Overview of HIV/AIDS Behaviour Change Communication Programming for the Workplace

1

Contents

Introduction: Why this toolkit? 1

1. What is behaviour change communication (BCC)? 4

2. Steps for developing an HIV/AIDS BCC programme at the workplace 6

3. Cross-cutting issues for implementation 19

4. Training in the implementation of the BCC toolkit 22

Appendix

Using the toolkit: a case study

International Labour Organization

Introduction: Why this toolkit?

This Behaviour Change Communication (BCC) Toolkit is designed to help users develop, implement and evaluate workplace programmes for behaviour change tailored to workplaces. The kit aims to operationalize key aspects of the ILO Code of Practice on HIV/AIDS and the world of work, which provides internationally recognized guidelines for the development of comprehensive HIV/AIDS workplace policies and programmes. The Code of Practice is based on ten key principles:

- The recognition of HIV/AIDS as a workplace issue
- Non-discrimination
- Gender equality
- Healthy work environment
- Social dialogue for the successful implementation of HIV/AIDS policy and programmes
- No screening for purposes of exclusion from employment or the work process
- Confidentiality
- Continuation of the employment relationship
- Prevention
- Care and support.

The HIV/AIDS workplace BCC programme is part of a comprehensive workplace effort to inform workers about HIV/AIDS, promote behaviour changes that will reduce the spread of the virus, reduce discrimination and support workers who are living with HIV/AIDS.

> *"Workplace information and education programmes are essential to combat the spread of the epidemic and to foster greater tolerance for workers with HIV/AIDS. Effective education can contribute to the capacity of workers to protect themselves against HIV infection. It can significantly reduce HIV-related anxiety and stigmatization, minimize disruption at the workplace and bring about attitudinal and behavioural change. Programmes should be developed through consultations between governments, employers and workers and their representatives to ensure support at the highest levels and with the fullest participation of all concerned. Information and consultation should be provided in a variety of forms, not relying exclusively on the written word and including distance learning, when necessary. Programmes should be targeted and tailored to the age, gender, sexual orientation, sectoral characteristics and behavioural risk factors of the workforce and its cultural context. They should be delivered by trusted and respected individuals. Peer education has been found to be particularly effective, as has the involvement of people living with HIV/AIDS in the design and implementation of programmes."*
>
> Section 6 of the *ILO Code of Practice on HIV/AIDS and the world of work*

The intended users of the toolkit are stakeholders responsible for HIV/AIDS programming at all levels in the world of work, with a particular focus on the workplace. They include staff and members of workers' and employers' organizations, representatives of management and workers, workplace HIV/AIDS focal points, members of workplace HIV/AIDS or heath and safety committees, and peer educators to be recruited from the workforce. In some countries factors common to different enterprises within an economic sector, such as mining or transport, mean that a sectoral programme may be appropriate and useful. The toolkit is also relevant for ministry officials with workplace-related responsibilities, and in particular for the government as an employer, to help it develop programmes for its own staff and public servants such as teachers and health workers.

In the framework of technical cooperation, the kit will provide HIV/AIDS focal points in ILO field offices and national project coordinators with a comprehensive tool for developing BCC programmes in the target sectors, in partnership with national non-governmental organizations and community-based organizations.

The kit is designed for people with little or no experience in communication planning. It consists of seven sections which can be used separately to learn more about specific elements or jointly to design and implement a comprehensive BCC programme at the workplace.

1 **Overview of Behaviour Change Communication Programming for the Workplace** – an overview of the contents of the toolkit, with an outline of the eight steps to follow in developing a BCC programme. It includes a case study from Kenya that illustrates the steps involved in the BCC process and shows how the toolkit can be applied in a specific workplace/ sector.

2 **Gathering Data for the Development of a Behaviour Change Communication Programme for the Workplace** – a step-by-step guide to collecting the information needed to design BCC programmes ('formative assessment'), tailored to the needs and interests of the target group, including a generic protocol for data collection.

3 **Designing a Behaviour Change Communication Strategy** – a detailed facilitators' guide to developing a strategy based on the formative assessment.

4 **Developing Materials for a Behaviour Change Communication Programme for the Workplace** – how to develop a range of materials to support the BCC programme.

5 **Guide to Conducting Peer Education at the Workplace** – a guide to training workers to carry out BCC and other prevention activities with co-workers. It includes tips for peer educators and sample training exercises.

6 **Tools for Monitoring and Evaluation of the Behaviour Change Communication Programme for the Workplace** – includes tools to monitor progress and evaluate the impact of BCC objectives.

7 **Training in the Use of the HIV/AIDS Behaviour Change Communication Toolkit for the Workplace** – provides facilitators with a guide to training BCC implementers on the use of the toolkit.

1. What is behaviour change communication?

Behaviour change communication (BCC) is an interactive process for developing messages and approaches using a mix of communication channels in order to encourage and sustain positive and appropriate behaviours. BCC has evolved from information, education and communication (IEC) programmes to promote more tailored messages, greater dialogue and fuller ownership. Participation of the workplace stakeholders is vital at every step of planning and implementation of the behaviour change programs to ensure sustainable change in attitudes and behaviour.

In the context of HIV and the workplace**, BCC is an essential part of a comprehensive programme** that includes services (e.g. care, counseling), commodities (e.g., condoms, drugs), and policies that promote non-discrimination and trust.

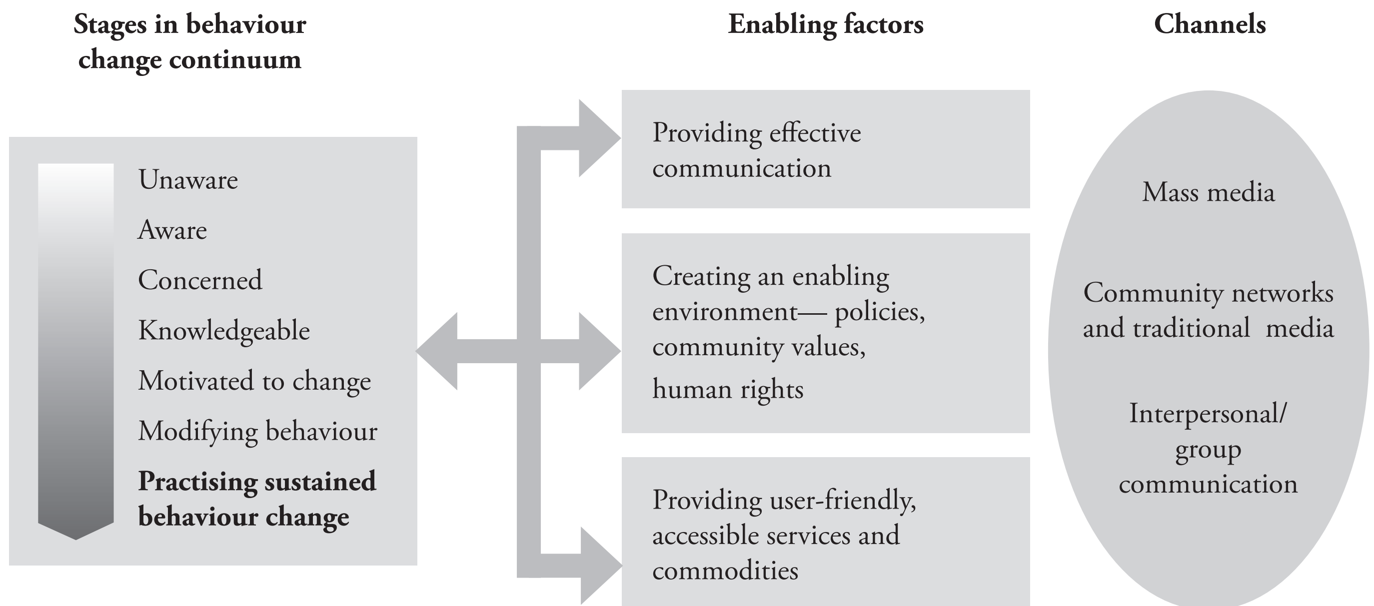
Before individuals and communities can reduce their level of risk or change their behaviours, they must first understand the basic facts about HIV and AIDS, assess and modify their attitudes, learn new skills, and gain access to appropriate products and services. They must also perceive their environment as supportive of behaviour change and the maintenance of safe behaviours.

To be effective, BCC programmes need to be tailored to specific target populations. In the context of the world of work, this entails communicating with workers in homogeneous groups, based on factors such as economic sector, type of job, education, gender. It also entails developing specific messages and approaches that will most effectively resonate with a particular workplace group.

Theories of behaviour change offer insights into certain aspects of health-related behaviour and can be useful in strategic planning in terms of understanding the target audience, development of messages, and allocation of resources.

The following is a practical model that combines ‘stages of change’, focusing on individual behaviour change, with enabling factors that support behaviour change. People may need different messages and information resources at different stages of change.

A framework for BCC design



Effective behaviour change communication can:

- increase knowledge of HIV/AIDS;
- stimulate social and community dialogue;
- promote essential attitude change;
- improve skills and sense of self-effectiveness;
- reduce stigma and discrimination against people living with HIV/AIDS;
- create a demand for information and services;
- advocate an effective response to the epidemic; and
- promote services for prevention, care and support of vulnerable populations.

2. Steps for developing an HIV/AIDS BCC programme at the workplace

The overall goal of an HIV/AIDS workplace programme is to reduce the prevalence and impact of HIV in the workforce and the wider community. The toolkit is designed to achieve that goal through a process that may be summarized in the following eight steps:

Step 1: Advocacy and stakeholder involvement

Step 2: Identification and segmentation of target populations

Step 3: Formative assessment for BCC

Step 4: Development of a BCC strategy

Step 5: Development of communication support materials

Step 6: Implementation of the BCC programme

Step 7: Monitoring and evaluation

Step 8: Feedback and revision

Step 1: Advocacy and stakeholder involvement

Government, businesses and trade unions exercise great influence over the lives of workers and society in general; for this reason, they have a unique opportunity to make a difference in the fight against HIV/AIDS. The impact of HIV/AIDS has placed a tremendous burden on the private sector and the national economy of many countries.

Enterprises with a workforce impacted by HIV/AIDS have to bear higher costs associated with health insurance, retirement funds, recruitment and training of new staff, widespread absenteeism and sick leave, and the loss of qualified staff. It is in the best interests of employers to take proactive steps to minimize the impact of HIV/AIDS on their staff and operations.

The loss of human capital is a consequence of the HIV epidemic that businesses, the public sector, and workers' organizations have to face on a daily basis. All can play an active role by adopting workplace policies and programmes that curb the spread and impact of the disease. This is necessary not only because it affects the workforce, but also because the workplace, as part of the local community, has a broader role to play in limiting the spread and effects of the epidemic.

Effective HIV/AIDS workplace behaviour change communication programmes, supported by practical measures, can significantly reduce HIV-related anxiety and stigmatization, minimize disruption at the workplace, and bring about changes in attitudes and behaviours among the workforce and surrounding communities. Successful programmes are targeted and tailored to the age, gender, sexual orientation, sectoral characteristics and behavioural risk factors of the workforce and its cultural context. Peer education has been particularly effective in workplace HIV-prevention programmes.

Step 2: Identification and segmentation of target populations

To effectively develop BCC programmes, it is important to understand who needs to be reached. The first step is to identify the different groups of people at a workplace and to consider those that may be most at risk. The target population can then be divided into subgroups that have commonalities, or according to ethnicity, language and education. Groups that have an influence over those who are most at risk must also be examined.

To be most effective, HIV/AIDS BCC programming for the workplace must work with primary and secondary target populations:

- **Primary target populations:** the main group of individuals whose behaviour we would like to influence and support. For example, in the transport sector, the primary target population could be truck drivers, because they are away from home for long periods of time and more likely to engage in risky behaviour.

- **Secondary target populations:** those who can affect the BCC activities or be affected by them, even though these BCC activities were not designed to reach them directly. They are often people whose support or neglect determines whether or not the primary audience responds to communication messages. They can include opinion leaders (such as government officials), gatekeepers (such as police officers and brothel owners), and policy-makers. In the case of truck drivers, the secondary target populations may include the owners of the vehicles. They may also be vulnerable or at risk, as a result of their association with the primary audience, but they are not necessarily the main beneficiaries of HIV/AIDS programming efforts. The wives and girlfriends of men who frequent sex workers might fall into this category. There are often several secondary target populations around one primary target group, requiring different communication approaches and messages.

Assessing the HIV/AIDS prevention, care and support needs of potential target populations is crucial. This information, as well as more practical information on the available human, financial and material resources and capacities, will guide decisions about:

- the objectives of the communication strategy;
- the communication approach;
- the content of the communication; and
- stakeholders.

Whether they are primary target populations or secondary populations, all of these people have a stake in the outcome of our programmes and thus constitute our **stakeholders.** The more we understand them, include them and involve them, the more successful and sustainable our communication interventions will be.

It is also important to segment or subdivide the target population(s) once the programme has identified the appropriate group or groups to work with. Groups that appear similar often have many differences. A group of truck drivers may appear to be similar, but the formative assessment may find that they differ in age, marital status, sexual partners, income etc. Programmes can therefore be more focused and effective if the truck drivers are divided into subgroups.

Step 3: Formative assessment for BCC

Assessing target groups is vital to the success of a BCC programme. The assessment allows programme staff and stakeholders to become aware of the realities of the target. This ensures that when the BCC programme is developed the messages, themes and channels resonate with the target group. If no BCC assessment is conducted, it is likely that the target group will misunderstand or reject the BCC messages and proposed activities. The assessment process also provides an opportunity to start involving the target group.

The formative BCC assessment will:

- identify opportunities and resources for BCC intervention;
- gather in-depth information about different target populations' behaviours, attitudes, hopes or fears about the future, likes and dislikes;
- define their social networks and their risk settings (environments in which they may be at risk of contracting HIV); and
- identify means to increase HIV/AIDS health-seeking behaviour.

Booklet 2, Gathering Data for the Development of a Behaviour Change Communication Programme for the Workplace, outlines specifics steps on how to:

- define assessment objectives based on what we already know and what we need to discover;
- select assessment activities relevant to the specific workplace setting, such as key informant interviews, in-depth interviews, or focus group discussions;
- conduct the assessment using in-depth interviews, key informant interviews, and other qualitative methods;
- process the results to provide the basis for developing the BCC strategy.

Step 4: Development of a BCC strategy

Moving from information-gathering to a BCC strategy is a critical step. A participatory workshop is the ideal context for developing a strategy. Booklet 3, *Designing a Behaviour Change Communication Strategy*, is a facilitators' guide for conducting a five-day BCC strategy-development workshop. It is also possible to develop a BCC strategy with the help of a BCC practitioner working with target populations for a longer period.

The following elements are essential for the development of a BCC strategy.

A description of the target population. General knowledge about the target population, combined with BCC formative assessment findings, provide the basis for a description of the target populations and their environment. A target population profile should include current and desired behaviours; hopes, fears and dreams; and factors that influence behaviours. These factors might include their preferred TV or radio programmes; the magazines and newspapers that they read; literacy level; health-care-seeking behaviour; and relationship to family, friends, community, religion, services and the broader society. It is important to clearly identify their current behaviours and the improved/desirable/feasible safer behaviours that the BCC programme seeks to promote (such as condom use, seeking information on HIV and other sexually transmitted infections, or opposing the stigmatization of fellow workers with HIV). The resulting profile is the starting point for the development of a comprehensive HIV/AIDS BCC strategy for the workplace.

Behaviour change objectives: Behaviour change objectives specify new behaviours to be adopted or maintained over a specific time period.

Objectives should be SMART: **S**pecific, **M**easurable, **A**chievable, **R**elevant and **T**ime-based.

Behaviour change communication objectives: BCC objectives specify a communication activity that *may change* knowledge or attitudes, which will contribute to the adoption of a specified behaviour. Adoption of that specified behaviour constitutes a behaviour change objective.

BCC objectives, if accomplished, support and promote behaviour change in the target population.

The matrix below provides examples of behaviour change and behaviour change communication objectives and highlights the difference between the two:

Behaviour change objectives	Behaviour change communication objectives
• Increase the use of condoms among long-distance truck drivers by 35% within one year of the start of the BCC programme	• Achieve a 60% increase in the number of long-distance truck drivers who believe that condoms are an effective or a very effective means of protection against becoming infected; • Achieve a 60% increase in the number of long-distance truck drivers who consider themselves at high or at very high risk of becoming infected with HIV within one year of the start of the BCC programme
• Achieve reduction of 25% in the number of sexual partners among the miners, within one year of the start of the BCC programme	• Achieve a 50% increase in the number of miners who believe that abstinence and fidelity protect them against becoming infected with HIV, within one year of the start of the BCC programme
• Reduce construction workers' use of sex workers at the site by 30% within two years of the start of the BCC programme	• Achieve a 50% increase in the number of construction workers who believe that commercial sex services place them at a high or very high risk of becoming infected with HIV within two years of the start of the BCC programme

Strong messages: A message is the information conveyed to the target population with the aim of motivating them to change, stimulating dialogue or promoting a product or service. A good message contains two parts: a desired behaviour and a benefit for the person adopting those behaviours. It is tailored and appropriate to the target group, as opposed to generic population-wide public health messages. To develop effective messages, one should do the following:

- **Identify barriers.** There are very often barriers to adopting a new behaviour. These could include lack of knowledge, distance to a health facility, lack of access to commodities, etc. Identification of the barriers will guide the development of messages and interventions.
- **Identify key benefits.** Finding out what could help to motivate a person or a community to change is an important step in developing an effective and convincing message. Data from the formative assessment and target population profile, including information about their hopes and fears, are used to develop key benefit statements. A key benefit statement is used with a statement of desired behaviours to form a message: "If I do X, I will get Y."

  - *In Guyana, minibus drivers and conductors often discriminate against people living with HIV/AIDS or those perceived to be HIV-positive. Most people see the drivers and conductors as disreputable characters, but the drivers and conductors actually crave respect. In a campaign in Guyana, minibus drivers and conductors have been involved as change agents in the community and are receiving training on issues relating to HIV/AIDS and stigma. The message "Give Respect, Get Respect" provides the key benefit for minibus drivers and conductors: being seen as people with knowledge and as role models for the community.*

  - *The major concern of sex workers in Kamatipura, Mumbai, India is the future welfare of their children or having a child. So all desired behaviours, such as seeking treatment for sexually transmitted infections and using condoms, are associated with an assurance of future fertility and of having and taking care of healthy children.*

- *In Kenya, many of the predominantly male workers in a sugar factory live apart from their families, have disposable income and, in their leisure time, have unprotected sexual encounters with women in the community. Peer education is a main component of the BCC strategy, supported by a mass media campaign, dubbed "kati yetu" – Kiswahili for "between us". The overall theme of the campaign is "Question (our) Relationships". This theme stimulates dialogue among workers, all of whom have relationships, both nearby and far away. Who are they interacting with? Are they relating to the right person, in the right way and at the right place and time?*

Characteristics of effective messages

Effective messages:
command attention;
are clearly stated;
communicate a benefit;
are consistently repeated;
reach the heart and the head;
create trust; and
call for action.

- **Ensure that messages are consistent across multiple channels and target populations, to avoid confusion.** Key messages can provide a framework for working with multiple target populations and form the entry point for discussions and BCC activities.

Communication channels: These are the vehicles that present, deliver and explain messages. Channels can range from face-to-face interactive activities to community-level interventions and mass media. It is important to choose the channels most readily available and acceptable to the target population and to keep cost-effectiveness in mind.

- **At the workplace, interpersonal channels such as peer education have proven to be very effective and should be the main strategy used in workplace programmes:** Mass media channels can raise awareness of specific issues, but more personal interventions (especially by peers) can have a greater impact on influencing behaviour change. Peer education is a process that involves members of a group or community learning informally together. Peers have similar backgrounds, values and jobs to others at the workplace, but are trained to provide information, education and even counselling. Peer-education initiatives generally focus on health education and prevention activities, and often aim to promote safer and healthier lifestyles. In the context of BCC, it means training members of the target group as key behaviour change communicators. The peer educator is the link between the programme and the target population. Peer education hinges on the idea that people are most likely to change their behaviour if people they know and trust encourage them to do so. Peer education is one of the most effective ways of inspiring behaviour change and conducting HIV/AIDS education at the workplace. Peer education:
    - breaks barriers to allow for discussion of sensitive matters without fear;

- brings about sustainable behaviour change in target populations;
- maintains confidentiality;
- is the most effective, informal way of sending the correct message to a specific target group;
- is less time-consuming than formal education activities or programmes;
- provides an open channel for on-going communication and problem-solving;
- costs very little.

Programmes can take advantage of other elements within the workplace to support and legitimize interpersonal channels. These might include newsletters, bulletin boards, company events, radio and print materials. Channels linked to workplace-based activities can also be useful: these include clinics, lunchrooms, basic and in-service training programmes, and organized recreational activities.

- **Identification of communication support materials:** Those involved in the BCC strategy-development process (whether in a workshop format, or by using a consultant or small team) need to identify the types of communication materials they should use to support the channels selected. These can include picture codes for peer educators (pictures that depict risky situations and can be used to initiate a discussion), client/provider support materials (such as flipcharts and pamphlets on various health-care services for HIV/AIDS), billboards, scripts for use in dramas, etc. Step 5 outlines specific strategies for the development of materials, which takes place after the development of the BCC strategy and with the close participation of target populations and skilled material-development practitioners.

Step 5: Development of communication support materials

Behaviour change communication materials should be based on the guidelines established by the BCC strategy for the workplace. The strategy will define an action plan, timeline, channels, and which materials to develop. Development of materials and messages should always correspond to the research conducted with the target population and through stakeholder consensus.

BCC budgets will need to take into account the development of support materials and the multiple steps linked to this process. BCC budgets often take into account only materials production, without considering the importance of other steps such as pre-testing (see below).

Issues to consider when developing support communication materials include:

- hiring and working with advertising or public relations agencies;
- if working with vendors, giving them what they need and being as specific as possible so they do the job correctly;
- including stakeholders in the entire process;
- providing information that is clearly and simply stated in order to enhance the response;
- repeating your messages frequently;
- making your materials as specific as possible for the target population to understand, taking into account appropriate language, culture, dress, setting, etc.;
- being careful not to stigmatize people living with HIV/AIDS in the materials; and
- being careful not to select images and words that promote negative behaviours.

Once personal prototypes of the materials have been developed, they need to be pre-tested. Pre-testing is a process of determining an audience's reaction to, and understanding of, messages or behaviour change information before materials are produced in final form. Regardless of which channels you choose, you will confirm the effectiveness of what you have developed through pre-testing.

After developing, pre-testing and revising the materials, you will need to distribute and monitor them. Further revision and modification may be necessary at a later stage. Given the time, money and effort required to produce effective HIV/AIDS BCC materials, it is not uncommon for programmers to plan and budget insufficiently for distribution and effective monitoring of communication products.

Every type of item you plan to produce need to be pre-tested, assuming that various items will utilize the same basic design concept. For example, if you are producing banners and posters at the workplace and they are all targeting the same audience, you can pre-test just one image for them all. Once the materials have gone through the pre-testing and revision process often enough to ensure a good-quality product, you can produce and distribute the material on a larger scale.

Step 6: Implementation of the BCC programme

While implementation varies depending on the sector, specific channels and activities you have chosen, some common issues and challenges are frequently encountered.

Your planning should include the following key areas:

- **Developing a workplan**
- **Sequencing programme elements**
- **Timing**
- **BCC Coordination and supervision**
- **Budgeting**
- **Interactivity and synchronicity of channels.**
- **Planning for interactivity and synchronicity of channels**

Developing a workplan: A detailed workplan is essential for translating a strategy into action. The workplan identifies activities, who will be responsible for each, and how the activity will occur. It also provides more information about where the activities will happen and what the expected outcomes are.

Sequencing programme elements: Sequencing is the order in which activities are implemented. Make sure you have a clear idea of the timing of all programme events to maximize their impact.

Timing: Timing means the scheduling of activities within your programme in relation to events happening in the broader context of a community, region or country outside of your project. It is important to remember that a programme is not taking place in a vacuum. Think ahead of time about other, unrelated events, such as holidays, celebrations or political events that could compete for time, attention of your target audience(s), broadcast space, or facilities.

BCC coordination and supervision: The best HIV/AIDS BCC programmes will have a specific person in charge of coordinating and supervising behaviour change communication. This person might be the HIV/AIDS focal point or a technical staff member, and will be responsible for ensuring that all BCC-related activities take place. Even if your programme is a team effort, one person should be responsible for coordinating the process. Effective coordination is crucial to ensuring the impact of multi-component BCC strategies and programmes. The key question to ask during the development and implementation process is, "Who can answer questions about the status of any part of the process?"

Budgeting: Promoting the budget that covers the costs of the entire HIV/AIDS workplace BCC strategy development process, in addition to the costs of developing and disseminating quality BCC products and activities, is an essential component of effective implementation planning. This requires expertise from BCC staff who have been through the process and can articulate in convincing terms exactly what should be involved, what it is likely to cost, and why. Consideration of the action steps provided later for each of the eight BCC programme-development steps can illuminate budget ramifications and make planning more accurate for the costs of each step. The primary task at this point will be to ensure that implementation stays within budget**.** Some planning tips to help make this more likely include the following:

- Baseline and follow-up evaluations: Have you budgeted for both baseline and follow-up evaluations?
- Distribution: Have you budgeted adequately for distribution? Programmes often underestimate the cost of distribution.
- Quantity of materials: Have you briefed stakeholders/funders on the extent of materials production/mass media broadcasting, events, etc? They may make requests later on for wider distribution or broadcasting that could have an impact on your budget.
- Unexpected incentives: Make sure that peer educators do not suddenly request ‘incentives’ for their work that you did not plan for.

Planning for interactivity and synchronicity of channels: A comprehensive HIV/AIDS BCC strategy for the workplace ensures that channels are truly interactive and promote consistent messages in a concerted fashion. The programme should say the same things at the same time though a variety of channels.

Collaboration: Effective collaboration means sharing ideas and experience, and effectively rationalizing resources. Without collaboration, BCC interventions can suffer from mixed or contradictory messages and duplication of interventions and services.

Step 7: Monitoring and evaluation

Monitoring

Measuring progress in achieving BCC objectives and determining whether the programme is on track require monitoring of activities and reactions. Once you have developed your BCC strategy and designed interventions, you will be ready to establish a monitoring plan. Monitoring must take place continually throughout the life of the programme. An effective and well-designed monitoring plan should have mechanisms in place to ensure that staff understand why monitoring is necessary and to help them see their hard work making a difference in the programme. The monitoring plan and tools are specific to the programme being implemented, and they are designed specifically for those who are collecting the data and for the target group. The tools should be simple enough to be understood by those implementing them. They should also be comprehensive enough to ensure that the information gathered is relevant and that the programme objectives are being met.

The monitoring plan should make sure that the information collected is used to improve the project. Monitoring results also provides a bigger picture of the programme, facilitating an understanding of its goals and objectives.

Evaluation

The monitoring process allows for evaluation—a critical component of HIV/AIDS BCC programming. Evaluation helps determine the effectiveness, relevance, reach and impact of BCC activities. It indicates whether the project is achieving its objectives, and it should be an integral part of the entire programme, not just a report at the end. It takes place at the beginning, when you conduct a formative assessment, when you develop BCC objectives, when you carry out pre-testing, and when you implement the programme in line with the envisioned process and output. Evaluation also serves to determine the outcome of the HIV/AIDS workplace BCC programme and the impact on the intended audience.

Measurable BCC objectives form the basis for evaluating BCC programmes. Outcome and impact evaluations form the basis for good evaluation.

Assessing the outcome and impact of a programme

Evaluation should answer the following questions: What outcomes are observed? What do the outcomes mean? Does the programme make a difference? For example, evaluation will help determine if a BCC objective, such as stimulating community dialogue on risk and stigma, was actually achieved. Evaluation will show if there is more open discussion on issues of risk and stigma in the community.

Questions asked should be based on, and refer to, behaviour change communication objectives and the behaviour change goals of the general programme.

People do not change their behaviour overnight. It takes time and it is often difficult to attribute the change to any one component of a comprehensive HIV/ AIDS programme. However, it is possible to achieve qualitative changes in the short term, such as improved worker morale, increased comfort in discussing HIV/AIDS issues at the workplace, improved access to services that support behaviour change, and a sense that the employer is trying to create an environment that is supportive of safer, healthier behaviours.

Examples of HIV/AIDS BCC programme outcome evaluation questions:

- What has been the impact on the knowledge levels of the target/general population?
- What has been the impact on attitudes and beliefs about HIV/AIDS?
- What has been the impact on risky behaviours (e.g., sexual, drug abuse, needle-sharing) by the target/general population?
- What has been the impact on stigma associated with people living with HIV/AIDS?
- What has been the impact on discrimination against people living with HIV/AIDS?
- What has been the impact on service utilization (e.g., health, HIV/AIDS, legal, economic, social, psychological services)?

Basic steps in planning for an outcome evaluation:

- Determine when an evaluation is required
- Determine objectives of the evaluation
- Choose methodology
- Ensure that there is a budget for evaluation.

Section 6 provides guidelines and tools for monitoring and evaluating BCC programming at the workplace.

Step 8: Feedback and revision

HIV/AIDS BCC messages and approaches often need revision during the course of the programme. Sometimes messages developed at one point in time become irrelevant or simply stop having the desired impact. As the BCC workplace programme evolves, it may also become necessary to shift resources from one approach to another, or to change the programme theme.

Monitoring is a very effective tool that allows BCC practitioners to fine-tune messages once they have launched the programme. Monitoring should be a required item in the budgets and schedules of all HIV/AIDS workplace BCC programmes. Often the results of monitoring alert programme managers to problem areas in materials or messages. BCC materials and messages can sometimes become less effective following programme implementation. The needs of the target population change as they confront materials that lead them to seek other information.

3. Cross-cutting issues for implementation

There are several cross-cutting issues to take into account while implementing an HIV/AIDS BCC workplace Programme:

- **Involvement of people living with HIV/AIDS:** Effective BCC programming for HIV/AIDS at the workplace ensures that people living with HIV/AIDS are involved in every aspect of programme development and implementation.

- **Confidentiality:** The ILO Code of Practice on HIV/AIDS and the world of work comments in detail on this issue. Confidentiality at the workplace is essential to developing an effective HIV/AIDS workplace programme. Peer educators and managers of the project must receive training on how to ensure confidentiality.

- **Gender:** The issue of gender is very important for the design and implementation of BCC programmes because gender-based inequalities are one of the driving forces behind HIV/AIDS and because socially-sanctioned gender norms usually dictate sexual behaviour. These factors shape the extent to which men and women are vulnerable to HIV, determine how the epidemic affects them, and determine their potential. Finally, gender considerations determine the extent to which women are allowed into the workplace, and the expectations that exist for women in society. Therefore, addressing gender-based norms and expectations is critical to achieving behaviour change.

  BCC interventions must always be mindful of gender-based concerns. For instance, programmes that focus on increasing condom use among women must address the issues that affect a woman's ability to procure condoms, negotiate condom use, and seek treatment for sexually transmitted infections. Including gender concerns in programmes can help make health messages more effective, as well as encouraging communities to discuss and respond to issues of gender inequality.

Gender considerations can be addressed in the following ways:

- Include a gender perspective in your formative assessment. Assess the gender-related roles, responsibilities and needs of your target populations and what your programme might do to respond to them.
- Monitor gender information. Develop programme goals, objectives and indicators that capture gender information.
- Develop separate audience profiles for men and women. Assess (as applicable) differences in HIV/AIDS knowledge, attitudes and practices; health concerns; media habits; social support networks; etc. Plan interventions with these differences in mind.
- Develop positive messages. Promote positive gender roles and relationships in your messages and materials.
- Involve men and women. Involve men and women from the target audiences in your programme in every stage of strategy development and implementation.
- Consider primary and secondary audiences. If your BCC strategy targets primarily women, consider the role of men as a secondary audience. For example, a strategy for prevention of mother-to-child HIV transmission would understandably have a central focus on women. Nevertheless, men can play important roles—from providing emotional and financial support, to getting tested and becoming more faithful.

▪ **Stigma:** For people living with, and affected by, HIV, the effects of stigma and discrimination are almost as deadly as the virus itself. Stigma and discrimination create an 'us versus them' mentality, whereby individuals refuse to look at their own behaviour and fail to assess their real risks of HIV infection. They also can keep people from undergoing HIV testing out of fear that their families, friends and communities will ostracize, reject and even harm them. This can accelerate the progression of opportunistic infections for HIV-positive individuals, and promote the spread of HIV to others. Stigma and shame can stifle community discussion and a desire for more information. This drives people living with HIV/AIDS into the shadows of society, where they fail to get care, support and treatment, and it allows governments, communities and individuals to deny the severity of the disease and downplay the need to scale up HIV/AIDS prevention, care and support efforts.

A comprehensive HIV/AIDS BCC approach to workplace programming should address stigma and discrimination through a variety of interventions, messages and channels. This can be done in the following ways:

- Conducting advocacy with key stakeholders to sensitize them to HIV/AIDS and the needs of those living with the virus, as well as those affected by, or vulnerable to, HIV. This is particularly important for senior management and any informal leaders at the workplace, whose example others are likely to follow.
- Thinking of people living with HIV/AIDS as stakeholders. Involve HIV-positive people and those affected by HIV/AIDS in every aspect of the development, implementation and management of HIV/AIDS programmes.
- Avoiding language that promotes stigma and discrimination. Include people living with HIV/AIDS in the development, pre-testing and delivery of BCC messages as much as possible.
- Striving to introduce 'zero tolerance' for stigma and discrimination at the workplace (including making a public stand) and ensuring that formal anti-discrimination policies are consistent with the ILO Code of Practice.
- Countering misconceptions by providing correct information about how HIV is and is not transmitted, means of prevention, HIV/AIDS symptoms, and care, support and treatment options.
- Promoting positive images, including family and community acceptance of people living with HIV/AIDS and the importance of caring for them.
- Promoting contact with people living with HIV/AIDS.
- Strengthening the capacity of providers to provide more compassionate and higher-quality care, support and treatment services.

4. Training in the implementation of the BCC toolkit

BCC practitioners will need to sensitize key tripartite leaders on behaviour change communication as an essential component of an HIV/AIDS workplace programme. These leaders will also need to be aware of the BCC toolkit and its uses. This can take the form of a half-day session aimed at business leaders, government officials, decision-makers, and facilitators in worker and employer organizations.

Training in using the toolkit

We recommend a five-day training course which consists of an orientation, an explanation of the kit and exercises to ensure mastery of every tool in the kit. The goal is to familiarize trainees with the substance and concepts of the toolkit. They will then be able to successfully facilitate training within their own sectors. Subsequent trainings within the sectors will enable the tripartite focal points to reach their goal of implementing HIV/AIDS behaviour change communication programmes at the workplace.

Training for peer educators

Training of peer educators is key to the success of a peer-education programme. Booklet 5 includes training topics and exercises.

Overview of HIV/AIDS Behaviour Change Communication Programming for the Workplace

1

Appendix

Using the toolkit: A case study

The case study outlined below illustrates how one workplace implemented an HIV/AIDS behaviour change communication (BCC) programme by using the BCC steps highlighted in the ILO toolkit.

Experience from an HIV/AIDS intervention in Mumias Sugar Company
IMPACT Project, Western Kenya
United States Agency for International Development (USAID)/
Family Health International (FHI)

Kenya is one of many African nations with a serious HIV epidemic. The HIV prevalence nationwide is estimated to be 6.7 per cent (9 per cent among women and 5 per cent among men, according to the Central Bureau of Statistics, 2003). Despite the lower-than-expected figure, the infection is still a generalized epidemic in Kenya, and efforts to bring it under control remain an urgent matter. One dramatic impact of AIDS-related deaths is the decline in life expectancy. The Kenyan Central Bureau of Statistics estimates that, without AIDS, life expectancy at birth would be about 65 years. However, because of the large number of AIDS-related deaths, it is actually only about 46 years and may decline to 45 years by 2010. Thus, almost 20 years of life expectancy have already been lost because of AIDS.

HIV infection is increasing rapidly in Kenya's Western Province, where the agro-industrial plantations are a zone of high transmission. Absenteeism due to AIDS-related illnesses, loss of experienced personnel, replacement and training costs, reduced productivity, and increased medical expenditure threaten the viability of Western Province's agro-industries.

Mumias Sugar Company (MSC) is the largest single sugar factory in Kenya, with 2,500 employees. Starting as a government-owned enterprise in the early 1970s, MSC has since been privatized and is listed on the Nairobi Stock Exchange. In 1999, the company began to work with Family Health International on the USAID-sponsored IMPACT project to implement a comprehensive HIV/AIDS workplace initiative targeting both workers and the surrounding residential community. These sites are particularly vulnerable to HIV infection, attracting large numbers of men who have disposable income, are away from their families, and are surrounded by low-income communities with disproportionate numbers of single women.

The programme includes behaviour change communication with a peer-education component, referrals for testing and treatment of sexually transmitted infections and voluntary HIV counselling and testing, as well as education, care and support in the community.

What follows is a description of BCC programme implementation at the Mumias Sugar Company, based on the eight-step process outlined in the ILO toolkit. The steps are:

Step 1: Advocacy and stakeholder involvement

Step 2: Identification and segmentation of target populations

Step 3: Formative assessment for BCC

Step 4: Development of a BCC strategy

Step 5: Development of communication support materials

Step 6: Implementation of the BCC programme

Step 7: Monitoring and evaluation

Step 8: Feedback and revision

Step 1: Advocacy and stakeholder involvement

When the programme began in Mumias in 1999, HIV/AIDS programming was limited within the company. However, since 1988, the company had been attempting to create general awareness about HIV/AIDS using traditional information, education and communication approaches (e.g., occasional lectures, brochures, etc.). The company medical officer spearheaded these efforts, directing them at the primary target population of unionized staff (approximately 1,500 front-line workers). The programme was implemented in collaboration with the Kenya Union of Sugar Plantation Workers (Mumias branch). Management and the families of all the workers comprised the secondary target population. But the company found it difficult to go beyond the stage of awareness creation.

When the IMPACT project team approached management at Mumias to talk about starting a more comprehensive HIV/AIDS programme at their workplace, they met with some resistance. As a result, the team sought the involvement of a number of top-level players and power brokers to persuade Mumias management to implement a workplace HIV/AIDS intervention. The stakeholders to whom HIV/AIDS BCC staff spoke were the following:

- Kenya Sugar Authority, the supreme sugar regulatory body in Kenya; and
- The Provincial Medical Officer of Health, who is in charge of all regional health matters. (The Medical Officer spoke to the Chief Executive Officer of Mumias and arranged an appointment for the team to meet him in person.)

The Chief Executive Officer and all eight departmental heads attended the meeting. The workplace HIV/AIDS BCC team gave a presentation to the top management of Mumias about why an HIV/AIDS intervention at their workplace would be beneficial. One of the most pivotal issues raised was the Kenyan HIV prevalence data. Another convincing aspect of the presentation that had an impact on management's decision to start a programme was the experience from other worksites that showed the benefits of starting HIV/AIDS interventions in large companies. The Chief Executive Officer concluded the meeting by directing the company doctor to accord the project team all the support it required.

Once the project had begun at the Mumias Sugar Company, the team organized further briefing sessions for various section and departmental heads to inform them of the planned intervention, its design, and the benefits of the programme for workers and the company. After presenting these points, the project team asked for, and received, the support of the section and departmental heads.

The project team also advocated prevention education and referral to other services (such as HIV counselling and testing and treatment of sexually transmitted infections). In addition, they advocated for the company to provide free and unrestricted treatment to all employees who tested HIV-positive. The treatment included medication for opportunistic infections, as well as antiretroviral drugs.

Step 2: Identification and segmentation of target populations

When Mumias initiated its project in late 1999, the company had slightly more than 4,700 employees. Employees currently number about 2,500.

The primary target population for the behaviour change communication initiative at Mumias is its permanent workers. The secondary target population is made up of the dependants of the workers who also live within the Mumias community, but are not necessarily employees of the company.

Segmentation

The project has been refining the target population as activities unfold. This approach has, for instance, enabled the project to identify high-risk sections within the larger workforce, such as the mobile sales and transport staff.

When the project began, it worked with the lower cadres, since they comprised the largest percentage of the workforce. Most of the peer educators were drawn from this group. As the project has grown, there has been more and more involvement of middle and senior cadres in the company's HIV/AIDS-related activities. For instance, the company medical doctor heads the company AIDS committee, of which the company legal officer is a member.

Step 3: Formative assessment for BCC

With the goal of designing an optimal intervention, the project team conducted a formative assessment. The assessment included the collection of baseline information prior to intervention, for comparison with a follow-up survey. This took the form of a baseline survey to establish employees' knowledge, attitudes and practices with regard to HIV/AIDS. This assessment analysed the Mumias Sugar Company as a whole, in terms of its structure, geographical location, social settings, and the risk factors both within and outside the company.

A variety of data-gathering methods comprised the assessment, including qualitative methods, such as in-depth interviews, focus group discussions and key informant interviews, and quantitative methods, such as a structured questionnaire. The qualitative

methods were designed to yield a deeper understanding of the reasons why people engage or do not engage in certain behaviours. The questionnaire—a quantitative method—served to collect numerical information (e.g., the number of workers who reported consistent use of condoms) for comparison with evaluation results over time.

Findings

The main findings of the assessment included the following:

- The majority of the workers had inadequate knowledge about how HIV is transmitted and how to prevent it.
- About 90 per cent of the workforce is male. The few female employees work within the administration department. The nature of the company's work probably explains the gender imbalance.
- Most of the employees had a negative attitude about HIV/AIDS, especially with regard to people living with AIDS. This led to stigma and, to some extent, discrimination. For example, employees did not want to mix with anyone they thought might have HIV/AIDS.
- Condoms were not readily available nor did the company distribute them. Knowledge of condom use was also limited. For example, some thought that the use of three condoms at one time would increase their effectiveness.
- Nearly all workers who had a sexually transmitted infection shied away from seeking treatment at the company clinic. The company policy outlawed treatment of sexually transmitted infections, labelling them "self-inflicted". This led to poor health-seeking behaviour by the affected, since they resorted to cheap, and often ineffective, treatment options from traditional health practitioners in the village.
- The main sources of information that employees relied on were the national media, friends and written materials.
- The majority of employees (particularly males) had disposable incomes, which they used mainly for leisure purposes.
- Many employees (particularly males) lived away from their families, and they often engaged in risky (unprotected) sex with sex workers and with some women from low-income settings in the surrounding communities.
- In some cases, female workers were at risk due to the sexual advances of more senior male employees in positions of power.
- The workers trusted their colleagues and the union, but not management, when it came to matters related to HIV/AIDS. This was particularly true of the lower cadres – the union staff.
- There was no company policy on HIV/AIDS. Treatment for HIV-positive workers was informal and generally available only to top management and chief executives.

Step 4: Development of a BCC strategy

The project developed a behaviour change communication strategy based on the findings of the formative assessment. There are six steps to devising a BCC strategy, which include development of the following elements:

- Target population profiles
- BCC objectives
- Key benefit statements
- Messages
- Theme
- Channels.

An interactive workshop was organized to develop the workplace BCC strategy. The target population profiles were taken from the formative assessment results. The project's behaviour change and behaviour change communication objectives follow.

Behaviour change objectives:

- Increase the proportion of workers who reported being faithful to one partner within a two-year period.
- Increase the proportion of workers who reported consistent use of condoms with female sexual partners within a two-year period.
- Increase the use of HIV counselling and testing services.

Behaviour change communication objectives:

- Increase the perceived distance between exposure and HIV infection, and HIV infection and AIDS.
- Increase in-depth knowledge about HIV/AIDS.
- Improve sexual and condom-use negotiation skills.
- Create a better understanding of, and confidence in, condoms.
- Create greater understanding of the risks of unprotected sex with multiple partners.
- Create greater interest and confidence in HIV counselling and testing.

One of the key benefit statements developed during the strategy design workshop was: "I will seek out sexually transmitted infection services because I don't want my wife to be mad at me." The message developed from this statement was: "Take care of your sexually transmitted infection and come home to a happy wife."

The communication strategy had various themes, the most prominent of which was "question (our) relationships". The theme was designed to be provocative, encouraging people to question their relationships. For example, whom are they relating to? Are they relating to the right person, in the right way, at the right place and time?

Mumias's BCC approach corresponded to IMPACT's larger strategy. Peer education was

the main activity. A mass media campaign dubbed 'kati yetu' – Kiswahili for 'between us' – supported peer-education efforts. This approach placed greater emphasis on interpersonal communication rather than production of communication materials, as had been the practice in the past. The idea was to stimulate community dialogue and discussion, create demand for information and services, and hopefully prompt people to adopt or maintain positive behaviour, thereby reducing the risk of infection and reducing stigma.

Step 5: Development of communication support materials

The project team adopted an interactive, learner-centred approach to the peer-education programme, weaving sessions around the needs and interests of participants. Facilitators (peer educators) start the discussion around pre-determined topics, but there is flexibility to bring in other issues, depending on the needs of the group and the ability of the peer educator to effectively handle them.

Support materials, such as small educational flipcharts and HIV/AIDS games, were developed for the peer-education project. A local artist was involved in the strategy-design workshop and drafted these materials with support from the HIV/AIDS project and workplace staff. The project team then pre-tested the draft materials with Mumias workers to see if they understood the illustrations, if they liked the games, and if they thought that the information in the materials was important and relevant. The team revised the materials based on workers' inputs, then pre-tested them again with other workers. Several more pre-tests and revisions took place before the final versions were ready for production.

The communication strategy also included a comic strip and a radio programme (*'kati yetu'*), aired on three channels, to support the interactive discussions at the workplace.

Step 6: Implementation of the BCC programme

To implement the BCC strategy, the Mumias Sugar Company took the following actions:

- Hired a full-time coordinator to manage the HIV/AIDS programme.
- Conducted sensitization sessions on HIV/AIDS for managers and union officials (some of whom were also trained as peer educators).
- Trained 100 peer educators. The ratio of peer educators to employees was about 1:50. Not all of the trained peer educators are currently active.
- Sponsored additional trainings for community peer educators (e.g., the wives and children of workers), who conducted group sessions and individual counselling for workers and their families in the community (e.g., in the factory-owned living quarters and beyond).
- Developed a life-skills curriculum, which included information on HIV/AIDS and was introduced in Mumias schools.

- Conducted trainings for health facility staff on HIV counselling and testing and sexually transmitted infections. A team of community health workers based in the health facility also received training on care and support for people living with HIV/AIDS.

Step 7: Monitoring and evaluation

Monitoring

The monitoring system is centralized. Peer educators hold weekly meetings with their peers, during which they facilitate interactive discussions about selected topics. Educators take note of difficult and unanswered questions and tackle them during subsequent sessions. Similar discussions are repeated during their meetings with their friends on a one-to-one basis. Peer educators fill in details about both meetings and submit them to a site-based BCC coordinator. These details are incorporated into the national system and form part of the project monitoring plan, as well as being a source of topics to cover in the national radio programme aired weekly on three popular radio channels. Mass media support the regional efforts by responding to issues that seem to be relevant in more that one region.

The project tracks progress based on data received from peer educators on the following indicators:

- Number of one-to-one counselling sessions held
- Number of group training sessions held
- Number of attendees at the group sessions
- Number of condoms distributed
- Number of referrals to sexually transmitted infection and HIV counselling and testing services (tracked on referral forms filled out by peer educators).

Outpatient records from the local health facility, St Mary's Hospital, also serve to track referrals.

Monthly site meetings initiated by the project also serve to monitor the progress of implementation of BCC activities at a particular site. All partners involved in implementation take part in the meeting and raise important issues that are addressed either instantly or forwarded to the regional and or national office for further assistance. In this way, implementation difficulties receive almost immediate attention.

Examples of monitoring indicators include:

- Number of trainings conducted
- Number of active peer educators
- Number of peer educators trained
- Number of peer educators attending refresher courses
- Number of people trained as 'trainers of trainers' in peer education
- Number of IEC/BCC materials developed and disseminated
- Number of group/outreach meetings held
- Number of target population reached through community outreach/group meetings, as well as one-on-one sessions broken down by gender

- Number of workplace managers and or supervisors trained
- Number of condoms distributed by peer educators
- Number of female condoms distributed by peer educators
- Number of sexually transmitted infection referrals made
- Number of HIV counselling and testing referrals made.

Evaluation

As mentioned previously, prior to launching the project, the project team conducted a survey among a sample of workers, in addition to carrying out a series of interviews and focus groups discussions. An evaluation of the Mumias project took place after its second year of operation to assess whether the knowledge, attitudes and behaviours of the workers had changed as a result. Using the same methodologies described in the baseline assessment, the project team conducted a survey questionnaire and interviews. One of the findings from the evaluation was that peer educators had better knowledge about HIV/AIDS than their colleagues who were not involved in the project.

Examples of evaluation indicators include:

- Percentage of targeted workers who correctly identify three or more modes of HIV transmission (sexual, mother-to-child, as a result of a blood transfusion)

- Percentage of targeted workers who correctly identify three means of protection against HIV infection (having no penetrative sex, using condoms, and having sex only with one faithful uninfected partner)

- Percentage of members of the target audience (men and women workers) who report having sex with a non-regular partner in the last 12 months

- Percentage of all workers who report having sex with a non-regular partner in the last 12 months

- Percentage of workers who report using a condom the last time they had sex with a non-regular partner

- Percentage of targeted workers accepting HIV counselling and testing services and receiving HIV test results in the last 12 months

- Percentage of targeted workers reporting personal knowledge of someone who has experienced stigma or discrimination due to known or suspected HIV-positive status in the last 12 months.

Step 8: Feedback and revision

Monitoring information is continually communicated to peer educators, workers, managers and administrators through interactive meetings, forums and discussions. In addition, monitoring data serves to improve the project. Based on the monitoring data, several changes have taken place within the Mumias Sugar Company. For example:

- The company now has a very active HIV/AIDS committee headed by the company doctor. The committee is charged with the overall coordination of HIV/AIDS-related activities within the company.
- The company policy has changed and now allows for the treatment of sexually transmitted infections.
- Any HIV-positive worker requiring treatment receives it (including antiretroviral therapy) without discrimination. No one is sent home. This applies to all cadres.
- Currently, the company is working closely with project staff on a transition plan for the assumption of full responsibility for all components of the project. While the medical department is the primary force in coordinating HIV/AIDS-related activities, the company is also exploring the development of a policy that includes a mandate for all departments to include HIV prevention in their programming (e.g., in staff meetings, safety talks, etc.).
- The peer educators have been able to meet their peers outside of work, if they are unable to get time off during normal working hours.