Building a Foundation - Communication for Development

"Mapping and Assessment of Communication Channels and Influential Actors at the Community Level"

ACKNOWLEDGMENTS

This research initiative was completed by UNICEF in partnership with the Health Promotion Division (HPD), Ministry of Health (MoH), National Statistics Bureau (NSB) and the Gross National Happiness Commission (GNHC).

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Photo courtesy: Mr Tashi Tshering, Information and Media Officer, HPD, MoH.
UNICEF Bhutan.

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FOREWORD

The Ministry of Health is pleased to publish the findings of this formative study report "Mapping and Assessment of Communication Channels and Influential Actors at the Community Level". This study was conducted by Ministry of Health and UNICEF in collaboration with Gross National Happiness Commission and National Statistics Bureau.

Getting effective and sustainable programme results requires a change in the mind-set and behaviours of individual and the society at large. This necessitates engaging individuals and communities in programming, and therefore the importance of communication for social and behaviour change in health promotion.

This formative study is an attempt to assess and explore existing level of awareness, knowledge, attitude and practices of individuals and families at the community level on issues related to child care and development. viz. maternal and child health (ANC, PNC, institutional delivery, exclusive breast feeding), child disability, ECCD, hygiene and sanitation and early marriage. The report also have useful insights about where families received information and who within their local community are influential in their decision-making.

Taking stock of source of information and understanding community dynamics are critical for designing effective communication interventions in health promotion.

I hope and urge colleagues to use the findings of the study as well as other information, so that our programmes plans are holistic and effective to facilitate better sustained results.

Tashi Delek.

Dr. DORJI Wangchuk
SECRETARY

LIST OF ABBREVIATIONS

ANC	Ante-natal care
BBS	Bhutan Broadcasting Service Corporation
BCC	Behaviour change communication
BHU	Basic health unit
C4D	Communication for Development
CBSC	Communication for Behaviour and Social Change
CSO	Civil society organization
EBF	Exclusive Breast Feeding
ECCD	Early Childhood Care and Development
FGD	Focus group discussion
GNHC	Gross National Happiness Commission
GPI	Gender parity index
HPD	Health Promotion Division
IPC	Interpersonal communication
JMP	Joint monitoring programme
KAP	Knowledge, attitudes and practices
MCH	Maternal child health
MDGs	Millennium Development Goals
MoH	Ministry of Health
MPI	Multi-dimensional poverty index
NFE	Non-formal education
NSB	National Statistical Bureau
PNC	Post-natal care
RNDA	Rapid Nero Development Assessment
RGoB	Royal Government of Bhutan
RUB	Royal University of Bhutan
SDGs	Sustainable Development Goals
SEM	Socio Ecological Model
TTM	Trans-theoretical Model
UNICEF	United Nations Children's Fund
VHW	Village Health Worker
WHO	World Health Organization

GLOSSARY OF DZONGKHA TERMS

Chiwog	Community
Dzongdag	District Governor
Dzongkhag	District
Gewog	Sub district administrative unit
Gomchen	Lay monk
Gup	Elected community leader
Je Khenpo	Chief Abbot
Karma	The Buddhist notion of cause and effect
Tsip	Traditional astrologer
Tshogpa	Elected community representative

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EXECUTIVE SUMMARY

Bhutan can take pride in the significant gains made in achieving the MDGs. This has been possible due to the receptive and responsive government policies, systems and services. However, this progress is slower among the rural population. Gaps exist in the delivery and utilization of services among vulnerable segments. If Bhutan needs to sustain the progress achieved under the MDGs and commit to the SDGs, conserted effort is required to strive for improving the lives of the vulnerable population.

Communication for Development (C4D) or communication for social and behaviour change is one key strategy to realising these aims. C4D provides opportunities for inclusion of vulnerable groups, listening to and learning from local knowledge and resources. C4D can contribute to shift in both individual behaviour and wider social change that are necessary for long-term, sustainable programme results. Integrating C4D into programming requires evidences to better understand "why' a problem exists. Why people behave the way they do; where do people get information; and who influences them in their decision-making processes (community dynamics).

UNICEF in collaboration with the Health Promotion Division (HPD) of Ministry of Health (MoH); Gross National Happiness Commission (GNHC) and National Statistics Bureau (NSB) initiated this qualitative study "Assessment and Mapping of Communication Channels and Influential Actors at the Community level" to explore level of awareness and understanding of individuals and families, their current practices on various topics. viz. maternal and child health, ECCD, child disability, and child protection. The study also assessed key information sources and influential actors in their decision-making on these topics. The study was carried out among women, men and children in western, central and eastern regions of Bhutan.

The study findings show knowledge and attitudes of respondents varied for different topics. For example, majority of the respondents had adequate knowledge and positive attitude on maternal and child health care. Majority could explain benefits of exclusive breastfeeding for six months, the importance of completing the required antenatal and post-natal checkups and delivering in a health facility. Their main sources of information for the topic were health workers, the broadcast media and their peers.

However, respondents' knowledge, attitude and practices differed for other topics. For example, while respondents have some awareness that corporal punishment is banned in schools, they do not know the negative impacts of corporal punishment on child's emotional, cognitive and physical development. As a result there is a general acceptance of corporal punishment in school and at home. This is partly because there is limited consultation, discussion at the community level and families have very limited knowledge and skills on alternative positive disciplining. And further the social norm of "spare the rod and spoil the child" is still strong among families at the community level.

The findings of the study showed that individuals and families generally rely on friends, relatives, neighbors and the media, particularly radio and TV, for general information. Respondents prefer to discuss with their friends and relatives, consult experts, local leaders to decide their actions. The majority listens to their parents, spouse and religious persons, and perceives consulting religious persons as important as consulting experts.

BACKGROUND

Bhutan has made impressive progress in achieving the MDG targets. This is reflected in the significant drops in under-five mortality rate (deaths per 1000 live births) which have decreased from 69 to the current level of 37.3. Infant mortality rate (deaths per 1,000 live births) now stands at 30.0 compared to 47 in 2012.[1] Antenatal care (ANC) coverage for at least four visits has also increased from 77.3 to 81.7 per cent. Stunting has declined from 33.5 per cent to 21.2 per cent between the years 2010 and 2015.[2] At the same time, improved sanitation facility coverage in Bhutan has risen from 58 per cent to 66.3.[3] Gender parity index (GPI) has improved with primary school level at 0.98 per cent, 1.16 per cent for higher secondary level and 0.78 per cent at the tertiary level.[4]

Despite these improvements, concerns remain on how to further boost progress and ensure equitable gains, especially for poor and non-literate families living in some of Bhutan's most remote communities. The Royal Government of Bhutan (RGoB), along with development partners, remains committed to ensuring health and education gains for all segments of society. Priorities include sustaining and scaling up progress made as Bhutan prepares to address the post-2015 development agenda and the SDGs. People's knowledge, beliefs and social norms are some barriers associated with bringing about the desired social and behaviour change.

Communication for Development (C4D) is central to realising these aims because inclusion of communities, particularly vulnerable groups, is key to sustainable development. C4D promotes shifts in both individual behaviour and wider social change, which are necessary for long term development. Systems strengthening and service delivery provision must go hand in hand with the active engagement of families and communities because parents and caregivers have an important role to play in caring for, protecting and nurturing children in order to sustain long-term positive impact and improved quality of life.

C4D is a strategic communication that stimulates engagement of stakeholders to provide supportive policies, legislation, resources and service delivery systems, which can empower parents and caregivers.

1 National Statistics Bureau, Royal Government of Bhutan, Bhutan Multiple Indicator Survey (BMIS) 2010, Thimphu, Bhutan, 2011, p. iii and Ministry of Health, Royal Government of Bhutan, National Health Survey (NHS) – Summary of Findings 2012, Ministry of Health, Thimphu, Bhutan, 2012, p. 6.
2 Ibid, p. iv (BMIS 2010) and p. 5 (NHS 2012) and the National Nutrition Survey (NNS, 2015).
3 Ibid, p. iii (BMIS 2010) and p. 4 (NHS 2012).
4 Policy Planning Division, Ministry of Education, Royal Government of Bhutan, Annual Education Statistics 2014, Ministry of Education, Thimphu, Bhutan, 2014, p. ix.

Enlistment of local service providers and community leaders/influencers through C4D interventions can contribute to promoting essential healthy behaviours. Bolstering ownership of healthy behaviours through improved knowledge, attitudes and practices, along with uptake of available services is necessary to shift existing social norms to promote health and development outcomes.

COMMUNICATION FOR DEVELOPMENT (C4D) – A STRATEGIC APPROACH

C4D is defined as a systematic, evidence-based process to promote positive and measurable individual and social change. It is an integral part of development programmes, policy advocacy and humanitarian work. C4D uses a broad range of tools and approaches and focuses on stimulating change at multiple levels through engagement and involvement of stakeholders and participants– including children, their families and community members.

C4D is both a tool and a process which provides caregivers and community members with essential information, skills, and confidence to make informed decisions on issues that affect their lives and well-being. Development efforts in the past often focused only on individual and household level behaviour change through the use of strategies that produced small-scale, fragmented, or short-term behaviour change results.[5] It is now recognized that in addition to changes related to individual-level knowledge, attitudes and practices; consideration of the wider social environment (both within the family and community) must also be addressed as sustainable change rarely occur in isolation. It is often influenced by the expectations of others.

C4D makes use of different types of communication to activate and engage communities and decision-makers at local, national, and regional levels, in dialogues promoting, developing, and implementing policies, programmes and actions that enhance the quality of life for all.[6] Behaviour change communication (BCC) is focused on the individual. Interpersonal communication (IPC), for example by a health worker to a client, can accelerate individual change. Social mobilization (including strengthening an enabling media and expanding partnerships), social change communication (which involves community discussion and dialogue in order to address social norms and promote empowerment) and advocacy initiatives can provide an enabling environment for sustained change.

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5 United Nations Children's Fund, *Global Strategy Development Guide for Maternal, Neonatal and Child Health: Key Communication Foundations and Practical Planning Steps for Communication for Development, 2015*, Overview, p. 1, <www.unicef.org/cbsc/index-65738.html>, accessed 28 December 2015.

6 Ibid, pp. 4 - 5.

C4D is most effective when applied through a combination of approaches involving different stakeholders and participant audiences which contribute to combined, cumulative and synergistic actions related to promoting change within the supporting environment (or social-ecological environment) where children, caregivers and family members live.

(Refer **Annex A** for a detailed description of communication approaches included as part of C4D, key features of each and how these can be used as part of a comprehensive C4D strategy or plan.)

THEORIES OF CHANGE

There are numerous communication theories and models which have been developed to explain or demonstrate the behaviour change process either at the individual or wider community level. Two models of change theories - the Socio Ecological Model (SEM) and the Trans-Theoretical Model (TTM) were used as a framework for this study. These models were used as they are linked to provide critical information related to identifying where participant groups are on the spectrum of change and what entry points for partners and influencers at various levels can assist with promoting movement to facilitate the change process that is important in terms of creating a foundation for the design and use of strategic C4D interventions.

THE SOCIO-ECOLOGICA LMODEL (SEM)

Behaviour affects and is affected by multiple levels of influence. The Socio-Ecological Model (McLeroy et al., 1988) provides a framework to specifically explore this.

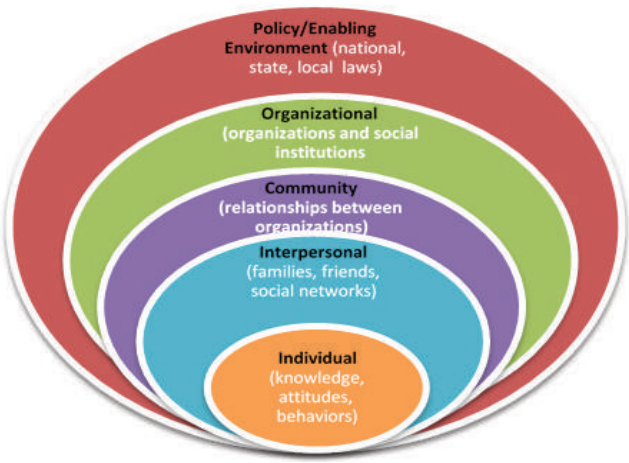


Fig 1: Socio Ecological Model

With parents or caregivers of children or with children themselves as the focus, five surrounding levels of support (as illustrated in **Figure 1**) can be used to promote change related to the adoption of new practices or uptake of services.

- The **individual level** addresses knowledge, attitudes and skills or understanding required

to take action or apply desired practices (KAPs).

- The **inter-personal level** includes relationships and interactions with family, friends, peers and neighbours who have the ability to influence knowledge, attitudes and actual practices of caregivers through IPC.

- The **community and organizational/ institutional levels** includes opinion leaders and trusted sources of information (also including service providers) who have strong roles to play in promoting both individual behaviour as well as stimulating wider social change.

- The **policy/ national level** supports the creation of an enabling environment based on existing and new legislation, policy and regulations along with financial and human resources that must be in place in order to enhance or extend services and ensure they are available / accessible to all.

Strategic C4D action promotes engagement with selected stakeholders at various levels, through different communication approaches. C4D also aims to create opportunities for dialogue, discussion and shared learning within communities or small groups. It strengthens communication skills and the use of IPC, and supports advocacy actions (both at community and national levels) as part of the creation of an environment that is conducive for change.

The Trans-Theoretical Model (TTM)

The Trans-Theoretical Model, represented in **Figure 2**, includes the stages of change and illustrates the continuum of steps related to individual level behaviour change. The sequence follows stages which include an individual moving from **being unaware to learning about an issue** to **considering its application or use.** Once a **decision is taken**, **trying out the new behaviour** or practice occurs and if successful or positive results are experienced, **the new behaviour or practice is maintained.** In some cases, the person may become **an advocate or champion of the new practice** or desired action for others in their immediate environment or wider community.

However, at any point in time, an individual may discontinue the practice or re-start the process based on intention, levels of motivation or other factors (difficulty in maintaining the change or due to pressure or influence from others).

C4D dimensions can support increasing the awareness and understanding an issue. Besides, it can support the actual uptake of new practices by facilitating discussions and interactions between families, service providers and other key influencers at the community. These interactions impact better awareness and capacity of all stakeholders and facilitate the behaviour change process, strengthening sustainable actions associated with each of the steps. Questions considered in application of the models and the subsequent development of a C4D response (which includes specific communication strategies, actions, development of communication products and an implementation plan) may include the following:

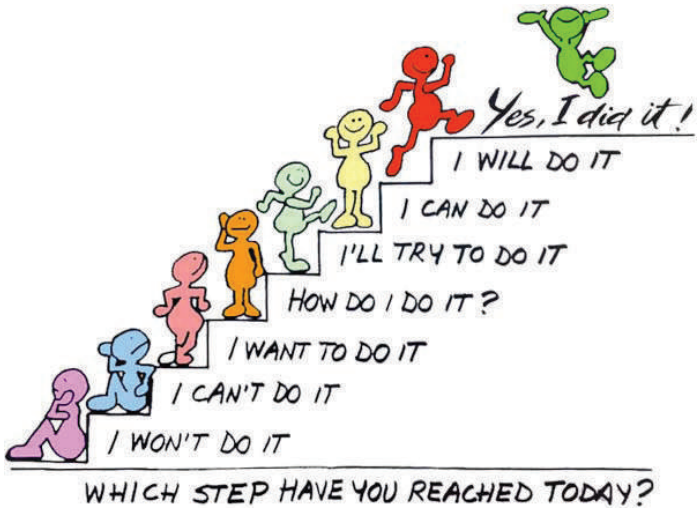


Fig. 2 : Trans-Theoretical Model of Behaviour

- Who is the primary participant group and what are their gaps in terms of awareness, knowledge, attitudes and practices?

- Who else (what other groups) could be enlisted to provide information, guidance, reinforcement and support (within the family, community or at the institutional/organizational level)?

- Do these influencers, opinion leaders or service providers need additional support (as secondary participant groups) in order to play a positive role?

- Where on the change continuum are participants placed and how can communication actions be used to promote their progress?

- What are the easiest and most effective ways (channels or types of communication) to reach them?

PURPOSE AND METHODOLOGY

Purpose and objectives

While there has been increased recognition of the role of communication in harnessing participation of individuals, groups and sectors towards achievement of development goals, there has been limited analysis on the use of strategic communication to support programmatic goals in Bhutan. In order to support equitable sharing of knowledge, access and utilization of services associated with survival of newborns, improved nutritional status, early detection of disability, promoting and improving early stimulation and increasing understanding on child protection including uptake of services, specific objectives of the assessment included:

- Identification of credible, preferred and accessible sources of information for families at the community level.

- Identification of key influential actors and change agents for families at the community level.

- Establishing a foundation for development of an integrated communication for behaviour and social change action plan for use in programming work.

- Engagement of relevant stakeholders at the community level for probable future partnership in follow up actions and work.

Methodology

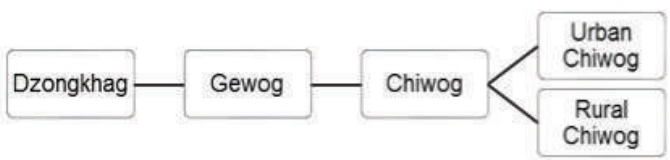
The assessment study and mapping was conducted using a combination of semi-structured interviews and focus group discussions (FGDs) to explore current levels of individuals' knowledge, beliefs, attitudes and practices at the community level. Partners and relevant agencies (including Health Promotion Division of Ministry of Health National Statistics Bureau, Gross National Happiness Commission, Royal University of Bhutan (RUB) and program staff from the UNICEF Bhutan Country Office were consulted as part of the process.

Sampling

While it is not a formal quantitative assessment, sampling was done through selection of six *dzongkhags* from three regions in the country based on the Multi-dimensional Poverty Index (MPI) performance (including one High Performing and Low Performing area in each of the three regions) and population size. The sampling frame was developed based on recommendations given by the NSB and the Planning, Monitoring and Evaluation Section of the UNICEF Bhutan Country Office.

Table 1: Sample Regions

Criteria	**MPI by Region**		
MPI Performance	**Western**	**Central**	**Eastern**
High Performing	1	1	1
Low Performing	1	1	1



Within each *dzongkhag*, the *gewog* with the largest population or presence of minority communities was chosen. Within selected *gewogs*, two communities (or *chiwogs*), one urban and one rural, were also included.

Focus group discussions (FGDs)

Within each *chiwog,* four focus group discussions were conducted by an experienced facilitator and two note takers. Participants were selected with the assistance of the *chiwog* leader based on availability. Extra effort was made to ensure that no two participants from the same household or family participated in the interviews.

Age ranges for those participating in the FGDs and in-depth interviews included the following:

- Women – Mothers/ Caregivers: 15 to 49 years of age
- Men – Fathers/ Caregivers: 15 to 49 years of age
- Adolescents: 12 to 18 years of age
- Children: 6 to 11 years of age

Individual in-depth interviews

Interviews were conducted with influential actors identified by participants during FGDs. From each *gewog*, a minimum of five in-depth interviews were conducted. These include:

- Heads of Households
- Community Leaders (Gup or Tshogpa)
- Government Officials and Staff (Teachers, Health Workers, Doctors)
- Religious persons (Monks, astrologers and lay monks).

Development and pre-testing of assessment tools

Tailored interview guidelines and questions were developed and used for each target group. The guidelines were translated into local language and pretested among the families and children. All enumerators were trained for three days on interview protocols and ethical considerations. The guidelines used for FGDs were also pretested and revised when and where necessary.

Key questions on communication dimensions, focused on the following:

- What is their current practice or behaviour associated with each issue or topic?

- What shapes their decisions on behaviours or practices relating to the topic?
- Where do they obtain information on the issue or topic (from what source)?
- Who else influences them or provides additional guidance and support?

Ethical considerations

All respondents consented to participate in the interviews and they were informed about the purpose and objectives of the study. They were also given the option to withdraw at any time. For participation of children under the age of 18 years, both the child's consent and that of the parent was obtained. The study protocol was also reviewed and endorsed by the ethics committee of the Ministry of Health and by the National Statistics Bureau.

KEY FINDINGS

Maternal and child health – ensuring a healthy start

While Bhutan has made excellent progress in reducing deaths among children, newborn mortality rate remains high. The National Health Survey 2012 highlights that 21 out of 1,000 babies born alive die within the first month, indicating that about 67 per cent of infant deaths occur within the first 28 days of life. Coverage of at least one antenatal care visit (ANC 1+) is 97 per cent, but declines to 81.7 per cent for at least four visits. Coverage reduces further to 26.1 per cent for eight visits (including both 4 ANC and 4 post-natal care (PNC) visits which is the ideal). Disparities exist in practices which support assisted delivery and in uptake of services between socio-economic levels, rural vs. urban groups and for those with varying levels of education.

Findings from the assessment indicate that men and women in both rural and urban areas have adequate knowledge related to mother and child health care. Majority cited ANC, institutional delivery and PNC as important for the health and safety of both the mother and the child. They also highlighted that it was important to access health facilities and follow advice of health workers on pregnancy and institutional delivery. Respondents said they have trust in health services and considered both doctors and health workers as an important source of information.

'Sometime delivering at a Basic Health Unit is not possible because health workers cannot say the exact [delivery] date. After the check-up, health workers would send us back asking us to come back next time. However, after reaching home, some mothers go into labor and are forced to deliver at home. Also BHUs do not have proper waiting facilities like room and even food is not being provided unlike in the hospitals. And it is not easy to find a place to stay at the health center until the mother delivers. So we go back home.' - A mother

The respondents, especially those who were non-literate, gained additional information and knowledge on mother and child health from friends and neighbours, as well as from village health workers, local leaders, and health programmes aired on BBS radio and television. A few literate mothers in urban centres also flagged the use of internet and the Mother and Child Health (MCH) handbook provided by health centres during ANC as the reliable sources of information.

The majority of women reported attending both ANC and PNC clinics for checkups prior to and following delivery at a health facility. This was due to advice and encouragement given by health workers and doctors. They also mentioned that parents, elders and friends also supported delivery at a health centre and encouraged them to follow up on all recommendations and advice provided by health workers.

Majority of the respondents believed that delivering at home was a practice of the past or an option only when access to health facilities and services were difficult due to long travel distances. However, many of them also agreed that there are still some mothers who deliver at home, particularly in rural areas. This is mainly because some families cannot afford financial cost for transportation, food and other support required while waiting for delivery at the health centre. While BHUs have maternity ward facilities, food is not being provided unlike in the hospitals. There is also the challenge of taking care of other children at home when both the parents have to come and wait at the health centre for days. These were cited as factors contributing to make decisions to deliver at home.

Some women also mentioned that the unfriendliness, negative attitudes of health workers and absence

of female health staff as other deterrent. While respondents believed that ANC and PNC visits are important for the health of the child and the mother, only few could state the danger signs of pregnancy or the complications of home delivery.

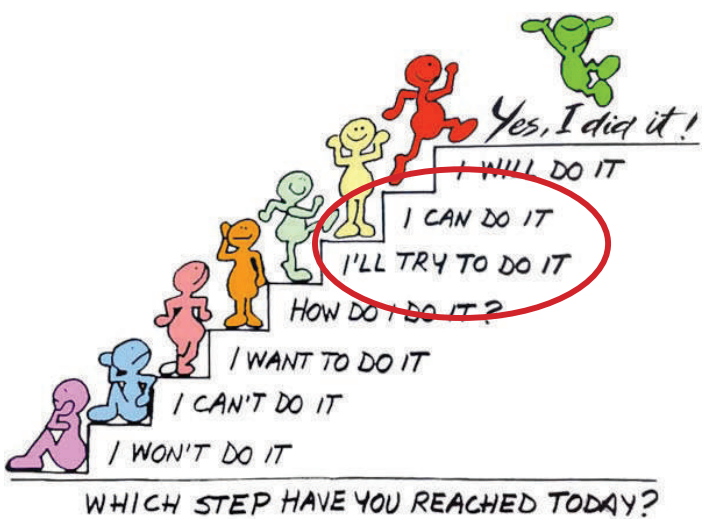
> *"While advice from health workers is important, it is also equally important to consult astrologers and perform rituals to appease local deities in order to have a safe delivery." –A mother*

Most women reported completing four PNC visits and mentioned that these are important for checking the health of the child and obtaining necessary immunizations. But it was also highlighted that some mothers do not attend health check-ups unless they face problem following the delivery. With regard to those who influence decision-making related to delivery and maternal-child health care, it was reported that many women turn to parents, spouses and health workers for support, advice and information. Alternatively, respondents from eastern and western regions mentioned that some families also consult astrologers or religious practitioners to determine the best place for delivery. Respondents also mentioned that these days, even some of the religious persons encourage them to deliver at health centres.

Respondent levels related to the behaviour change process: contemplation, decision-making and taking action.

Summary: Overall, both men and women respondents had a high level of knowledge and positive attitudes on the importance of ANC, institutional deliveries and PNC. They also believed that these practices are important for better health and well-being of the mother and the child.

While there is good knowledge and positive attitudes towards ANC visits, safe pregnancies, institutional deliveries and PNC visits, there are gaps in practice related to institutional delivery due to competing priorities like quality of services, attitudes of health workers, distance and cost of transportation and facility to stay at the health centres.



Infant and young child feeding practices – exclusive breastfeeding and introduction of complementary foods

Stunting is the most common form of chronic under-nutrition among children. It is the outcome of long-term nutritional deprivation which results from poor nutritional diets during pregnancy and inadequate nutrient intake during infancy and early childhood. Exclusive breastfeeding for first six months and improved complementary feeding practices after six months along with breast milk for at least first two years of life can significantly boost adequate nutritional requirements for children. In Bhutan, the national average for exclusive breastfeeding is 49 per cent. The figure is even lower for those from poorer households, residing in rural areas and with lower levels of education.

"I don't know if advice on exclusive breastfeeding for six months is possible in practice. While health workers and doctors recommend this to us, they do not practice it themselves." - A mother

From the FGDs, both men and women across the regions mentioned that infants should be exclusively breastfed. However, based on their past experience, the estimated timeframe for exclusive breastfeeding ranged from three to four months. There was a general agreement that exclusive breastfeeding for the first six months was not possible for the majority of women. Reasons given for not being able to breastfeed exclusively for six months included the following:

- Unable to stay at home for full six months as mothers had to return to work. Women in rural areas said they have to resume work even sooner and as a result babies are left with grandparents.

- Some mothers cannot produce sufficient milk so that they are compelled to start complementary feeding early.

- Relatives of the mother, mostly elderly women often recommend giving additional food during the first six months. Respondents said although they trust the advice of the health workers but many respondents said that they also trust the advice of the village elders as they have the experience. Respondents felt this to be a more practical approach.

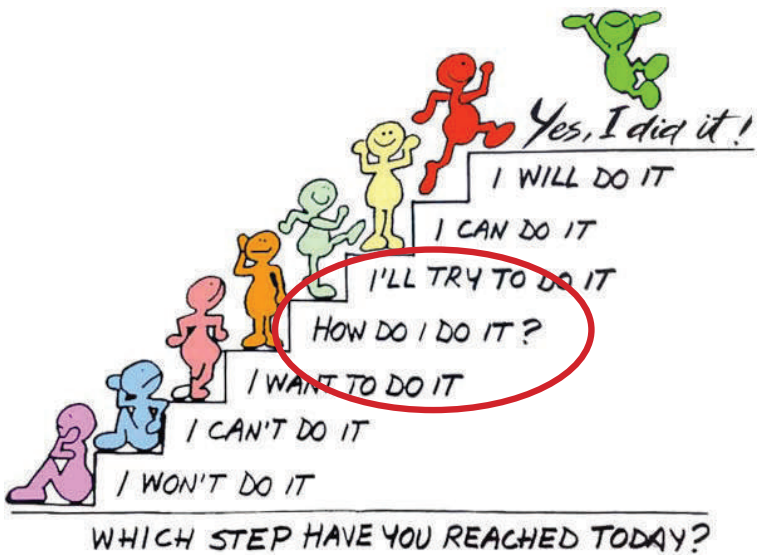
- Some mothers mentioned giving food during first six months when babies cry too much or when babies get fussy or cranky, which they believed was due to inadequate feeding.
- Mothers decided to give other foods when they were sick and felt that they could not breastfeed the

child. *(Refer Annex B for list of complementary foods given to babies during first six months)*

The main source of information on the importance of breastfeeding included broadcast media (BBS radio and TV), friends and colleagues, elder women and their own mothers. Health workers, doctors, village health workers were also mentioned as main contacts from whom they receive additional information on exclusive breastfeeding. Some literate mothers in urban towns also mentioned seeking out additional information from the internet.

Respondent levels related to the behaviour change process: contemplation, decision-making and taking action and maintenance.

Summary: Both men and women across all regions knew that babies should be exclusively breastfed for six months, but there was knowledge gap related to the practice. There was general agreement that the majority do not fully uptake exclusive breastfeeding due to factors associated with breastfeeding not being "practical" and due to influence from others (especially elders) to start giving complementary food in addition to breast milk prior to completing six months.



Early childhood care and development (ECCD) – at home and beyond

Interaction and engagement with children in the early years ensures strong development from the start. Good practices related to ECCD begin at home through proper care, nurturing and the provision of a stimulating environment. Enhancing the quality of early childhood experiences contributes toward reduction of social inequities, helps ensure a successful start to quality education and helps raise levels of productivity for society and the nation as a whole.

While work around promoting ECCD in Bhutan has begun, according to the Ministry of Education's Annual Education Statistics (AES, 2014), only 9 per cent of children aged 3 to 5 years attend or are linked

to formal ECCD facilities or centres. Furthermore, the Bhutan Multiple Indicator Survey (BMIS) 2010 highlights children from poorer households are less likely to be engaged in early learning than their wealthy counterparts.

From FGDs it was found that respondents believed that spending time with children and telling stories is an important activity to pass on tradition and culture. Very few mentioned early stimulation and its linkage to intellectual development. With regards to sending their child to an ECCD centre, while some parents mentioned benefits such as improved social skills and school readiness, others felt the programme was beneficial to working women as they had less time to spend with their children.

Others mentioned that ECCD centres provided a safe place for children while parents were at work. Some respondents even mentioned that sending a child to the centre was better than leaving with other relatives or grandparents.

"Some parents and ECCD facilitators expect children to learn how to read and write which should not be the case. Children should be enjoying and having fun at this age. This expectation imposes pressure on children and puts them under stress, therefore, we have to weigh the benefit of sending them to the ECCD centre." - a father

Constraints mentioned by respondents in sending children to ECCD centres included costs associated with private facilities and that the practice was more practical for those in urban areas with steady salaries or incomes. Other concerns included that it was important to know the proper age, because if sent too early, this could be stressful to the child as they would be forced to learn or do things the children might not be ready for (i.e. being forced to learn how to read and write). Others expressed reservations on the qualification or experiences of ECCD facilitators.,

The majority of respondents agreed that it is important to spend more time with children so as to give proper care and feeding. Besides care and feeding, playing, telling stories and singing songs are some ways parents and caregivers spend time with their children. Women explained that spending time with children is important to support the child's development and to pass on age-old Bhutanese culture and traditions. On the other hand, men felt spending time with the child is important as it develops bonding between the parents and the child. They also believed that reading to younger children could help make the child smarter, contribute in confidence building and prepare them for formal education. One challenge identified and mentioned by all respondents was the lack of or limited time they had due to the demands of work. Despite a preference of some respondents to send children to attend ECCD

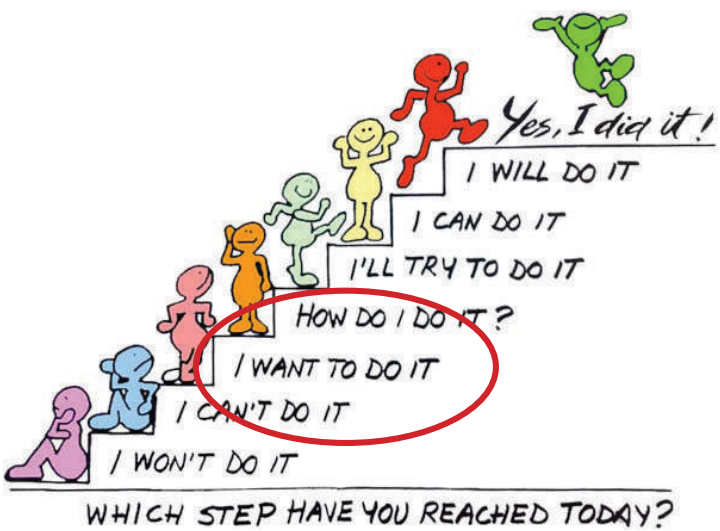
centres, most children had to be left in the care of other relatives, mostly grandparents, in both rural and urban settings due to cost.

Information sources related to ECCD included BBS (both radio and TV including the BBS television program "Do You Know Your Child?"). Teachers, friends, neighbours and health workers were also mentioned as trusted sources of advice on the topic. In addition, information was also provided through announcements given by local leaders (Gup) at public meetings. Some also mentioned learning from school teachers, NFE learners and children themselves. Both men and women agreed that they would be willing to discuss and learn more about ECCD with those who have sent their child to ECCD centres as they have direct experience.

The majority felt it was important to consider the views of their parents and spouses in making decisions about children's enrolment in ECCD centres. However, some men, mainly those from minority communities, reported that they would not discuss child-rearing or household topics with their wives as this is not a tradition in their community.

Respondent levels related to the behaviour change process: pre-contemplation, contemplation and decision-making.

Summary: While many parents agreed that ECCD is important for the development of children, there are also a wide range of beliefs associated with what ECCD is and where it can take place (at centres vs. at home). Some had concerns about certain activities being forced upon children while others questioned the qualifications of ECCD facilitators and teachers. Others felt sending children to ECCD centres beneficial especially for those parents who have work. However, sending children to centres was primarily viewed to be a service for those in the urban locations and with better income.



Many mentioned learning about early stimulation through the BBS radio and television. A challenge pointed out was parents do not have enough time to interact with their children and children are left in the care of grandparents or relatives.

Child disability –identification and response

While children with disabilities are entitled to the same rights as all other children, they are more at risk to discrimination, abuse and exploitation. The Bhutan Two-Stage Disability Study (2012) indicates an overall prevalence of 21 per cent disability in the country, of which 26 per cent for children who come from poor families, compared to 14 per cent coming from the highest wealth quintile.

"My friend's child was healthy until he was three. After that the child started vomiting and was paralyzed. He was unable to speak but could still hear and see. The parents took him to the hospital but the doctors were unable to help so they took him to a Rimpoche. The Rimpoche said that the child was reincarnation of a lama and because of impure habits of the parents, the child turned out like this.". - A mother

The findings of this assessment showed individuals and families have limited knowledge about child disability. For majority of the respondents, disability was associated with physical disability or impairment. Developmental disabilities were rarely mentioned.

Karma (or the Buddhist notion of cause and effect) was cited as the main cause of disability which also resulted in attitudes associated with pity or blame towards both the parents and the child. Some respondents highlighted the carelessness of mothers during pregnancy, lack of proper diet, consumption of un-prescribed medicines, smoking and alcohol use– along with missed immunizations or domestic abuse as other factors contributing to child disability.

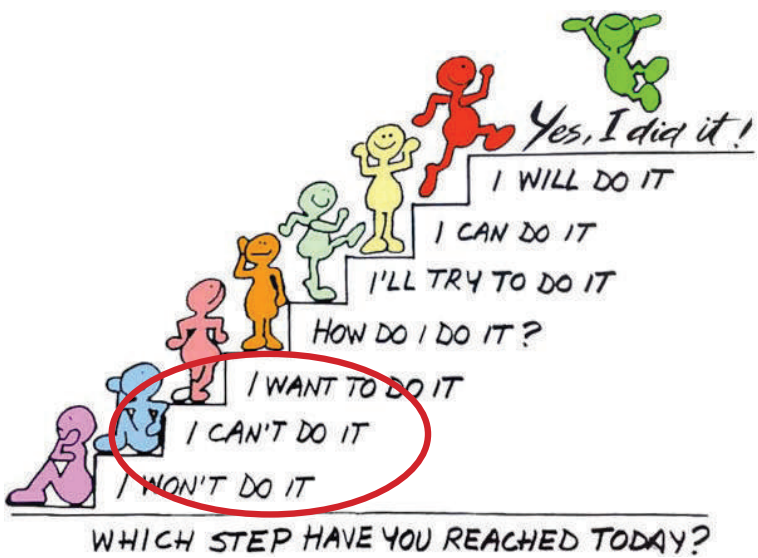
When asked about early identification of disability, most respondents were not sure who to go to except for checking to see if the child could properly see, hear and speak. They said they wave objects in front of the child to check if the child can see and make a loud and sudden noise to see if the child can hear.

All respondents agreed that if they felt their child might have a disability, they would consult a doctor. However, some mentioned that hospitals cannot provide cure for disability. Many mentioned the importance of taking the child to religious practitioners so that religious cleansing rituals (such as *ka-goh* and *jab-thru*) are performed, believed to remove obstacles and negative *karma*.. .

For the most part, respondents were unsure who to seek treatment or advice if their child had a disability apart from health care providers and religious persons. While parents were aware of special schools to support children with physical disabilities, they also felt that these were few in number and located far away. There was no mention of physical therapy services like rapid nero-development assessment (RNDA) tools available at hospitals as another potential service resource. Due to this, they reported that family members had no other option but to keep the child at home.

The sources of information on disability included broadcast media (BBS television), health workers, community leaders, friends and neighbours. In terms of decision-making related to disability, the most trusted persons included health workers, religious leaders, community leaders (Gups), relatives and their own parents. Some mentioned that they might also seek help from various civil society organizations (CSOs) such as the Tarayana Foundation in order to provide guidance related to taking next steps.

Respondent levels related to the behaviour change process: *pre-contemplation and contemplation.*



Summary: Throughout the country there exists a mixed understanding of disabilities, how disabilities are developed or caused and what to do when parents believe their child may have a disability of some sort, including where to seek services and support. The majority of adult participants were able to clearly identify physical disabilities (such as vision, hearing and speech impairment)., However, very few mentioned or were aware of developmental disabilities. Most of them lacked understanding on early detection of disability and who to turn to for help. While the issue of stigma was not investigated or discussed, the participants explained that the main cause of disability is due to *karma*– the Buddhist beliefs of cause and effect and "fault" of the parent/caregiver due to improper care.

Based on this, it is possible that these views or attitudes continue to contribute to a less supportive

environment for parents and caregivers and social pressures which might cause their children to be kept at home or hidden away. It was also understood that it was the parent's fate to support the child yet few had clear ideas what this "support" would entail.

Handwashing and use of clean toilets

Bhutan has made exceptional progress related to creating access to improved water sources raising this from 54 per cent in 1990 to 98 per cent in 2012.[7] The challenge, however, remains that only an estimated 58.4 per cent of the population has access to improved drinkable water and an estimated 50 per cent to improved sanitation as of 2015.[8] This estimate is as per the WHO/UNICEF Joint Monitoring Programme (JMP) definition of Improved Water and Sanitation.

"It is important for us to wash our hands with soap and use a clean toilet because it can prevent spread of diseases, and helps to lead a healthy and happy life" – A primary school student

"If we don't wash hands we will get diseases like diarrhea, cough and cold and other diseases. Virus and germs will get into our stomach and lay eggs. If we don't keep the toilets clean, flies from toilets will sit on our food and we will get sick." – A primary school student

Based on the finding of this study, handwashing with soap and water has become a common practice in Bhutan, especially in schools. Respondents think this is the result of the extensive handwashing campaigns held throughout the country, and primarily an outcome of the global handwashing campaigns carried out in schools. Majority of respondents mentioned that both handwashing with soap and water and use of a clean toilet are important for health as this reduces the spread of diseases. Both men and women reported washing their hands after using a toilet, after handling faeces, before feeding a child and before handling or eating food.

Compared to adults, the children aged 6 to 18 years had very good knowledge and skills on handwashing and using clean toilets. These children also highlighted the fact that it was important to stay healthy so that they don't miss the classes. Children were also able to mention the critical times for handwashing and demonstrated the eight steps of proper hand washing techniques.

7 World Health Organization and United Nations Children's Fund, Joint Monitoring Programme for Water and Sanitation, Bhutan Country File, 2015, <www.wssinfo.org>, accessed 4 January 2016.

8 Ibid, 2015

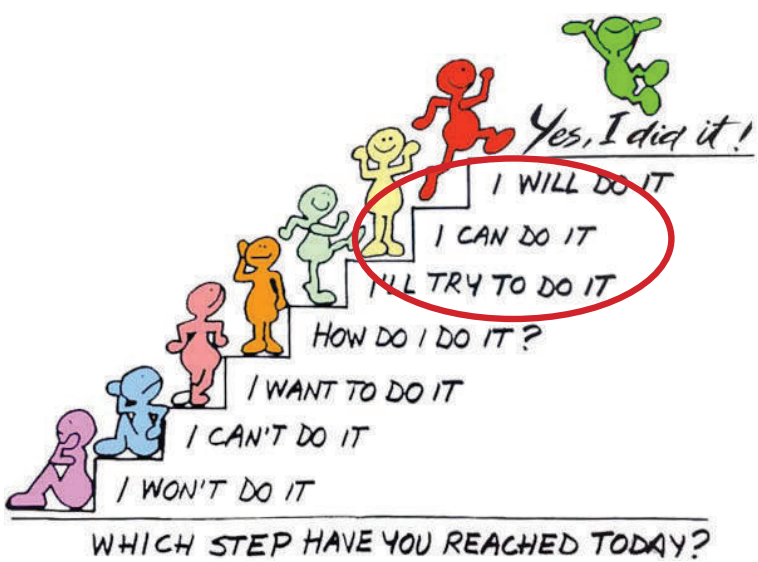
Through the FGDs, it was revealed that while there is good knowledge and positive attitudes on hygiene and sanitation., Respondents also felt that not all families in rural areas have toilets which are in good condition or with access to running water. This impedes their ability to follow positive behavioural practices. In some instances, toilets may be available but maintenance and keeping clean may be a problem.

For the majority of men and women, mass media (BBS radio and TV), friends, village health workers and school-going children were the main sources of information (and encouragement / inspiration) on hygiene and sanitation. It is interesting to note here that the school-going children have major influence on the behaviours of adults in this field.

"Children are constantly bombarded by messaging about the importance of washing hands with soap – from the Global Hand Washing Day to having hand washing stations outside their classroom, posters of hand washing in their classes and learning songs about hand washing from their teachers. These messages are then brought back to family members and friends when the child returns home from school." - a father

For children, the main sources of information were TV advertisements, Global Hand Washing Day and teachers. Children feel they would listen to teachers, particularly school health coordinators, health workers, doctors and friends to decide on hygiene and sanitation practices.

Respondent levels related to the behaviour change process: *decision-making, taking action, maintenance.*



Summary: The majority of respondents mentioned that both handwashing and use of a clean toilet as important in preventing spread of diseases and for living healthily. Children had even higher knowledge on this topic. Both men and women self-reported washing hands after using toilet, after handling faeces, before feeding children and before handling or eating food. While there was good knowledge and

positive attitudes about the practices, participants also felt that not all families have access to improved/ functional toilet facility with running water. Children were found to be the source of information on importance of handwashing with soap and water and using a clean toilet; and had influence over family members, relatives and friends.

Child protection - corporal punishment

All children need a protective environment where they are free from violence, exploitation and harm. Harmful practices such as corporal punishment bring devastating consequences including low self-esteem, depression, learning difficulties and performing poorly at school. Although corporal punishment is banned in schools, it continues to be used and is also commonly applied at home by parents despite the existence of legislative frameworks that protect children. Research has shown that physical abuse and violence against children can later lead to risky behaviours, self-harm and destruction and promotes intergenerational learning around the continued use of violence as a way to resolve disputes and control others.

Corporal punishment in school

Both men and women agreed that the use of corporal punishment in some way is acceptable if the child is at fault and that use of this disciplinary method is justified in order to "improve" the child. They also stated that its use is also necessary for teachers to maintain order and promote learning within the classroom. Men and women reported that the corporal punishment should be used in the case of extremely inappropriate or harmful behaviours of students which negatively impact other children, or the school, but not for a minor mistakes or misbehaving. They also felt that the use of corporal punishment should not result in injury to the eyes, ears or head. Men and women also stated if they came to learn that extreme physical punishment was used in schools for no valid reason and resulted in injury to the child, they would report the case to the class teacher, Principal, District Education Officer, community leaders or to Police.

Children said they do not like the use of corporal punishment due to the pain and emotional damage it inflicts, especially when received in front of fellow students. When discussing the consequences of its use, children mentioned poor confidence, low self-esteem and some extreme cases, could contribute to children wanting to discontinue their education or even commit suicide.

While children reported preference for verbal advice and guidance over the use of corporal punishment, like adults, they too also believed that in some situations and to a certain degree, corporal punishment is justified. This is mainly to deal with those students who repeatedly misbehave or cause problems at school but definitely not as punishment for poor academic performance.

"One time, my brother's child was playing with his friends and one friend stepped on a piece of glass and started bleeding. This was reported to the principal who blamed my nephew and when a teacher heard about it, teacher slapped him on the ear without even asking about it. This was not right because the boy didn't do anything wrong. The parents tried to file a case but it was later dropped because the principal insisted on resolving it internally. Unfortunately the boy cannot hear properly and he eventually left school and became a monk." - A mother

The majority of children reported either receiving corporal punishment at school or witnessing friends receiving it. Common types of physical punishment used included punch on the back, pulling of ears, having the student hold their ears and do sit ups in front of the class or having to do repeated frog-jumps.

Children also mentioned extreme forms of corporal punishment such as beating with sticks or being slapped, but stated that they felt they could not report such incidents to anyone. Reasons cited for non-reporting was that parents might blame them and they would receive additional punishment at home. They also feel if incidents were reported, this would create negative repercussions for them and the teacher involved, and may contribute to stigmatizing the child involved. Majority of children, especially those from urban areas, said they would tell their parents or the Principal if they had been given extreme physical punishment without a good reason. Most girls mentioned that they would first discuss it with friends before deciding what else to do.

Corporal punishment at home

Similar to the situation of the use of corporal punishment in schools, it was also found that there is an overall acceptance of its usage at home. This is a result of limited knowledge of positive discipline practices and prevailing attitudes reflected by the saying, "spare the rod, spoil the child". While some parents acknowledged that use of corporal punishment can create a distance between the child and parents, others believed that disciplining a child required the use of physical punishment. Women were more prone to try and give verbal guidance first before resorting to the use of physical punishment. Both men and women felt that if physical punishment was given, care should be taken not to injure vital

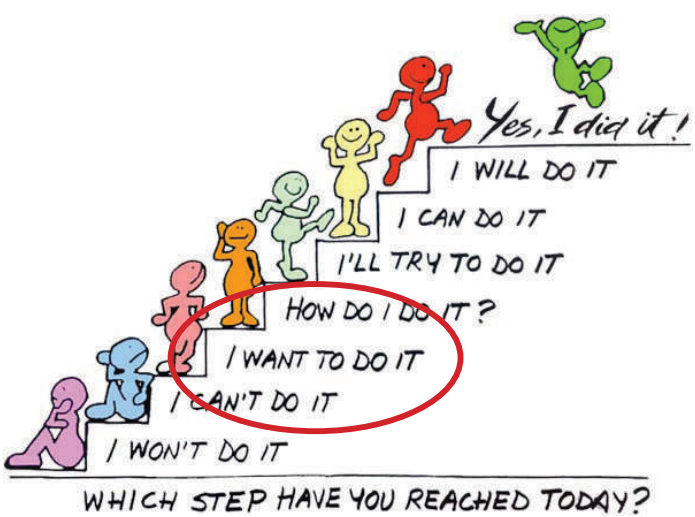
parts like ears, eyes and head. At the same time, a majority of the adults stated that it would be better to first discuss issues with the child instead of beating them but that this was also not practical as children seemed to respond better to physical punishment instead.

Children generally feel that the use of physical punishment at home is justified. They said it is due to their own mistakes or "bad" behaviours and what they receive is for their own "good". Children also felt that they receive more physical punishment from mothers as opposed to fathers. This is due to children being around and spending more time with their mothers. They also mentioned they did not know who to turn to or talk to if they experienced corporal punishment at home.

Majority of respondents, including children, said the source of information on corporal punishment is mass media, (from news coverage on incidents such as teachers being taken to court for beating up children despite a law against corporal punishment). Other information sources included friends, School Principals, parent-teacher meeting forums, local government leaders, non-formal education instructors and, in few cases, from civil society out-reach activities. Children also mentioned teachers, parents, elders, friends, relatives, and school captains as other sources of information specifically for them.

Children also highlighted that while many different sources of information about corporal punishment exist, they would rely on advice given by friends, parents and elders with regard to deciding the course of action to take if they faced this problem at school.

Respondent levels related to the behaviour change process: *pre-contemplation, contemplation and decision-making.*



Summary: There is a dichotomy of attitudes towards the use of corporal punishment both at home and in schools. While both adults and children know it is not a good disciplinary option, and are also aware of the ban of its use in schools, they also believe corporal punishment should be used in certain situations. Very few mentioned the long-term, harmful consequences of corporal punishment. Most adults felt that they had no

other option than to use physical disciplining and were unaware or felt that other forms of punishment would not work. While parents seem to accept the use of corporal punishment in schools, some would like to try giving advice or guidance at home rather than beating them.

Child protection - early marriage

The majority of respondents mentioned that marriage before the age of 18 years is against the law. However, they felt they would not report a case if couples were happy. Respondents felt this is a personal choice and internal family matter. However, it was also mentioned that if family members were receptive, they would advise and discourage early marriage within their community.

The majority of older women respondents reported that they were married before the age of 18 years but agreed that the ideal age for marriage should be between 20 to 25 years of age. They felt this is the right age so that economic and social stability is established. The majority felt that these days many women marry between 20 to 25 years as they consider economic benefits and social status a priority compared to past social norm that a girl's place being only in the home.

> *"I knew about the minimum age for marriage from a friend. She wanted to get married and went to the Court for marriage certificate but was denied because she was under-age. I also heard about the 18 years as minimum age for marriage from Court officials and from public meetings." - one woman*

Adolescent respondents had higher knowledge related to the risk of early marriage and felt that completing an education and securing a job first, in order to create a firm foundation for family life was important. They also highlighted health risks associated with early marriage and pregnancy at a young age, including girls dying from childbirth or having a weaker child. They also mentioned increased risk for domestic violence and divorces that could arise from early marriages.

For the majority of adolescents, the preferred age for marriage was 21 to 22 years. They believed 18 years and below to be too young for marriage and the family responsibilities associated with it. They also mentioned the existence of a law which prohibits marriage before the age of 18 years.

Overall, the majority of respondents felt there was a decline in the number of early marriages as compared with the past but also mentioned that there are still some cases where girls do marry at a very young age.

Poverty underlies early marriage with girls from poor families or single-child families needing to obtain economic support through a child's marriage. Another factor contributing to both early marriage and early pregnancy was rural to urban migration– especially with regard to young men moving to the city in search of employment or work. Once the young men leave, it was reported that more girls are left in the village and this leads to an increase in extra-marital affairs and pregnancies.

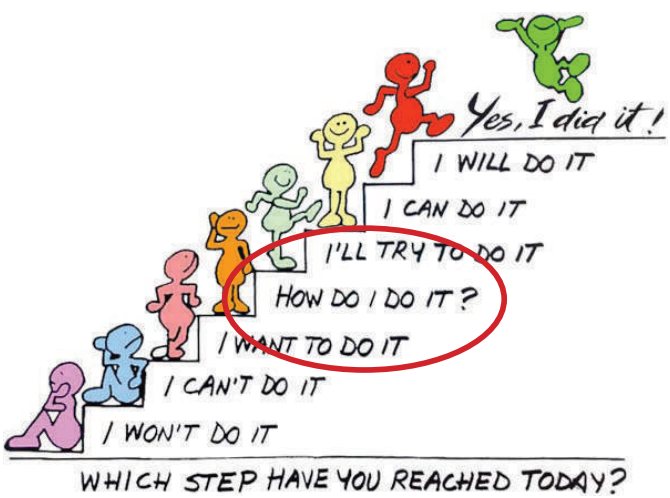
Information sources about the law against early marriage included mass media (BBS TV, radio and print news), from local leaders and district officials during public meetings and health workers. For children and adolescents, main sources of information included friends, teachers, health workers and parents. Adolescents also mentioned that they would take guidance from parents and relatives about decisions related to marriage because they have experience and would "know best" while others mentioned listening to advice from friends and teachers as well.

Respondent levels related to the behaviour change process: *contemplation, decision-making and taking action.*

Summary: While there seems to be a gradual shift away from general acceptance of marriage under the age of 18 years, many still feel it is an issue between two consenting parties and would be reluctant to interfere outside of their own family. Recognizing the benefits that come with waiting until age 18 years to marry, women felt it would be even better within an older age range (20 to 25 years of age). Adolescents had high knowledge related to the negative consequences associated with early marriage. Both adults and adolescents were aware of the law which prohibits marriage before the age of 18 years.

The majority of respondents seemed to prioritize education and economic stability over early marriage but also prefer maintaining social stability as opposed to reporting or prosecution of those who violate the law.

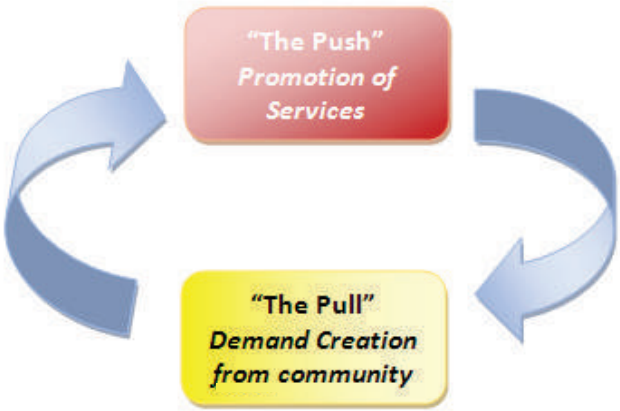
Additionally, while many had heard of some prominent cases of perpetrators of underage marriage being prosecuted, this knowledge made them less likely to report such cases as they also believed the punishment was too severe.



CREDIBLE SOURCES OF INFORMATION & TRUSTED INFLUENTIAL ACTORS

The starting point for addressing an issue begins with providing information to raise awareness and generate understanding on why there is need for change. Communication interventions have traditionally been used as part of **campaign approaches** (which include radio spots, posters, brochures and public service announcements). However, providing information alone is not enough to bring behavioural and social change. Strategic communication also includes the engagement of others who have an influence over the individuals. **Community-based communication approaches** can create this enabling environment and assist in skill development so that action can be taken up or services utilised.

'The Push' of promoting services together with 'The Pull" of generating demand as shown in **Figure 3** work together to inform and activate behaviour and social change. C4D interventions can help to further strengthen both these dimensions:



Information provision for awareness-raising on needed behaviours or practices and available services is the "push" dimension of communication.

Opportunities for discussion, dialogue and encouragement (as well as learning and skill development) together with others stimulates or activates the "pull" or demand for action or services and translates as putting knowledge and information into actual practice.

The tables on the following pages present current key information sources and channels related to the provision of along with other actors who are important in encouraging or influencing decision making and helping to shift attitudes around either practices or uptake of services.

For easy reference, information sources and channels are categorized under different levels of knowledge, attitudes and practices, and the "push" or "pull" communication dimensions. While there are sometimes overlaps, colour-coding is used to highlight opportunities and differences.

Capacity building or training dimensions provide an opportunity for generating awareness and learning while at the same time, through discussion and interaction with others, also support the decision making and process of putting information to actual use.

It is important to note that while sources, channels or contacts are not included, these are important possible entry points to further explore and consider in moving ahead.

(Refer to **Annex C** for a more detailed break-down of this information including findings based on specific regions.)

1. Maternal and child health – ensuring a health start through ante-natal care and post-natal care visits

	Campaign Approaches - the "Push" Approach			Capacity Building	Community-based Approaches/Social Mobilization - Supporting "Pull" Factors			
	Mass Media	**Outdoor Media**	**New Technology**	**Training sessions and materials**	**Group Discussion, Dialogue & Forums**	**Inter-personal communication (one to one)**	**Service provider interaction**	**CSO Engagement**
Awareness, information and knowledge building	BBS Radio and TV	MCH posters in health centres	Social media (urban)	NFE curriculum	District Officials, NFE learners	Friends, neighbours, local leaders *(gup and tshogpa)*	Doctors, Health workers, VHWs, NFE instructors, school teachers	
Development of attitudes and influencing actual behaviour and practice	BBS Radio and TV	Flip charts used by Health workers	Social media (urban) - but some forms also interactive so "Pull" as well!	MCH Handbook		Friends who have children, relatives, parents, grand-parents, spouse	Health workers, Doctors, Child Specialists, village health workers, religious persons/ astrologers	

2. Infant and young child feeding practices – exclusive breastfeeding

	Campaign Approaches - the "Push" Approach			Capacity Building	Community-based Approaches / Social Mobilization - Supporting "Pull" Factors			
	Mass Media	**Outdoor Media**	**New Technology**	**Training Sessions and Materials**	**Group Discussion, Dialogue & Forums**	**Inter-personal Communication (one to one)**	**Service Provider interaction**	**CSO Engagement**
Awareness, information and knowledge building	BBS Radio and TV	MCH posters in BHUs and hospitals		NFE curriculum.	NFE learners	Friends, neighbours, relatives,	Doctors, health workers, VHWs, NFE instructors, school teachers	
Development of attitudes and influencing actual behaviour and practice	BBS Radio and TV		Social media (urban) and mobile phones (rural)	MCH Handbook		Friends who have children, educated relatives, parents, grand-parents and spouse	Health workers, Doctors/Child Specialists	

3. Early childhood care and development (ECCD) - at home and beyond

	Campaign Approaches - the "Push" Approach			Capacity Building	Community-based Approaches / Social Mobilization - Supporting "Pull" Factors			
	Mass Media	**Outdoor Media**	**New Technology**	**Training Sessions and Materials**	**Group Discussion, Dialogue & Forums**	**Inter-personal Communication (one to one)**	**Service Provider interactions**	**CSO Engagement**
Awareness, information and knowledge building	BBS Radio and TV, local cable TV	Posters in public places		NFE curriculum, Parenting Education	District education officials, NFE learners	Friends, neighbours, children, other community members	Doctors, health workers, NFE instructors, private ECCD owners	
Development of attitudes and influencing actual behaviour and practice	BBS Radio and TV			Training and workshops; Parenting Education		Relatives, grand-parents, spouse, children	Health workers, teachers, school principals	

4. Disability development – identification and response

	Campaign Approaches - the "Push" Approach			Capacity Building	Community-based Approaches / Social Mobilization - Supporting "Pull" Factors			
	Mass Media	**Outdoor Media**	**New Technology**	**Training Sessions and Materials**	**Group Discussion, Dialogue & Forums**	**Inter-personal Communication (one to one)**	**Service provider interactions**	**CSO Engagement**
Awareness, information and knowledge building	BBS Radio and TV					Friends, neighbours,	Doctors, health workers	To seek additional information
Development of attitudes and influencing actual behaviour and practice	BBS Radio and TV					Relatives, friends with children, astrologers, religious persons, parents and grand-parents	Doctors and Child Specialists, Teachers, School Principals	NGOs and CSOs

5. Hand washing and use of clean toilets

	Campaign Approaches - the "Push" Approach			Capacity Building	Community-based Approaches / Social Mobilization - Supporting "Pull" Factors			
	Mass Media	**Outdoor Media**	**New Technology**	**Training Sessions and Materials**	**Group Discussion, Dialogue & Forums**	**Inter-personal Communication (one to one)**	**Service provider interactions**	**CSO Engagement**
Awareness, information and knowledge building	BBS Radio and TV	Posters in public places	Social media (urban)	NFE curriculum	Local leaders, District Officials, NFE learners,	Friends, neighbours, children, other community members	Doctors, Health workers, VHWs, NFE Instructors, School Counsellors	
Development of attitudes and influencing actual behaviour and practice	BBS Radio and TV	Posters in schools and health centres		School curriculum	School health clubs	Relatives, parents, grand-parents, spouse, children	Health workers, VHWs, doctors, teachers, School Principals, School Health Coordinators	

6. Child protection: exploring corporal punishment at home and in schools

	Campaign Approaches - the "Push" Approach			Capacity Building	Community-based Approaches / Social Mobilization - Supporting "Pull" Factors			
	Mass Media	**Outdoor Media**	**New Technology**	**Training Sessions and Materials**	**Group Discussion, Dialogue & Forums**	**Inter-personal Communication (one to one)**	**Service provider interactions**	**CSO Engagement**
Awareness, information and knowledge building	BBS Radio and TV, Kuensel newspaper articles		Social media (urban)		Local leaders *(gup, tshogpa & mangmi)*	Friends, neighbours, children, other community members	School Counsellors	
Development of attitudes and influencing actual behaviour and practice	BBS Radio and TV				Police, District Officials, children	Relatives, parents, grand-parents, spouse, children	Teachers, School Principals, Police, Religious persons,	

7. Child protection: awareness and prevention of early marriage

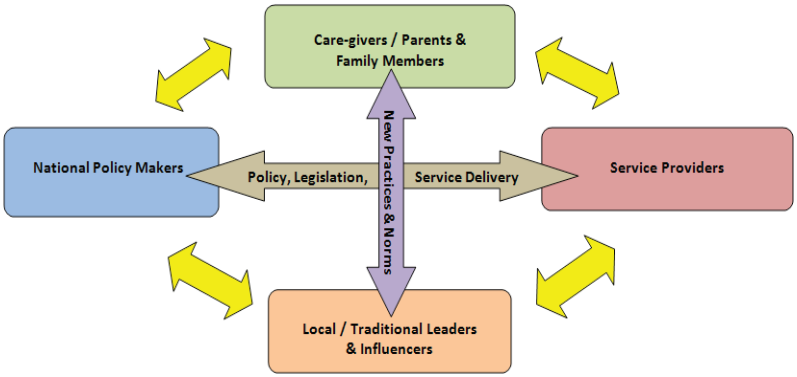
	Campaign Approaches - the "Push" Approach			Capacity Building	Community-based Approaches / Social Mobilization - Supporting "Pull" Factors			
	Mass Media	**Out-door Media**	**New Tech-nology**	**Training Sessions and Mate-rials**	**Group Discussion, Dialogue & Forums**	**Inter-personal Communica-tion (one to one)**	**Service provider interactions**	**CSO Engage-ment**
Awareness, information and knowledge building	BBS Radio and TV	Posters in public places			Local leaders	Friends, neigh-bours, children, other communi-ty members	Doctors, Health Work-ers, School Counsellors	
Development of attitudes and influencing actu-al behaviour and practice	BBS Radio			School curriculum, trainings and workshops,	School clubs, Police, District Officials	Relatives, par-ents, grand-par-ents, spouse, children	Health work-ers, Doctors, teachers, School Prin-cipals, Police, District Offi-cials, Religious Practitioners, Astrologers	

ANALYSIS OF FINDINGS: TRUSTED INFLUENTIAL ACTORS AT THE COMMUNITY LEVEL

As illustrated in the tables above, use of C4D is most effective when delivered through a combination of approaches involving different actors. Such an approach can contribute to cumulative and synergistic actions that promote change. This works across the supporting environment (or social-ecological environment) where children, caregivers and family members reside. C4D builds on the understanding that through multiple stakeholder engagement, change occurs for primary participant groups (i.e. parents and caregivers) but at the same time also affects and influences other important social actors (see **Figure 4**) as part of the process of wider social change as well.

Findings from the mapping and assessment exercise highlight that a variety of individual actors within both the family and community (including formal and non-formal service providers) were identified as important sources of information that influences the decision-making processes of parents and

caregivers. But the question remains with regard to how often these sources have been engaged or involved in the past in adopting new behaviours or encouraging use of services?



For some of the issues (such as importance of ANC/PNC visits, facility-based delivery, exclusive breastfeeding and handwashing practices at critical times for adults), information and knowledge levels were found to be high yet challenges remain in adoption of practices or services. Other topics, including early childhood care and development (especially home-based options) and identification of and available services for children with disabilities, will require further awareness-raising and understanding at both the individual and household level in order to kick-start the process of contemplation, decision-making and taking action for change.

In addition, exploring new opportunities for creating linkages with existing systems or networks as part of social mobilization efforts will help to strengthen efforts. The engagement of non-traditional opinion leaders or those who can serve as local advocates will also enhance opportunities for discussion, learning and contribute to the creation of an environment conducive for change.

In some cases, such as corporal punishment and early marriage, despite the existence of legislation banning such practices, the social norms which support existing practices and the failure to fully enforce the laws must be better understood and addressed. The development of better parenting skills in the case of corporal punishment or preventing the drivers for child marriage will also be needed to support change.

The enlistment and support of trusted and credible leaders is key to addressing and changing attitudes and practices linked to sensitive social norms and to gain consensus and community-wide support in order to apply new behaviours and practices related to these more sensitive issues.

RECOMMENDATIONS

Based on findings from this study, the following recommendations (both general and specific) are provided as possible entry points for use of C4D. The recommendations are meant to stimulate further thought and discussion around the use and application of C4D to ensure a more sustainable and long-term approach to individual and wider social change.

It is important to note that C4D actions can only address behavioural-related outcomes and more specifically, those associated with changes in awareness or knowledge, improved attitudes, behaviours and practices.

Ideally, all C4D work should follow the development of a specific communication strategy involving a wide range of stakeholders and based on evidence with specific communication objectives and indicators to measure progress. As a starting point, however, some recommendations below propose immediate actions which can be taken up and used to initiate the strategic communication process.

General recommendations:

- There is a need to invest in engaging the stakeholders and influencers at the community level in order to promote sustainable and long-term behaviour change (as opposed to only disseminating information).

- Additional resources need to be allocated for C4D interventions to facilitate pro-active engagement of families and communities to take actions and focus on prevention of negative behaviours as opposed to reactive problem-based solutions.

- While this assessment study provided a good overview on the topics explored, there is need for more in-depth research like KAP surveys to further investigate existing social norms which often act as barriers to recommended or desired practices.

- Consider developing comprehensive evidence-based C4D strategy for each issue (or combined issues) in consultation with relevant multi-sector partners and representatives.

- Explore opportunities for further enhancing C4D capacity building and application of C4D tools, approaches among the implementing partners.

- In addition, focus on community level interactions and dialogue; reinforce and promote the wider sharing of key messages through social media platforms.

- Continue to build on partnerships and engagement with the media and promote the use of creative and engaging program formats such as entertainment-education and enhanced interactive dimensions to support two-way learning and exchange.

Specific recommendations

Based on the respondent levels related to the behaviour change process at different levels, following actions are recommended:

1. ***Maternal and child health – (ANC, facility-based delivery and PNC)***

- Consider use of communication interventions to address negative attitudes of health service providers and build their interpersonal communication (IPC) skills for improved quality services.

- Explore opportunities to engage village elders (elder women, grandparents and other key community influencers) in support of accessing services for improved health of both the mother and the child.

- Strengthen engagement of *gomchens* (lay monks) or *tsips* (astrologers) to promote uptake of healthcare services in addition to their role of completing traditional rituals.

2. ***Infant and young child feeding practices – exclusive breastfeeding and introducing complementary foods***

- Address knowledge gaps related to exclusive breastfeeding: on misconceptions such as mothers having no enough breastmilk and not breastfeeding the child when the mother gets sick.

- Feeding practices are deeply rooted in cultural / traditional practices - explore involvement of elders (older women, grandparents and other relatives) and other women in discussions and group learning to support shared knowledge, increased understanding and generate collective support of improved practices despite challenges and obstacles.

- Highlight recent changes approved by the government in support of new policy extending maternity leave to six months in order to fully support uptake of the practice. This may be an excellent way to revitalized discussion on exclusive breastfeeding's importance.

3. ***Early childhood care and development (ECCD) – at home and beyond***

- Provide additional information to parents and caregivers and build understanding on the benefits of ECCD and early stimulation including home-based stimulation through community discussion and training.

- Position home-based ECCD and early stimulation as part of Bhutanese culture and tradition and include discussion/dialogue through the national radio and television programme as well as through

various forums for group/community discussion.

- Explore opportunities to promote skill development and training for caregivers (relatives and grandparents) and parents related to home-based ECCD and early stimulation activities.

- Seek out opportunities to share experiences and stories from positive role models and satisfied clients in order to build confidence in ECCD and through opportunities for group discussion.

- Provide additional information to parents and caregivers through community-based discussion on what ECCD involves (not forcing children to do something too early which causes stress) and address issues related to qualification of teachers or facilitators to lower resistance and alleviate parental concerns.

4. Disability and development – identification and response

- Provide more information to parents and caregiver on disability, types and causes, and available services; and the need for early detection through engagement of partners including community organizations, service providers and other influencers at the community level, as well as through mass or social media.

- In addition to the traditional partners, explore new partners with CSOs, children's organizations, private sector to support provision of information and resources as well as address existing social norms.

- Identify and role model positive parenting (through sharing of stories/experiences) from those who have children with disabilities. At the same time, this can also bolster skill development and provision of additional information (in terms of where to go for support and assistance) as this will impact upon immediate needs and concerns as well as slowly help to change attitudes and negative perspectives.

- Explore involvement of influential community members, leaders or religious practitioners in addressing early identification of disabilities, sharing of information and promoting available services and assisting with the process of shifting social norms related to disability.

5. Handwashing and use of clean toilets

- Continue reinforcement of the practice (at all the critical times) to maintain the existing level of practices and further explore opportunities to encourage children and adults to serve as advocates and role models for others.

- Continue to reinforce messages on the need to maintain and keep toilets clean and functional, and perhaps consider the use of a community pledge or commitment to ensure support on this from the full community, *geog* or district through community based partners and media.

- If access to water is problematic, support advocacy actions at the community or sub-national level (enlisting support from civil society, the private sector, development and government) to address these needs so that positive practices can be taken up or carried out.

6. Child protection – exploring corporal punishment at home and in schools

- Build the capacity of parents and teachers on alternative positive disciplining tools and skills so that other options of non-violent discipline can be used.

- Engage with positive role models and positive deviants who avoid use of physical punishment yet succeed in classroom management or at home in the guiding and setting boundaries with children. Use their experiences and stories to shift attitudes, norms and practices. Share the experience, success and learning through the media, exchange and training for others schools and teachers.

- Engage local media to discuss and reinforce key messages and information on harmful or negative consequences of corporal punishment and legislation and alternative positive disciplining experiences.

- Engage with community leaders, religious leaders or other respected persons at the community to advocate and lead discussion on the issue and the existing ban (in schools).

7. Child protection – awareness and prevention of early marriage

- Based on feedback from the community, the most effective way to communicate or position

discussion around the prevention or elimination of early marriage is through emphasis on continued education, protecting the health of girls and encouraging financial stability which can all be achieved by waiting to marry. This approach should be promoted and used both in community discussions, through one to one contacts and exchanges and through enlistment of the media.

- As focus group discussions also highlighted, cultural norms are moving away from child marriage but legal aspects related to the marriage law needs to be reinforced in order to harmonize social norms with legal norms that are currently in place / exist. This can be addressed through community leaders, service providers, religious leaders and other influencers within the community and also reinforced through media channels as both dimensions are needed in order to accelerate progress.

- Social norms related to maintaining good community relations appear to deter members from reporting (out of fear of disrupting society or creating social disharmony), yet it would be useful to explore – through non-threatening group discussions and forums or through service providers (such as health workers and teachers) – both sides of the problem.

  Through discussion it may be possible to unpack the "perceived" positive and negative outcomes related to early marriage and highlight additional negative consequences of the practice which may lead or contribute to further aspects of social disharmony (such as domestic violence / abuse, reproductive and other health problems) in the long run.

- It may also be useful to explore and enlist partners for social mobilization on the issue (such as gender-focused CSOs, NGOs and international organizations) in order to bring the issue from a private setting / sphere (i.e. within the family) into one that is more public so that the benefits are well recognized along with the harm that comes to girls who are married off too young. Media can also support discussion and interaction on this in order to further stimulate the shifting of social norms and justifications for applying the practice in the past.

REFERENCES / RESOURCES

[1] National Statistics Bureau, Royal Government of Bhutan, *Bhutan Multiple Indicator Survey (BMIS) 2010*, Thimphu, Bhutan, 2011, p. iii and Ministry of Health, Royal Government of Bhutan, *National Health Survey (NHS) – Summary of Findings 2012*, Ministry of Health, Thimphu, Bhutan, 2012, p. 6.

[2] Ibid, p. iv (BMIS 2010) and p. 5 (NHS 2012) and the National Nutrition Survey (NNS, 2015).

[3] Ibid, p. iii (BMIS 2010) and p. 4 (NHS 2012).

[4] Policy Planning Division, Ministry of Education, Royal Government of Bhutan, *Annual Education Statistics 2014*, Ministry of Education, Thimphu, Bhutan, 2014, p. ix.

[5] United Nations Children's Fund, *Global Strategy Development Guide for Maternal, Neonatal and Child Health: Key Communication Foundations and Practical Planning Steps for Communication for Development, 2015*, Overview, p. 1, <www.unicef.org/cbsc/index-65738.html>, accessed 28 December 2015.

[6] Ibid, pp. 4 - 5.

[7] World Health Organization and United Nations Children's Fund, *Joint Monitoring Programme for Water and Sanitation*, Bhutan Country File, 2015, <www.wssinfo.org>, accessed 4 January 2016.

[8] Ibid, 2015.

[9] Ibid, 2015.

Communication for Development; strengthening the effectiveness of the United Nations, 2011

Toolkit: Qualitative Research and Rapid Assessment Methods for Use in Level 3 SRA Monitoring; UNICEF

Writing a Communication Strategy for Development Programmes. A Guildeline for Programme Managers and Communication Officers. UNICEF Bangladesh 2008.

Bhutan Information and Media Impact Study 2013. Department of Information & Media. Ministry of Information and Communications. Royal Government of Bhutan.

Report of Qualitative Research on Communication Channels in Use in Somalia; 2000; UNICEF-Somalia

Annex A:
Summary of communication approaches, key features and participant group engagement

Communication Approach	Key Features	Participant Groups
Advocacy	· Focuses on policy environment and seeks to develop or change laws, policies, and administrative practices. · Works through coalition-building, community mobilization, and communication of evidence-based justifications for programs.	· Policymakers and decision-makers · Programme planners · Programme implementers · Community leaders
Social Mobilization	· Focuses on uniting partners at the national and community levels for a common purpose. · Emphasizes collective efficacy and empowerment to create an enabling environment. · Works through dialogue, coalition-building, group/organizational activities.	· National and community leaders · Community groups/organizations · Public and private partners
Social Change Communication	· Focuses on enabling groups of individuals to engage in a participatory process to define their needs, demand their rights, and collaborate to transform their social system. · Emphasizes public and private dialogue to change behaviour on a large scale, including norms and structural inequalities. · Works through interpersonal communication, community dialogue, mass/social media.	· Groups of individuals in communities
Behaviour Change Communication	· Focuses on individual knowledge, attitudes, motivations, self-efficacy, skills building, and behaviour change. · Works through interpersonal communication, mass/social media campaigns.	· Individuals · Families/households · Small groups (e.g. mothers' support group)

(Source: adapted from *Communication Strategy Guide for Maternal, New-born, Child Health and Nutrition: Key Communication Foundations and Practical Guide – Communication for Development*, UNICEF 2015. Available at: www.unicef.org/cbsc/index-65738.html.)

Annex B
Types of food given to young children after 3 or 4 months by region

Types of Other Foods	Source of information by region		
	West	**Central**	**East**
Types of other foods given to a child after 3 or 4 months in addition to breast milk	✓ Rice flour cooked with some butter and salt ✓ *Cerelac/Lactogen* ✓ Boiled and mashed vegetables (i.e. Green vegetables, pumpkin) ✓ Cooked dal ✓ Mashed fruits ✓ Cow milk	✓ Beaten rice ✓ Wheat flour coked in butter and salt ✓ Fruits & vegetables ✓ Buckwheat ✓ *Lactogen/Celerac* ✓ *Suji* – semolina cooked with milk, sugar and butter ✓ Dal ✓ Boiled rice	✓ Sugar tea – when the child is a few days old ✓ Rice flour cooked with butter, salt and water ✓ Fruit juice ✓ Cow milk ✓ *Cerelac* ✓ Water ✓ Maize

Annex C

Source of information and influential actors for women on maternal child health by region

	Source of information by region		
	West	**Central**	**East**
Knowledge	· Mass media (BBS TV and Radio) · Friends	· BBS TV and radio	· Mass media (BBS TV and radio); Village health workers; · Tshogpa and Gup and health workers
Attitude and practices	· Health workers; doctors and friends · Own experience · Friends who have children · Parents and relatives · Astrologers and religious persons	· Village Health worker · Health Workers and doctors · Friends · Parents and grandparents · Spouses	· MCH handbook, · Internet · Child specialists · Friends · Health workers · Doctors · Astrologers and religious persons

Source of information and influential actors for men and women on exclusive breastfeeding by region

	Source of information by region		
	West	**Central**	**East**
Knowledge	· BBS Radio and TV · Internet · Village health workers	· Media (BBS Radioand TV) · Non-formal education (NFE) instructors · NFE curriculum	· Mass media (Radio and TV) · Internet · Friends
Attitude and practices	· Health workers, doctors · Child specialists · Friends	· Health workers · Doctors · Educated relatives · Friends · Parents	· Health workers · Doctors · Friends · Parents · Spouse

Source of information and influential actors for men and women on early stimulation and ECCD by region

	Source of information by region		
	West	**Central**	**East**
Knowledge	· BBS TV 2 and Radio · Private cable TV advertisements · Friends · Neighbours	· BBS News and programs · Owners of Private ECCD/pre-school centre · NFE learners	· Children · Television, Radio, Broadcast media · Other working people in the community
Attitude and practices	· Friends · Neighbours · School teachers	· Local leaders (Gup and Tshogpa) · Friends · Teachers	· Community ECCD centres · Neighbours · Trainings and workshops on ECCD. · District Health · Officials from education Ministry · Friends · Parents and elders · Spouse

Source of information and influential actors for men and women on disability by region

	Source of information by region		
	West	**Central**	**East**
Knowledge	· BBS TV · Friends · Neighbours	· School for disability · Friends	· Media · Friends & neighbours
Attitude and practices	· Religious persons · Friends · Neighbours · Health officials · CSOs like Renew & Tarayana · Parents	· Religious persons · Neighbours · Health officials · Gup · Spouse · Health officials · Religious persons	· Health officials · Religious persons · Relatives · Spouse

Source of information and influential actors for men and women (18 – 49 years) on handwashing and use of clean toilets by region

	Source of information by region		
	West	**Central**	**East**
Knowledge	· Mass media (TV & Radio)	· Posters displayed in public places (hospitals and schools) · Parent-teacher meetings in schools · Radio and TV advertisements · NFE Books and classes	· BBS – Television & radio · Posters in schools and health centres · Village health workers
Attitude and practices	· Media (TV & Radio) · Health workers · Children	· Children · School teachers · Village health workers · Health workers · Friends	· Health workers School children · Food safety trainings conducted by BAFRA. · School teachers

Source of information and influential actors for children & adolescents (aged 6 – 18) on handwashing and use of clean toilets by region

	Source of information by region		
	West	**Central**	**East**
Knowledge	· Internet · Posters in schools, · BBS TV 2 · Radio	· Science text books · Library · Mainly learn from textbooks · Advertisements on backside of notebooks · Posters on notice boards	· During Global Hand Washing Day in school · Television · Posters · Reading materials
Attitude and practices	· Teachers · Science lessons and books · School health coordinators	· Teachers · Parents · Relatives · Health workers	· Teachers · School health coordinators · Health workers (hospital) · Doctors

Source of information and influential actors for men and women related to corporal punishment in school by region

	Source of information by region		
	West	**Central**	**East**
Knowledge	· Mass media news (TV, Radio) · Local leaders during public meetings	· Broadcast media · Friends,	· Broadcast media (BBS news coverage) · Word of mouth through friends, · RENEW · Gup
Attitude and practices	· Teachers; through parent-teacher meetings · Friends · Neighbours · Spouse · Children.	· ECCD centres, · Non-formal education book (for those that attended an NFE course) · Friends, · Teachers during parent teacher meetings · Spouse (particularly wife)	· Word of mouth through friends, · RENEW · Gup

Source of information and influential actor for children on corporal punishment in school by region

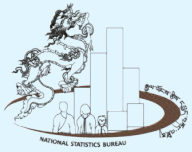
	Source of information by region		
	West	**Central**	**East**
Knowledge	· School councillors · Internet · Books · Radio.	· Mass media news · Friends · Parents	· Parents, Mass media news (BBS, Kuensel · School captains · Community leaders (e.g. Gup).
Attitude and practices	· Principals · Teachers · Parents · Elders · Friends · Relatives	· Parents · Friends · Teachers	· Friends · Teachers · Parents

Source of information and influential actors for children, men and women on corporal punishment at home

	Source of information by region		
	West	**Central**	**East**
Knowledge:	· Mass media programmes (TV, Radio)	· Broadcast media (BBS TV) · NFE books	· Media News - BBS TV programs
Attitude and practices	· Spouse · Health workers · Parents and grandparents · Own experience	· Health workers · Parents and elders · Friends	· Doctors and health workers · Local leaders (Gup) · Parents and elders · Own experiences

Source of information and influential actors related to early marriage by region

	Source of information by region		
	West	**Central**	**East**
Knowledge:	· BBS (TV, Radio) · Friends · Teachers · District officials and local leaders (Tshogpa, Gup) during public meetings, · Health workers in the hospital	· Broadcast media (BBS TV) News coverage · Local leaders (Gup) · Health workers · District officials · Friends · Doctors and health workers	· Media News - BBS TV programs · Friends · Community members during public meetings
Attitude and practices	· Science teachers, · Elders & parents · Law enforcement officials (Police) · Friends · Health class/clubs in schools, · Teachers · Health workers	· Local leaders (Gup) · Doctors and health workers · District officials · Friends · Doctors and health workers · Parents and elders	· Friends · Court officials · Police · Health officials · Health class · Science class · School health clubs · Teachers · Own experience



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