefore plays a facilitative role in public dissemination of information on important Health Priorities especially in the era of HIV/AIDS.

The objective is to provide efficient and effective health education and promotion, in order to empower individuals, families and communities with appropriate knowledge to develop and practice healthy lifestyles (MoH, 2011).

Therefore, the health promotion unit is involved in:

- Broad communication strategy development.
- Mobilisation for Community Action.
- Mass media information and material development.
- Coordination of all IEC/BCC activities in the country.

- Planning events for Special National/international Health Commemoration Days.
- Capacity building and training in IEC/BCC.
- Creation of supportive environments.
- Advocacy for healthy public policies.

3.1.1 Central level

Health promotion initiatives in Zambia are structured along three main tiers, comprising the central, provincial and district level. The National Health Promotion Unit (NHPU) at the Ministry of Health has a mandate to coordinate the implementation of health promotion through health education, information, and communication programmes in Zambia. The unit is tasked with the responsibility of developing health promotion policies, national health promotion strategies, capacity building for implementation of health promotion, development of guidelines and standards for health promotion, research, monitoring and evaluation of health promotion and advocacy for health public policy. The NHPU is headed by the Chief Health Promotion Officer.

3.1.2 Provincial level

At provincial level, the function of health promotion falls under the Senior Health Promotion Officer (SHPO). The Senior Health Promotions Officer (SHPO) works as the link between the Central level and District Level. Currently, the SHPO position in all provinces is fully staffed with qualified personnel.

3.1.3 District level

The district is the most critical level in the delivery of the health promotion/BCC interventions, in that the districts acts as a link between policy guidelines, interventions, and the actual beneficiaries. The actual implementation of health promotion activities also occur at this level. The challenge is that the position of District Health Promotion Focal Person in most districts does not exist or is not full time and are officially employed to perform other duties besides health promotions. Further, there is no specific budget line for health promotion/BCC activities at provincial, district, and or health facility levels because health promotion is viewed as a cross cutting issue and is catered for within the budgets for specific program areas. The non-availability of full time staff significantly places the district at a disadvantage in that the cross cutting budget and lack of designated personnel poses challenges in the implementation of BCC programs.

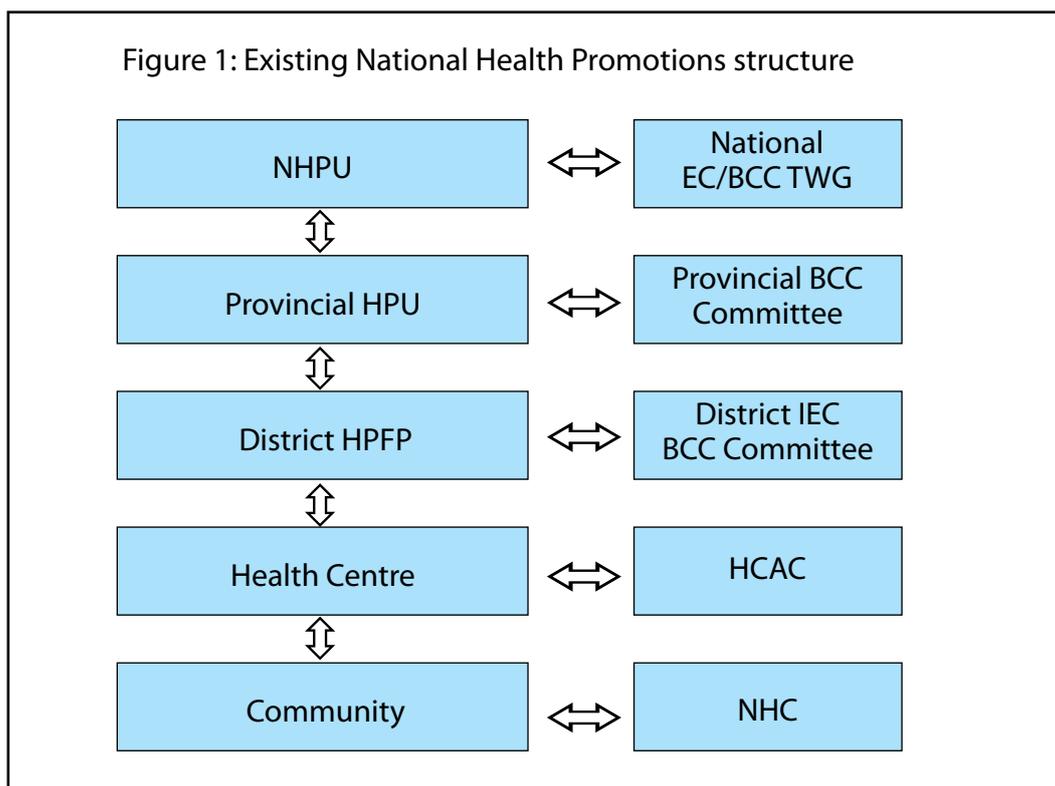
This framework is recommending the formation of the Social Behavior Communication Coordinating Committee (SBCCC) at the district level that will be tasked to coordinate these activities. Coordination is fundamental in ensuring that there are no overlapping and contradictory messages at district and community level.

3.1.4 Health Center level

Health promotion at health centre level is overseen by the Health Centre In-charge. The implementation structure for health promotion is coordinated by any person designated by the Health Centre in-charge, this could be an Environmental Health officer or any health care provider directed to implement health promotion. The health centre acts as the direct link between the district health office/BCC committee and the community level through the Health center Advisory committee and the Neighborhood Health committees (NHCs).

3.1.5 Community level

At community level, existing structures that include NHCs, comprising (volunteers, community health Assistants/workers, lay counselors, and/or members of Safe Motherhood Action Groups (SMAGs)). These community volunteers under NHCs are supervised by health workers at the local health center. Each health center elects a Health Center Advisory Committee (HCAC) from various NHCs in the catchment area. The Health Center (HC) acts as the secretariat. The HCAC acts as a



link to the health center with the aim of representing the interests of the community through the members of NHCs who are identified from the various zones in the health center catchment areas. The HCAC is expected to play an advisory role to the health center. However, very few members of the NHCs are trained to develop BCC plans, there is a need for members to be oriented or trained to enable them implement community BCC activities.

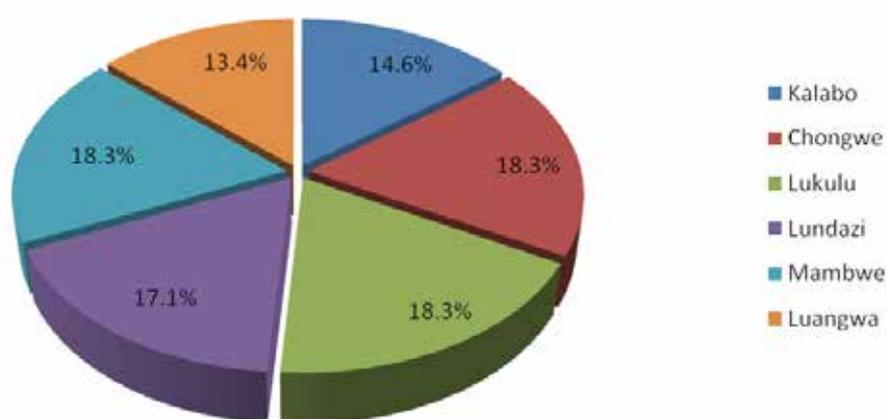
3.2 Stakeholder Analysis

There are several stakeholders implementing BCC activities in Zambia. These stakeholders are involved in the funding, production, material provision, distribution/dissemination of BCC materials. The majority of stakeholders are involved in the promotion of BCC on HIV/AIDS. The stakeholders include: Center for Infectious Disease Research in Zambia (CIDRZ), ZISSP, and Society for Family Health (SFH), World Health Organization (WHO) and Center for Disease and Control Prevention (CDC) in the five thematic areas of HIV/AIDS, Maternal and neonatal health, Child Health, Nutrition and family planning.

3.3. Results from inventory of IEC/BCC materials conducted

The Ministry of Health with support from ZISSP conducted an inventory of BCC and IEC materials in three provinces namely, Lusaka, Eastern and Western. Within these provinces two districts were sampled (Chongwe, Luangwa, Lundazi, Mambwe, Kalabo and Lukulu). The Analysis of Behaviour Change Communication (BCC) Materials in selected districts of Zambia study revealed that Chongwe, Lukulu and Mambwe had more partners involved in the production and distribution of materials compared to the rest of the sampled districts. The study shows that most communication materials are designed centrally, with little or no involvement of the intended audiences, and is often implemented by partner organizations which often do not coordinate their activities with the District Health Offices.

Figure 2: Distribution of Partners/Stakeholders Involved in the Distribution of BCC Materials by District



Source: Analysis of Behaviour Change Communication Materials (BCC) in selected districts of Zambia, 2012

Most of the Materials collected were on HIV/AIDS followed by Malaria while Nutrition was the least. A total number of 135 BCC materials were collected from the study districts. Most of the materials collected were from Mambwe at 20.7 percent (28) followed by Chongwe representing 20 percent (27). There were no IEC/BCC materials recorded in Mongu as all the materials were distributed to the districts.

3.4 BCC Materials at Community Level

The “Analysis of Behaviour Change Communication (BCC) Materials in selected districts of Zambia study, (2012) reported that none of the communities within the Health Center Catchment visited had visible IEC/BCC materials. Communities were only exposed to IEC /BCC materials in the event of an outbreak or when one visited a Health Center.

4.0 Problem statement

Lack of decentralized planning of BCC activities at district and community level, lack of coordinated BCC efforts and lack of harmonization and synergy among stakeholders and an imbalance in access of health information

5.0 Overall Vision

Communities empowered with knowledge and skills to adopt and maintain positive health behaviors and lifestyles.

5.1 Guiding Principles for the Framework:

FOCUSED

Communication will be focused on promoting the most essential health actions among (EHA) priority audience groups

COMMUNITY PARTICIPATION

The framework will be implemented through genuine community participation

- Implementation will be monitored and evaluated

OPERATION

Community BCC will engage the involvement of extension workers and staff from health as well as other sectors (e.g. agriculture, education, gender e.tc).

- The framework will work through existing structures to the extent possible

RESOURCES

Empower communities to draw on their local resources

CAPACITY STRENGTHENING

Capacity strengthening will be at its center;

- Communication will be audience centered, based on an understanding of the people it is trying to influence and tailored to their unique situation.
- The framework will empower communities to draw on their own resources to communicate about healthy practices.
- It seeks to **coordinate** communication across partners.
- Interventions and materials will be designed to **promote dialogue** about priority health issues, rather than simply telling people what to do.

6.0 Conceptual Framework for the Community BCC framework

6.1 Pathways for Community Health

Several models of behaviour and behaviour change exist; however this framework utilized one important model called the “**Pathways model**” in guiding the development of the community BCC framework. The Pathways model provides a suitable and well-rounded framework in developing interventions at different levels.

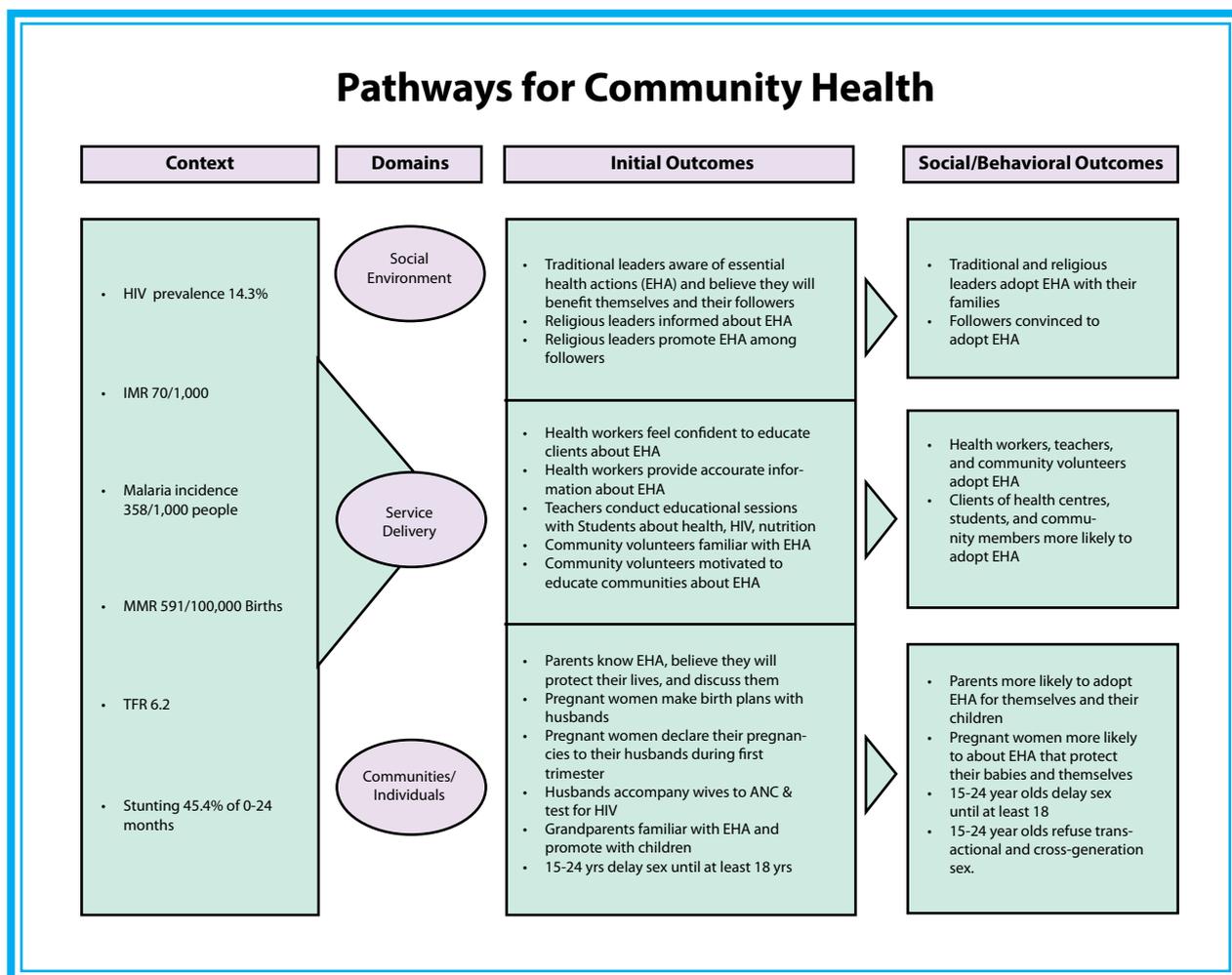
The **Pathways** model developed by Johns Hopkins Bloomberg School of Public Health Center for Communication Program (CCP) for Community Health amplifies the scope of BCC in that in the development of the interventions, it embraces a supportive environment taking into consideration behaviours at the individual and community levels. The Pathways model is based on a socio-ecological model of behavioral adoption and maintenance which recognizes four domains of influence on health behavior: socio-political, service delivery, community, and individual.

According to this theoretical model, in order for an individual to take action, communication must address barriers at multiple domains. For example, sometimes policies and laws need to be changed in order for individuals to adopt new practices (socio-political domain). In other cases, services are not provided in a manner that promotes uptake and communication must address these issues to influence behavioral adoption (service delivery domain). In many cases, social norms at the community level reinforce the status quo, and must be addressed for individuals to adopt new practices (community domain).

At the individual level, lack of information, or incorrect information as well as negative attitudes toward health practices must be addressed in order for behavior change to occur (individual domain). This model states that, individuals’ decisions to adopt new behaviour are influenced not only by their own knowledge, attitudes, beliefs and intentions, but also by the social networks or communities they belong to, the accessibility and quality of social services available to them,

and the policies, laws, and media environment surrounding them. All these are influenced by their social context. The model shown below depicts the Pathways to Community Health model adopted for Zambia.

Figure 4 Pathways for Community Health Model:



7.0 The Strategic framework

The strategic framework has outlined the priority audiences, the actual behaviours of these audiences, key barriers affecting their adoption of EHAs, communication objectives required to design communication materials, desired behaviours and communication channels.

This framework critically defines Essential Health Actions (desired behaviour) recommended by MOH. The framework will lead to harmonized field approaches that result in greater progress, synergies and health impact. Therefore, in order to harmonize community approaches and messages with each of these priority audiences for structures at the community such as Neighborhood Health Committees (NHCs) and other community resource persons, the framework has outlined the Essential Health Actions (EHA) in the matrix as Appendix 2

7.1 Priority Audiences

For each priority audience, the framework defines the essential health actions (desired behavior) recommended by the MoH, and some are based on research, as well as the practices that are the current norm among each audience (actual behavior). It also identifies key barriers to adoption of essential health actions, and priority communication objectives. The framework also identifies potential communication channels for reaching each audience.

The priority audiences for each domain and the desired behavioral outcomes have been highlighted in this document. Further these priority audiences have been linked to communication objectives, and potential communication channels for use. To impact behaviour change at all levels, the framework will focus at all levels of care from the health center to family and community level. In operationalizing the pathway, each domain within the framework identifies priority audiences. The priority audiences for each domain have been tabulated in table 1 below.

Table 1: Priority Audiences for each domain

Socio-political	Service Delivery	Community & Individual
Traditional leaders	Health Workers	Women of childbearing age (includes pregnant women and mothers of under-5 year olds)
Religious leaders	Teachers	Men of childbearing age (includes partners of pregnant women and fathers of under-5 year olds)
	Community Health Volunteers	Sexually active young people 15 – 24 years old
		Children 10 – 14 year olds
		Grandparents
	Community counselors	

7.2 Essential Health Actions for Individual Domain Audiences

This framework highlights Essential Health Actions for each of the four individual domain audiences. The individual domain audiences are important because they are the entities directly responsible for the health of the individual and families. These Essential Health Actions should be the focus of discussion to influence specific domain audiences in adopting, promoting and maintaining them. These EHA have been drawn from national communication strategies for malaria control, safe motherhood, HIV/AIDS, nutrition, and maternal, neonatal and child health (MNCH). Table 2 below shows priority audiences and Essential Health Actions

Table 2: Priority Audience and Essential Health Actions

Priority Audiences	Essential Health Actions
Parents of under-five year olds	<ul style="list-style-type: none"> • Begin breastfeeding immediately after birth • Breastfeed exclusively for the first 6 months • Introduce soft foods in addition to breast milk when a baby is 6 months old • Give child soft foods in addition to breast milk at least 3 times each day • Breastfeed the child until he/she is 2 years old • Continue to feed the child even when he/she is sick • Ensure the child sleeps under an ITN • If the child has fever, take the child to a health worker for malaria test immediately • Ensure child is fully immunized before age of 1 and receives Vitamin A and deworming tablets 2 times each year • Use modern family planning to space pregnancies at least 2 years apart
Pregnant women & their husbands/partners	<ul style="list-style-type: none"> • Begin ANC before 16 weeks of gestation • Attend ANC at least 4 times during each pregnancy • Sleep under ITN and take IPT three times during pregnancy • Test for HIV together with your partner and follow PMTCT guidelines if you are HIV positive • Prevent HIV infection by remaining faithful to one partner, testing for HIV together with one's partner, and using condoms • Prepare a birth plan • Deliver at a health facility • Attend post natal care within 2 days of delivery • Start a modern FP method soon after delivery
Children 5 – 14 years old	<ul style="list-style-type: none"> • Eat 3 meals each day that include a variety of foods • Sleep under ITNs • Wash your hands with soap and water after using the toilet and before eating • Abstain from sex until you are at least 18 years old • Age appropriate information about sex, pregnancy, condoms, and STI prevention
Sexually active youth 15 – 24 years old	<ul style="list-style-type: none"> • Abstain from sex until you have one mutually faithful partner • Delay sex debut • Use condoms • Stick to one sexual partner who does not have other sexual partners • Get tested for HIV together with your partner and agree on a risk reduction plan • Refuse to accept or give gifts, favors, or money in exchange for sex • Drink alcohol responsibly or not at all • Eat 3 meals each day that include a variety of foods • Sleep under an ITN

8.0 Barriers to adoption and maintenance of essential health actions

Barriers to adoption and maintenance of essential health practices may be environmental, attitudinal, cultural, or cognitive. Awareness of desired health practices does not ensure that people will embrace them. BCC objectives, therefore, usually focus on addressing key barriers to adoption of desired health practices, rather than focusing on the desired health practices themselves. For example, the vast majority of men and women in Zambia know that the MOH recommends women to deliver their babies at a health facility by a skilled health attendant. Yet, many continue to deliver at home with the assistance of untrained family or community members. This is a typical example highlighting how knowledge alone does not change behaviour. In order to change that behavior, BCC needs to address the reasons why women continue delivering at home. So, the objective of BCC is to promote institutional deliveries and focus on removing women's perceived barriers to delivering at health facilities.

There are several common barriers to adoption of the essential health actions by the four priority audiences.

1. Lack of trust in the efficacy of desired health practices. Both men and women often do not believe that the health practices promoted by the MoH are effective.
2. Belief that they are not vulnerable to health risks. Many men and women think that negative health outcomes will not happen to them.
3. Belief that there is little they can do to influence their health. Many men and women think that they cannot change the course of events. They believe that sickness and health are determined by God or fate, not themselves.
4. Poor communication between couples. This is particularly the case with reproductive health and HIV. Men and women rarely discuss these issues openly with their partners. One of the reasons could be that couples may feel uncomfortable to discuss certain issues due to sensitivity of the topic in question.
5. Gender norms that dictate how men and women should behave can undermine adoption of essential health practices. For example, men are expected to prove their virility by having many sexual partners and fathering many children, and women are expected to express their femininity by being submissive to their partners and bearing as many children as possible. These norms contribute to the spread of STIs including HIV.
6. Cultural and social norms for example the belief that the new born baby should not be taken out of the house until after a month despite the need for the mother to take the new born for post natal review.
7. Lack of access to information and advice about health issues. Men and women, particularly young people, continue to get their health advice from family and friends who are no more knowledgeable than they are. Information is also lacking due to long distances to health facilities and lack of appropriate materials
8. Distance and lack of transport to health facilities

Consequently, many of the communication objectives for priority audiences focus on building self-efficacy, trust in the efficacy of health actions, challenging gender norms and feelings of invulnerability. For a more detailed analysis of key barriers to adoption of the essential health actions, see the tables in Appendix 2.

9.0 Guidance on community BCC, Coordination, planning, implementation, monitoring and evaluation

This section describes the means for coordinating, planning, implementing, monitoring and evaluation of community BCC. In summary, the recommendation is that Neighborhood Health Committees will be trained to facilitate a community-based process of developing and implementing BCC workplans based on priority health problems. This planning will be coordinated with the annual planning cycle so that community BCC plans become part of the annual health plans for the districts. With assistance from the Health Center Advisory Committee Chairpersons, District Health Promotion Focal Persons and other NGO partners, and NHCs will implement their BCC plans using locally available human and material resources (e.g. NHC members can promote the essential health actions and counter common barriers to their uptake during village meetings, church groups, youth groups, and other existing community groups and community events such as weddings, christenings, circumcision, and burial ceremonies).

In order to make this a reality, District HPPF, HCAC Chairpersons, NHCs and other community resource persons will require orientation and capacity strengthening. The Health Promotion Office of the MOH will provide guidelines, job aides, and training materials for use by resource persons. All training will include an orientation to the essential health actions for each priority audience. Working with its partners, the Health Promotion Office will develop/reproduce communication materials for use at health facilities and communities for each of the priority audiences defined in this strategic framework. These materials will be supplied in relevant languages to community resource persons and health providers.

9.1 National Coordination

Community BCC will be guided by guidelines and communication strategies designed by the National Health Promotion Office (NHPO) of the Ministry of Health, with guidance and input from IEC Technical Working Group comprising of representatives from implementing partners in BCC, technical officers, and representatives from other line Ministries actively involved in health promotion. The USG Partners' Forum will also provide input into BCC guidelines and strategies. The NHPO will be responsible for developing and disseminating policy guidelines, communication strategies, as well as conducting and disseminating results from formative research in different thematic areas as well as designing and disseminating communication materials. The NHPO will also monitor, evaluate and report on BCC indicators defined in this strategic framework.

9.2 Provincial Coordination

At the provincial level, coordination of health BCC is the responsibility of the Senior Health Promotion Officer in collaboration with the provincial Partner's Forum and a Technical Working Group comprising of representatives from all partners in IEC/BCC working at the provincial level. The SHPO will be responsible for the following:

- Coordinating and providing guidance on the planning of BCC activities by partners and districts
- Conducting bi-annual partners' meetings
- Monitoring, evaluating and gathering provincial level data for planning
- Mobilizing resources for BCC activity implementation
- Capacity building of the district and provincial BCC partners, and
- Ensuring appropriate local language material availability and distribution.

9.3 District Coordination

At the district level, the Health Promotion Focal Person (HPFP) will be responsible for coordinating BCC activities in collaboration with a Behaviour change Communication Coordinating body at the district level. The coordinating body will consist of representatives from all partners working in IEC/BCC in the district as well as Program Officers and health center staff. Coordination will take place through regular zonal meetings. HPFPs will be responsible for disseminating BCC materials, implementing BCC guidelines, supervising the development and implementation of community BCC Coordination, planning, monitoring and reporting on BCC activities, and providing training in community BCC for Health Centers and HCACs.

9.4 Health Centre Coordination

At Health Centre level, BCC shall be coordinated by the Health Centre In-charges or any Health Care Provider delegated by the Health Centre In-Charge. The responsible person will coordinate BCC activities in collaboration with a Behaviour change Communication stakeholders within their catchment areas such as Teachers, Agriculture extension workers, NGOs, HCACs and any other partners identified by the HCACs.

9.5 Community Coordination

At community level, the Health Center Advisory Committee (HCAC) which comprises of Chairpersons from all NHCs around the health center catchment area, will coordinate the BCC activities of community based volunteers, oversee community based BCC planning and implementation, provide BCC materials, hold quarterly progress review and planning meetings, monitor and report

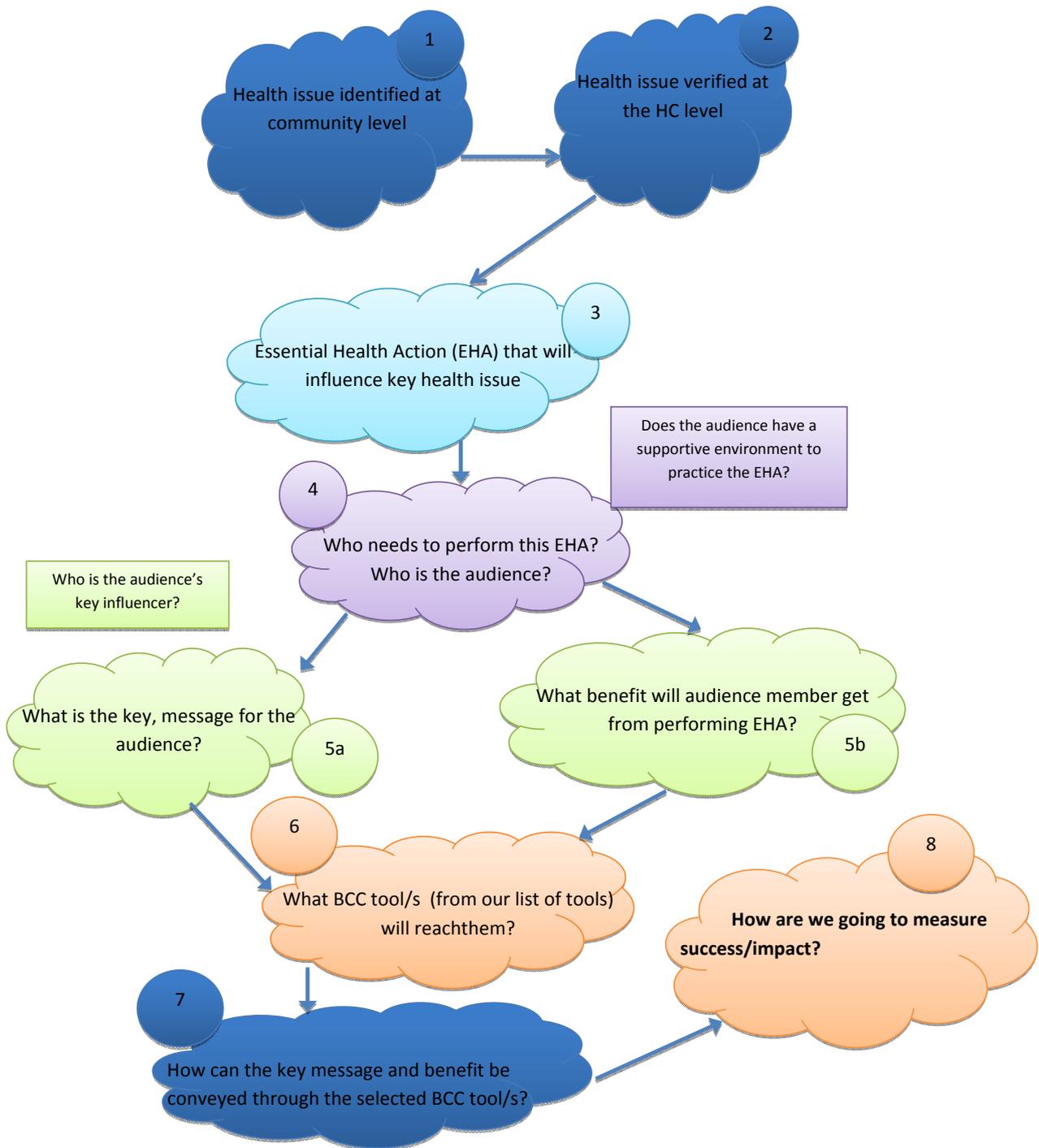
on community BCC activities, conduct orientations and trainings for community based volunteers and leaders, and conduct exchange visits to share experiences with other communities

10.0 Community BCC Planning

During every MOH annual planning cycle, the HCAC Chairperson will facilitate a BCC planning exercise with the NHC representatives, following guidelines developed by the MOH. The process will involve a participatory community meeting to identify priority issues and potential barriers based on health statistics and community member's concerns and barriers to adopting EHAs. Based on this analysis, the NHCs will identify priority audiences to address with health communication, and, maximizing on available resources in the community, they would then identify channels for communication and champions who can be engaged further to communicate with these priority audiences. These plans for community level SBCC activities will focus on health priorities identified at the health facility level and will feed into annual district plans. The BCC plans will be implemented by the NHC, with assistance from the health facility, DHPO, and non-governmental partners. The DHPO and HCAC Chairperson will monitor the workplan and provide training and technical assistance to the NHC for its implementation.

Find on the next page diagram depicting steps to planning and using community BCC.

STEPS TO PLANNING AND USING COMMUNITY BCC



STEPS TO PLANNING AND USING COMMUNITY BCC – SPECIFIC ISSUE



11.0 IEC/BCC Materials Production and Distribution

Often health communication materials are produced only in English and in very limited quantities. The distribution and replenishment system among provinces, districts, health facilities and communities needs strengthening. Most communication materials are only distributed during national health days such as SADC Malaria Day, Child Health Weeks or World AIDS Day. Further, the majority of communication materials focus on HIV and malaria, not on other health issues. The study also noted that there is very little integrated health communication. Furthermore, communities are rarely involved in the development of health communication interventions in support of national communication strategies, and very few health communication programs are monitored and evaluated.

- The Health Promotion and the IEC Technical Working Group (TWG) acts as a clearing house for all materials produced by the Ministry and its partners. The working group reviews and approves IEC /BCC materials on behalf of the MoH.
- The Health Promotion Unit and TWG develops guidelines for the development and management of IEC/BCC materials, ensures that all partners involved in materials development are trained to ensure the process of planning and development of IEC materials are in line with stipulated guidelines and the dissemination plan.
- The Health Promotion Unit and its partners will involve the community in developing materials. It is expected that partners will conduct an assessment at community level to identify the gaps and identify IEC/BCC needs, types of information needed and preference of materials to be developed.
- Designing of materials will be done at central level, with participation of the Senior Provincial Health Promotion Officers
- All communication materials will be pretested with their intended audiences and revised accordingly before approval, according to MOH Health Promotion Unit protocol of standards
- Community feedback – In order to identify the needs for communication materials, to ensure that materials are developed to address those needs, and to trigger resupply of communication materials, each district will institute routine supportive supervision visits to the NHCs together with representatives of the HCAC. In addition, during the annual planning exercise, NHCs will identify communication materials that they need, and these requests will be consolidated at district level and reported to provincial and national levels.
- Materials distribution – MoH is creating a data base to document all health communication materials. The MoH will distribute materials to the provinces and the provinces will then distribute the materials to the districts, which will distribute to communities using a distribution plan. All materials will be developed in English for consistency and can be further translated if needed. Furthermore, the district and health facility will ensure that the same messages are translated and disseminated through interpersonal communication utilizing community level resources and tools. If need be, stakeholders who would like to translate materials into other languages can do so based on the need of the community. Neighborhood Health Committees will identify appropriate distribution channels such as radio, drama and counseling.

12.0 Types of BCC channels at the community level

12.1 Interpersonal

This is the most direct and is people to people. If the groups are well trained and can carry the message well, this method can be very personal and effective.

- Community drama
- Community events
- Health talks using good quality teaching aids
- Music and dance
- Counseling
- Advocacy
- Social mobilization

12.2 Electronic

When you want to reach many people at the same time with entertaining and educational materials that are also consistent, then electronic media is good. You can show an effective film on a topic to a group at a clinic or on a mobile video unit. Community radio is now listened to by many people. If your audience members are radio listeners then this may be a good tool.

- Video (educational films)
- Radio (National & Community)
- Television (National & Community)

12.3 New media

As we move more towards the electronic age, young people and even those of other ages are starting to get their information through cell phones and the internet (friends on social media). For audiences with access to mobile phones, this can be an effective approach.

- Mobile phone messaging
- Internet
- Social networking (facebook, twitter)

12.4 Print

This works for audiences who can read. If it is done with very few words and more pictures, print can be an effective tool to share information that people can carry with them. In the case of posters a simple message with attractive images can be put up in an area like a clinic or a public space and be seen by many people.

- Poster
- Leaflet/ pamphlet/ brochure
- Flip charts
- Magazines
- Newspaper inserts

13.0 Capacity strengthening

In order to implement this framework, knowledge levels for SBCC, and skills of health promotions at provincial, district, and community levels will need to be strengthened. At the very least, actors at all levels need to be oriented to the Community BCC Framework, including its planning, implementation, monitoring and evaluation process.

The table below describes the resource persons who will be involved in implementing the community BCC framework and their training needs.

Table 3: Resource Persons and Training Needs

	Priority Training Needs	Equipment Needs	Training Resources Required
Provincial level: SHPO, PACA, TWG, CH Coordinators, NGOs, other line ministries	<ul style="list-style-type: none"> ▪ Orientation to BCC Framework & the essential health actions ▪ M&E ▪ Qualitative research & BCC design ▪ Resource mobilization ▪ Training & supervision skills ▪ Gender 	<ul style="list-style-type: none"> ▪ BCC materials and job aides ▪ Community BCC planning & M&E tools 	<ul style="list-style-type: none"> ▪ Resource mobilization guidelines ▪ Planning tools for community BCC ▪ BCC training manual ▪ Trainers
District level: HPFP, DACA, TWG, NGOs, other line ministries	<ul style="list-style-type: none"> ▪ Orientation to BCC Framework & the essential health actions ▪ Behaviour change communication ▪ Community mobilization ▪ Community BCC planning ▪ M&E ▪ Gender 	<ul style="list-style-type: none"> ▪ BCC materials and job aides ▪ Community BCC planning and monitoring tools 	<ul style="list-style-type: none"> ▪ BCC training manual ▪ Planning tools for community BCC ▪ Community BCC planning guidelines & training materials ▪ Community BCC monitoring guidelines, tools, and training materials

	Priority Training Needs	Equipment Needs	Training Resources Required
Community level: NHC, Community Volunteers, CATFs, village heads, traditional leaders	<ul style="list-style-type: none"> ▪ Orientation to BCC Framework & essential health actions ▪ Needs identification and community BCC planning ▪ Interpersonal communication, counseling & drama ▪ Monitoring community BCC plans ▪ Gender 	<ul style="list-style-type: none"> ▪ Job aides (ie. flipcharts, cue cards) ▪ Planning & monitoring tools ▪ Bicycles, mobile phones, radios 	<ul style="list-style-type: none"> ▪ Community BCC planning and monitoring training materials ▪ Training materials on integrated promotion of essential health actions, including gender issues ▪ Training materials on community mobilization, interpersonal communication, counseling, and drama.

Some training in behavior change communication has already been done at provincial and district levels, using existing training materials. There are also training materials and job aides that have been developed for NHCs in the past by the Health Communication Partnership (HCP) that may be adapted for future use. Training will be cascaded from province to district, district to health facility, and health facility to community supported by the MoH and partners.

14.0 Supervision

The MOH will monitor implementation of this framework through a combination of routine support supervision visits, monitoring and reporting by NHCs, HCACs, District HPFPs, and Provincial HPOs. To evaluate the effects of the framework, the MOH and its partners will conduct surveys of key audiences named in this framework to assess their knowledge and adoption of the essential health actions, and their attitudes and beliefs concerning key barriers to adoption of essential health actions.

District HPFPs will conduct regular support supervision visits to health centers and NHCs. During these visits, HPFPs will follow a supervision tool to determine whether or not community BCC plans are being implemented, whether communication materials and tools are in use, what capacity strengthening inputs are required, and what sorts of effects the community BCC activities are having on the uptake of health services and practices. Reports of these supervision and monitoring visits will be shared with the Senior Health Promotions officer (SHPO) at Provincial level, who will prepare integrated reports from all Districts in the province for the NHPO. The NHPO will collaborate with stakeholders to design support supervision tools for use at provincial,

district, health facility and community levels. These tools will include tracking information about communication materials, as well as requests for new materials. In addition, NHPO will conduct periodic supportive supervision visits to SHPOs at Provincial level, and DHFPs at district level. Table 4, shows an illustrative monitoring and evaluation indicators.

15.0 Implementation, Monitoring and Evaluation

Community BCC will be guided by guidelines and communication strategies designed by the National Health Promotion Office (NHPO) of the Ministry of Health, with guidance and input from a Technical Working Group comprising of representatives from all partners in BCC, technical officers, and representatives from other line Ministries actively involved in health promotion. The NHPO will also be responsible for monitoring and reporting on indicators included in the Framework.

Table 4: Illustrative monitoring and evaluation indicators

Indicator	Source of Data	Period of reporting
1. Percentage of communities with Community BCC Plans	Community BCC Plans	Annually
2. Percentage of communities with evidence that they are implementing their BCC plans	Supervision reports	Quarterly
3. Proportion of SHPOs trained as trainers for community BCC planning, implementation, M&E	Training reports	Quarterly
4. Proportion of District HPFPs trained in community BCC planning and supervision	Training reports	Quarterly
5. Proportion of NHC members trained to plan, implement and monitor community BCC	Training reports	Quarterly
6. Proportion of priority audiences who can state the essential health actions.	Surveys	Bi-Annually
7. Proportion of priority audiences who are practicing at least 50% of the essential health actions	Surveys	Bi-Annually
8. Proportion of priority audiences who have been reached through communication promoting the essential health actions.	Surveys	Bi-Annually

Neighborhood Health Committees (NHC) will be trained to facilitate a community-based process of developing and implementing BCC work plans based on priority health problems. This planning will be coordinated with the annual planning cycle so that community BCC plans become part of the annual health plans for the districts. Plans for community level BCC activities will focus on health priorities identified at the health facility level and will feed into annual district plans. The BCC plans will be implemented by the NHC, with assistance from the health facility, DHPO, and non-governmental partners. The DHPO and HCAC Chairperson will monitor the workplan and provide training and technical assistance to the NHC for its implementation.

Through a system of regular supportive supervision and reporting, DHPOs will collect, analyze and report on a set of indicators that measure the extent to which community BCC plans are in place and being implemented, as well as the needs for communication support materials. To assess the effectiveness of community BCC, NHPO will design and conduct bi-annual surveys of health knowledge, attitudes, intentions and practices.

APPENDIX 1: Stakeholder Analysis

Stakeholders/Theme	Role	Strengths	Challenge
WORLD VISION			
HIV/AIDS	distributing BCC material	Work with communities and deliver Bcc material directly to them.	Language in which BCC materials were written in was a barrier
NUTRITION	capacity building / training	They are found in hard to reach areas	language barriers
ZISSP			
HIV/AIDS	Provide funding and capacity building, data review meetings.	funding is available and they are there for capacity building	they exist at PHO and not found in districts
FP/RH	capacity building to institutions, districts and local communities	have funding, have focal person at the district looking at health programs	community programs have just started and have not reached all the places
MALARIA	Provide incentives to the communities after sensitization meeting on malaria prevention	to try and reduce malaria cases in communities and also be sure that any patient know their status on malaria	Need financial support to help everyone in the province
MNCH	facilitate capacity building to staff and communities	funding available	only at provincial level
NUTRITION	the main role is to build capacity and train communities on young child feeding, integrated management in childhood illness	the funds are available	ZISSP only exist at provincial level and only in a few districts

		to educate the mothers on child health	language barriers
JICA			
HIV/AIDS	production of BCC materials, distribution and material support to DHMT	work with DHMT	language barrier
MNCH	give machinery e.g. CD4 machine, lab equipment, reagents, training on HIV	work directly with health centers	lack of trained staff
UNICEF			
FP/RH	production of bcc materials and supply of contraceptive pills	Educate mothers on the use of family planning methods	No challenge stated
MALARIA	Provide anti malaria and ITNs and chemical to use for spraying.	provide mosquito nets and ITNs	constant supply is not there especially on ITNs
MNCH	capacity building for staff or health staff.	provide medication and equipment for delivery	not regular. it takes time to provide the kit
	they give us vaccine for MNCH	to reduce problem of MNCH in the communities and also making sure that MNCH level goes down	can't reach remote areas because of transport problems due to the Geographical locations
NUTRITION	train community based Volunteers and health staff	provide equipment such as weighing scales and BCC materials	supply is not constant
	Collaboration with national food nutrition commission	training on logistics, training on child growth	the program is coming to an end

WHO			
HIV/AIDS	they help us with machinery for using on VCT testing	they have transport to visit some of the remote areas in helping people with more knowledge on HIV	not sure of the challenges
FP/RH	don't know just see their name on bcc materials	educate people with more knowledge on the method of family planning	not sure of the challenges
MNCH	they buy bicycles for the community workers so that they can be giving more messages to mothers on MNCH	to make sure that the community are reached and receive vaccine	No challenge stated
CDC			
HIV/AIDS	financial and material support	have good financial base	depends with the situation of the day in terms of political and economic situations
FP/RH	Integration of PMTCT into FP.	NA	NA
MNCH	Provide home base care support on HIV and TB	provide drugs	would not know
CHAZ			
HIV/AIDS	sensitizing of community members on importance of VCT	they are able to hold a big number of patients	they don't have transport and financial support
	Provide man power as health workers to be doing VCT in our health institution.	they help people who are on ART so as to strengthen their life or	don't have enough ARVs to cover all communities and all districts in western province
MALARIA	Distribute IT nets	mobilize resources, also make sure that there is a decrease of malaria cases.	They can't manage to supply enough nets to every household in the areas because the funds are not enough.

CHILD FUND			
HIV/AIDS	training on HIV/AIDS prevention	Provide both finance support and capacity building	having meetings with partners, repeating same things
MALARIA	help in malaria prevention	distribute of mosquito nets	they don't leave reports, they don't do it often
HCP-USAID			
HIV/AIDS	Provide home based care program.	trained staff and provide materials	it's not constant its occasional
MALARIA	to train the community and health center staff on BCC materials	They work with time. they had the money to organize the workshop to train the staff and give the kit	work within a certain period
USAID			
HIV/AIDS	distribution of BCC materials to their partners	collaboration with MoH	production of BCC materials is not in local language
SFH			
FP/RH	provide long term family planning method	they have partnership with DHMT	people not accepting the FP methods especially families that cherish children
	distribute family planning methods e.g condoms and contraceptive pills	ensure that family planning is accessible and utilized	the funders are not consistence at times
		Safe motherhood is well funded.	No challenge stated

MALARIA	distribute mosquito nets in health centers	able to work hand in hand and control the high levels of malaria	inadequate
	provides mosquito nets and chorine	work with the community	provide a few mosquito nets to few communities
	they buy and delivery mosquito nets to districts	Adequate supply. about 95% coverage to reduce malaria cases	No challenge stated
			Transportation of the nets is a challenge .they are not able to supply to the whole district because they can't manage due to shortage of funds
MNCH	supply family planning measure	NA	they are not consistent in their supplements
DATA			
HIV/AIDS	coordinate all BCC HIV/AIDS related activities in the district	Have resources. they have formed up committees in the community	they don't have transport . the depend on the MOH's for condoms
	provide a forum on HIV/AIDS, they have structures at community level e.g. CATF	exist in districts, full time person at district level	funding is not adequate from NAC

Source: Survey tools

APPENDIX 2: Domains of Influence on Health Behaviour

2.1 Socio-Political Domain

Priority audiences	Actual Behaviour	Key Barriers	Communication Objectives	Communication Channels	Desired Behaviour
Health Workers	<ul style="list-style-type: none"> • Often conduct client education in groups, which is not tailored to the needs of the clients • More involved in clinical care than preventive education and counseling 	<ul style="list-style-type: none"> • Large workload which reduces time for client education and counseling • Lack of visual Aides and support materials for client education • Some lack up to date information, particularly concerning testing for malaria and nutrition. 	<ul style="list-style-type: none"> • Health workers will feel confident in their ability to educate clients about preventive practices. • Health workers will provide accurate information about the essential health actions to their clients. 	<ul style="list-style-type: none"> • Counseling quick guides on the essential health practices. • Visual aides to use when educating and counseling clients. • Training to strengthen client education and counseling skills 	<ul style="list-style-type: none"> • Provide focused health education and counseling according to client's needs • Educate clients about new recommender health and nutrition practices • Adopt preventive health practices in their own lives
Teachers	<ul style="list-style-type: none"> • Teach students what is in the syllabus, nothing more • Many do not adopt positive health and HIV prevention practices. 	<ul style="list-style-type: none"> • Do not know what to teach students about health, HIV, and nutrition. • Lack the Visual Aids and lesson guides to teach students about health, HIV, and nutrition. • Many are unaware of recommended health and nutrition practices 	<ul style="list-style-type: none"> • Teachers will have the necessary information to conduct educational sessions with students about health, HIV, and nutrition. 	<ul style="list-style-type: none"> • Session plans on the essential health practices • Visual aides to use when conducting educational sessions with students • Orientations to session plans and job aides. 	<ul style="list-style-type: none"> • Teach students about health, HIV prevention, and nutrition practices. • Adopt healthy practices and act as role models in their communities and schools

2.2 Service Delivery Domain

Priority audiences	Actual Behaviour	Key Barriers	Communication Objectives	Communication Channels	Desired Behaviour
Community Health Volunteers	<ul style="list-style-type: none"> • Tend to spend most of their time in health facility • Delay in referring patients from the community to health facilities • Some administer unauthorized drugs • Irregularly give health education talks in community • Irregularly conduct village health inspections • Some assist with home deliveries and run health posts 	<ul style="list-style-type: none"> • Lack of allowance or incentives • Lack transportation • Distance to health facility • Large catchment areas • Infrequent training and supervision • Lack of communication support materials 	<ul style="list-style-type: none"> • Community volunteers will be familiar with the essential health actions for each audience • Community volunteers will feel capable of and motivated to educate community members about the essential health actions 	<ul style="list-style-type: none"> • Community health tool kits that contain illustrative materials to use during health education • Training and supervision by health workers • Regular CHV meetings 	<ul style="list-style-type: none"> • Work in both the health facility and the community • Refer clients in need of services to health facility • Participate in the design and implementation of community level health campaigns • Give health talks about the essential health actions to communities and patients at health facilities • Conduct community/ village health inspections • Refer pregnant women to the health facility for ANC and deliveries

2.3. Community and Individual Domain

	Actual Behaviour	Key Barriers	Communication Objectives	Communication Channels	Desired Behaviour
<p>Mothers of children under 5 years</p> <ul style="list-style-type: none"> • Discard colostrum • Introduce porridge soon after birth • Delay introducing foods other than porridge until after 6 months • Children often sleep without ITNs • Get herbs or go to traditional healers when children have fevers • Often do not complete the full course of immunizations • Stop feeding babies when they are sick • Rarely discuss family planning or HIV prevention with their husbands/partners 	<ul style="list-style-type: none"> • Lack of information about optimal infant feeding practices and other essential health actions • Cultural beliefs concerning infant feeding • Fear side effects of immunizations • May not have enough ITNs for everyone in the household • Distance to health facility and costs of transport • Some religions discourage condom use and family planning • Fear of marital discord if they discuss FP or HIV testing with husband 	<ul style="list-style-type: none"> • Mothers of under-fives will know the essential health actions they should adopt to protect their children's health • Mothers will believe that these essential health actions are effective and that they are capable of adopting them • Mothers will discuss the essential health actions with their peers and partners/husbands 	<ul style="list-style-type: none"> • Counseling and health education by health workers • Discussions during women's group or religious group meetings • Home visits by community volunteers • Community drama • Community radio programming 	<ul style="list-style-type: none"> • Begins breastfeeding immediately after birth • Breastfeeds exclusively for the first 6 months • Introduces soft foods in addition to breast milk when baby is 6 months old • Gives baby soft foods in addition to breast milk at least 3 times each day • Breastfeeds the baby until he is 2 years old • Continues to feed the baby even when he is sick • Ensures the baby sleeps under an ITN • If the baby has fever, take to a health worker for a malaria test immediately • Ensures child is fully immunized and receives Vitamin A and deworming tablets 2 times each year • Uses modern family planning to space pregnancies at least 2 years apart • Avoids HIV by remaining faithful to partner, testing for HIV together with partner, and using condoms 	

	Actual Behaviour	Key Barriers	Communication Objectives	Communication Channels	Desired Behaviour
Fathers of children under 5 years	<ul style="list-style-type: none"> Leaves child health and family planning decisions to his wife. Avoids HIV counseling & testing. Does not pay attention to how his wife is feeding his children Sometimes uses ITNs for fishing or other purposes; rarely hangs them over the children's sleeping beds or mats. Unaware of his children's immunization status 	<ul style="list-style-type: none"> Believes that child health and family planning are a woman's business. Lacks full information about infant feeding, immunization, family planning, Fear of knowing his HIV status Male gender norms that encourage multiple sexual partners and large families Believe family planning may encourage their wives to become promiscuous 	<ul style="list-style-type: none"> Fathers will believe that their children's health is their responsibility Fathers will know the essential health actions that will protect their children and wives from illness Men will discuss the essential health actions with their wives 	<ul style="list-style-type: none"> Community radio Meetings with opinion leaders who are role models for family health Community video shows 	<ul style="list-style-type: none"> Ensures children sleep under ITNs and get diagnosed and treated within 24 hours for fever Get tested for HIV together with wife, sticks to one partner and uses condoms Discusses family planning with his wife Ensures that infants are breastfed exclusively for 6 months, and started on soft foods in addition to breastmilk at 6 months of age Ensures his children are fully immunized.

	Actual Behaviour	Key Barriers	Communication Objectives	Communication Channels	Desired Behaviour
Pregnant women	<ul style="list-style-type: none"> • Begin ANC after their fifth month of pregnancy • Attend one ANC visit • Deliver their babies at home • Have no plan for childbirth • Few women attend postnatal care • Very few pregnant women discuss family planning with their partners 	<ul style="list-style-type: none"> • Women traditionally do not tell anyone they are pregnant until they begin showing • Lack of information about the essential health actions during pregnancy • Transportation costs for visits to health facilities • Cultural practices that require a woman to remain at home during the postnatal period • Belief that there is no need for ANC if one is not having problems • Long waiting times at health facilities and then ANC is provided in a very rushed manner 	<ul style="list-style-type: none"> • Pregnant women will know and value the essential health actions they need to take during pregnancy • Pregnant women will make birth plans together with their partner/husband and family • Pregnant women will declare their pregnancies to their husbands during the first trimester 	<ul style="list-style-type: none"> • Counseling and education by health workers • Home visits by SMAGs • Community dramas • Radio programmes • Poem and storytelling contests • Posters 	<ul style="list-style-type: none"> • Initiate ANC before 16 weeks gestation • Complete at least 4 ANC visits during each pregnancy • Prepare a birth plan together with their family • Sleep under ITN and take IPT at least twice during pregnancy • Get tested for HIV and enrolled in PMTCT if HIV positive • Deliver their babies at health facilities • Receive post natal checkups within 2 days of delivery • Begin using modern family planning soon after delivery • Get malaria test at first symptom & if positive, take the full course or correct medicine.

	Actual Behaviour	Key Barriers	Communication Objectives	Communication Channels	Desired Behaviour
Husbands of pregnant women	<ul style="list-style-type: none"> Discourage wives from going to health center of ANC 4 times during pregnancy, and delivering with skilled birth attendant. Expect wife to make decisions regarding pregnancy and delivery Refuse to test for HIV with their partners 	<ul style="list-style-type: none"> Women do not tell their husbands they are pregnant until they are showing Lack of information about essential practices to make childbearing safer Male gender norms that encourage men not to involve themselves in matters to do with pregnancy and childbirth 	<ul style="list-style-type: none"> Husbands aware of the essential maternal health actions Husbands discuss pregnancy and delivery plans with their wives Husbands accompany wives for ANC and get tested for HIV. 	<ul style="list-style-type: none"> SMAGs Community meetings Community video shows Printed materials Radio programs Community dramas 	<ul style="list-style-type: none"> Ensure wife attends ANC at least 4 times, beginning in the first trimester Discuss a birth plan with his wife and family Ensure his wife delivers with the assistance of a trained birth attendant Ensure his wife sleeps under an ITN and takes IPT twice during the pregnancy Tests for HIV together with his wife
Grandparents	<ul style="list-style-type: none"> Many conduct home deliveries Counsel young parents to conform to traditional practices which are sometimes harmful Reinforce traditional gender norms which prevent men from involving themselves in child care or pregnancy-related issues. 	<ul style="list-style-type: none"> Strong adherence to traditions Lack of information about essential health practices Believe in some myths and misconceptions regarding health 	<ul style="list-style-type: none"> Grandparents will be familiar with essential health actions for children under 5 and for pregnant women. Grandparents will discuss the essential health actions with their families and encourage uptake. 	<ul style="list-style-type: none"> Group discussions Radio programming Storytelling Radio listening groups 	<ul style="list-style-type: none"> Encourage women to deliver in health facilities Adopt essential health practices Encourage their families to adopt essential health practices.

	Actual Behaviour	Key Barriers	Communication Objectives	Communication Channels	Desired Behaviour
Children 10 – 14 years	<ul style="list-style-type: none"> • Many abstain from sex • Some are sexually active but do not use condoms • Some become involved in trans-generational and transactional sex 	<ul style="list-style-type: none"> • Lack of access to condoms • Lack of information about sex, HIV, pregnancy, FP • Desire for items that they cannot afford • Cultural norms that make it difficult for a girl to refuse an older man 	<ul style="list-style-type: none"> • Girls and boys will know how to prevent HIV and pregnancies • Girls and boys will intend to delay sexual debut until they are at least 18 years • Girls will feel empowered to refuse trans-generational and transactional sex. 	<ul style="list-style-type: none"> • School and youth clubs • Drama & music • Radio programs for young people • Group discussions at churches • Counseling from parents and grandparents 	<ul style="list-style-type: none"> • Delay sexual debut until they are at least 18 • Use condoms if they have sex • Refuse transactional and trans-generational sex
Sexually active youth 15 – 24 years	<ul style="list-style-type: none"> • Many have unprotected sex • Many have multiple concurrent relationships • Some are involved in transactional sex • Few get tested for HIV • Many eat only 1 or 2 meals per day which are low in protein, minerals and vitamins 	<ul style="list-style-type: none"> • Condoms are inaccessible to many • Gender norms that encourage young men to prove their virility by having many sexual partners • Fear of adults/parents learning that they are sexually active 	<ul style="list-style-type: none"> • Sexually active youth will be aware of recommended dietary practices • They will believe they are at risk of HIV and plan to get testing and counseling 	<ul style="list-style-type: none"> • Music and drama in schools and on radio • Group discussions and entertainment-education games • Posters • Magazines • Peer educators • Youth groups 	<ul style="list-style-type: none"> • Use condoms • Avoid multiple concurrent sexual relationships • Refuse to exchange sex for gifts, favors, or money • Get HIV testing and counseling • Eat at least 3 well-balanced meals per day

	Actual Behaviour	Key Barriers	Communication Objectives	Communication Channels	Desired Behaviour
		<ul style="list-style-type: none"> • Lack of information about dietary recommendations • Many believe in rumors and misconceptions about fertility and HIV 	<ul style="list-style-type: none"> • They will adopt HIV risk reduction strategies, including condom use and avoiding concurrent sexual relationships • They will refuse to exchange sex for gifts, favors, or money 		

Community Counselors	Actual Behaviour	Key Barriers	Communication Objectives	Communication Channels	Desired Behaviour
	<ul style="list-style-type: none"> • Reinforce traditional taboos such as dietary restrictions during pregnancy • Promote sexual cleansing after initiation rites • Some conduct traditional circumcision for males, and tattooing for girls • Encourage the use of herbs and discourage modern medicine • Encourage men to have many sexual partners • Train brides not to question their husband's infidelity "as long as he comes back" • Teach new mothers to discard colostrum because it is dirty. • Encourage women to deliver at home. 	<ul style="list-style-type: none"> • Subscribe strongly to traditional norms and practices • Inadequate knowledge about health and essential health actions 	<ul style="list-style-type: none"> • Community counselors will provide accurate information about health • Community counselors will encourage their clients to adopt essential health actions 	<ul style="list-style-type: none"> • Meetings and workshops • Low literate visual aides • Video shows • Radio programming 	<ul style="list-style-type: none"> • Reinforce traditional taboos such as dietary restrictions during pregnancy • Promote sexual cleansing after initiation rites • Some conduct traditional circumcision for males, and tattooing for girls • Encourage the use of herbs and discourage modern medicine • Encourage men to have many sexual partners • Train brides not to question their husband's infidelity "as long as he comes back" • Teach new mothers to discard colostrum because it is dirty • Encourage women to deliver their babies at home

<p>Traditional leaders</p>	<ul style="list-style-type: none"> • Many have not adopted recommended health practices • Few promote health practices among their followers • Few advocate for health services or resources 	<ul style="list-style-type: none"> • Health sector has not fully involved traditional leaders in its programmes • Lack of information about health matters and recommended health practices 	<ul style="list-style-type: none"> • Traditional leaders aware of essential health actions, and believe that they will benefit themselves and their followers 	<ul style="list-style-type: none"> • Meetings and orientations to BCC Framework • Demonstrations • Radio programmes 	<ul style="list-style-type: none"> • Act as role models by adopting recommended health practices • Promote health practices among their followers • Advocate for health resources and services
<p>Religious leaders</p>	<ul style="list-style-type: none"> • Do not promote health practices • Hinder some practices (e.g. condom use, ART, FP, immunization) 	<ul style="list-style-type: none"> • Do not see health as their core business • Lack information about health • Religious beliefs may be at odds with desired health practices 	<ul style="list-style-type: none"> • Religious leaders informed about the essential health actions, and • Religious leaders promote the essential health actions among their followers. 	<ul style="list-style-type: none"> • Information packs • Meetings to orient them to BCC framework • Modeling desired behavior by religious leaders on radio and television. 	<ul style="list-style-type: none"> • Counseling their followers on health matters • Promoting good health practices • Integrating health into religious activities

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