Integrated Social and Behavior Change Communication Programs Implementation Kit

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HEALTH COMMUNICATION CAPACITY COLLABORATIVE

Contact:

Health Communication Capacity Collaborative
Johns Hopkins Center for Communication Programs
111 Market Place, Suite 310
Baltimore, MD 21202 USA
Telephone: +1-410-659-6300
Fax: +1-410-659-6266
www.healthcommcapacity.org

Cover photo credit: A health worker immunizes a child at Khuwi maternity clinic in Malawi. © 2014 Donna Murray, Courtesy of Photoshare.

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*The participant list of individuals and their organizational affiliation can be found **here**.

ACRONYMS

ANC	Antenatal Care
AOR	Agreement Officer's Representative
ARV	Antiretroviral
BCS	Behavior Change Support
BNI	Bounded Normative Influence
C4SC	Communication for Social Change
CCP	Johns Hopkins Center for Communication Programs
CHC	Communication for Healthy Communities
CHL	Communication for Healthy Living
CHW	Community Health Worker
COP	Chief of Party
DOI	Diffusion of Innovations
EHP	Essential Healthcare Package
FGD	Focus Group Discussion
GOE	Government of Egypt
HCC	Health Communication Component
HC3	Health Communication Capacity Collaborative
HEU	Health Education Unit
HEP	Health Extension Program
HIV	Human Immunodeficiency Virus
IBP	Individual Birth Plan
ICT	Information Communication Technology
IDI	In-depth Interview
I-Kit	Implementation Kit
IMCI	Integrated Management of Childhood Illnesses
INGO	International Non-governmental Organization
IPC	Interpersonal Communication
IPTp	Intermittent Preventive Treatment in Pregnancy
ITN	Insecticide-Treated Bed
LMIS	Logistics Management and Information System
MAG	Management Advisory Group
MCH	Maternal and child health
MCSP	Maternal and Child Survival Project
M&E	Monitoring and Evaluation
NGO	Non-governmental Organization
NURHI	Nigeria Urban Reproductive Health Initiative
PHC	Primary Health Care unit
PHE	Population, Health and Environment
PMTCT	Prevention of Mother-to-child Transmission
PASMO	Pan American Social Marketing Organization
PDA	Positive Deviance Approach
RFA	Request for Applications
RFP	Request for Proposals
RM&E	Research, Monitoring and Evaluation
SBCC	Social and Behavior Change Communication
SDG	Sustainable Development Goal
SP	Sulfadoxine-pyrimethamine
SSD-I	Support for Service Delivery Integration
STI	Sexually Transmitted Infection
SNA	Social Network Analysis
STRADCOM	Strategic Radio Communication
TB	Tuberculosis

TOR	Terms of Reference
TCCP	Tanzania Capacity and Communication Project
TTHV	Tchova Tchova Historias de Vida
UNFPA	United Nations Population Fund
WHO	World Health Organization
WHIP	Western Highlands Integrated Program

INTRODUCTION

Recent years have witnessed a shift from development programs that focus on a single health or development topic, to initiatives that encompass multiple topics within a single program. This shift is reflected in the Sustainable Development Goals (SDGs) indicating that integrated programming is a priority across the range of global development areas. In global health specifically, the shift to an integrated approach is a key focus of movements concerned with universal health coverage, primary health care, health systems strengthening and client-centered care. Corresponding to this larger trend toward integrated development, interest in integrated social and behavior change communication (SBCC) programming–SBCC that addresses multiple health topics and behaviors under the same program–has also been increasing as a critical strategy to improve health and development outcomes.

WHAT IS INTEGRATED SBCC?

Integrated SBCC refers to SBCC programming designed to cohesively address more than one health or development issue within the same program. Typically, this involves developing a logical and unified SBCC strategy that addresses multiple topics and/or behaviors and considers how they relate or interact with one another. Examples include programs that address:

- Human Immunodeficiency Virus (HIV) and Tuberculosis (TB)
- Population, health and environment (PHE)
- Handwashing and improved child feeding practices
- Family planning and HIV prevention
- Reproductive, maternal, newborn and child health (RMNCH)
- Antenatal care (ANC), prevention of mother-to-child transmission of HIV (PMTCT) and prevention of malaria in pregnancy
- Integrated management of childhood illnesses (IMCI)
- Agriculture and nutrition
- Immunization and family planning

What Are the Models for an Integrated SBCC Program?

Integrated SBCC programs can follow one of four different models:

- **Add-on:** A new program integrates additional health topics into an existing vertical SBCC program.
- **Phased Implementation:** A program phases in health topics and/or behaviors gradually over a period of time, presenting information in progressively manageable pieces.
- **Overarching Umbrella Brand:** A program develops and promotes an overarching brand encompassing all the included health topics.
- **Combination:** A program chooses a mix of the above integrated programming models.

More detailed information on these models can be found in the Implementation section.

SBCC programs may integrate to varying degrees among several dimensions, such as **co-location**, **coordination**, **collaboration** or **cross-training** (FHI360, 2016). While these dimensions may indeed (and perhaps should) be part of any integrated SBCC initiative, taken separately, they do not constitute complete integration. This I-Kit seeks to guide SBCC programs looking to achieve complete integration, that is when multiple health sectors (e.g., family planning, HIV and RMNCH) jointly plan and implement activities, and comprehensively address all relevant audiences. A completely integrated SBCC program is able to deliver cohesive and logically packaged SBCC interventions that unite divergent health areas.

An **integrated SBCC program** addresses the interplay among multiple topics. In contrast, a **vertical SBCC program** addresses an issue in relative isolation. For example, a vertical program may develop an SBCC strategy only for malaria control or only for increasing demand for family planning, but not address RMNCH, HIV or other health topics in the same strategy.

Vertical SBCC Programs

Address an issue in relative isolation.

Integrated SBCC Programs

Address the interplay among multiple health topics.

ABOUT THIS I-KIT

What Is the Purpose of this I-Kit

This I-Kit provides guidance to programs seeking to develop an integrated SBCC strategy. It offers insights, recommendations, examples, tools and links to useful resources. It focuses on the aspects of SBCC unique to integrated programming and avoids basic SBCC content that would be applicable to any SBCC program. For information on general SBCC strategy development, visit HC3 SBCC Implementation Kits and SBCC How-To Guides. The emphasis of this I-Kit is health, but the concepts and tools may be applied to a range of development issues.

Who Is the Audience for This I-Kit?

The intended users of this I-Kit are project managers who are considering developing an integrated SBCC strategy, regardless of *whether or not* service delivery is integrated. This I-Kit assumes the user has prior experience designing and implementing SBCC strategies and wants guidance specific to SBCC for integrated programs. Staff who are not directly implementing programs but who provide oversight or funding for integrated SBCC programs, such as those working for a government ministry or donor agency, and who want to develop a general familiarity with SBCC integration will also benefit from this I-Kit.

What Does This I-Kit Contain?

- A synthesis of promising practices for integrated SBCC as currently understood;
- Guidance and considerations for developing, implementing and evaluating integrated SBCC programs;
- Case studies of integrated SBCC programs;
- Sample tools to assist in the development of integrated SBCC programs (e.g., landscape mapping analysis templates); and
- Links to additional resources such as how-to guides for a number of different aspects of SBCC.

How Should This I-Kit Be Used?

Managers may use this I-Kit as a guide to help develop, implement and evaluate an integrated SBCC program that covers multiple health and development topics. Please carefully consider which recommendations may apply to *your* program and which may need to be modified.

This I-Kit is organized into five sections, each containing a variety of resources:

1. Start by **deciding whether or not to use integrated SBCC**. What are the pros and cons of integrated SBCC, and what evidence exists to demonstrate its value?

2. Next, **lay the foundation** for integrated SBCC by mapping the landscape, engaging support and preparing for implementation.

3. Then, **strategically design** or adapt the integrated SBCC program. Learn what to take into consideration when designing integrated versus vertical programs, how formative research differs in integrated programs and what elements of a communication strategy and concept and materials development and testing are unique to integrated SBCC programs.

4. Finally, learn about the **implementation** considerations specific to integrated SBCC programs; and

5. Consider how to **monitor and evaluate** integrated SBCC, with an emphasis on how to assess the extent and impact of integration.

Case studies and other **resources** provide examples to support I-Kit users' efforts to develop, implement and assess integrated SBCC programs.

How Was the I-Kit Developed?

This I-Kit is a collaboration of the United Nations Commission on Life Saving Commodities and the Health Communication Capacity Collaborative (HC3). Based on an initial systematic literature review, it was clear that SBCC professionals are still in the process of exploring what does or does not work in integrated SBCC programs and how programs can be improved. This I-Kit reflects the findings of that review as well as a two-day expert consultation that convened over 40 experts from around the world to develop recommendations and guidance on the design, implementation and evaluation of integrated SBCC programs. Other source materials include literature reviews, articles and program documents (listed in the Resources section of this I-Kit) as well as interviews with SBCC professionals who have designed and implemented integrated SBCC programs.

PART 1: THE DECISION TO INTEGRATE SBCC

SBCC integration is a decision. Sometimes the funding agency may require integration in its Request for Applications/Request for Proposals. Other times the implementing partners may drive the decision during the proposal or project design phase. At the very least, implementing partners should understand to what extent the project they have accepted is amenable to integration.

Integration advances the concept of holistic and client-centered care, and has the potential to significantly improve health and development outcomes. It can also potentially lower costs by reducing the redundancy inherent in implementing several vertical SBCC programs (see Making the Case for SBCC to learn more about the evidence for integration).

However, the decision to integrate SBCC should not be automatic. Programs should consider the environment for SBCC integration, the pros and cons of integration in their particular context and, most importantly, if and how integration will benefit the target audience, then decide whether it is both feasible and worth the effort.

ADVANTAGES

SBCC integration has many potential **advantages**. Programs may choose to integrate SBCC in order to:

- **Approach audiences more holistically** by organizing programs in a way that reflects the audience's reality (i.e., audience's lives are not divided by health topic);
- **Avoid message fatigue** by linking similar messages together;
- **Reduce missed opportunities** for the audience and the program by addressing behaviors that happen together or are linked to one another (e.g., HIV and substance abuse, or offering FP counseling when new parents bring children for immunization services);
- **Increase the reach** of SBCC interventions, either by serving a larger number of people or reaching new or underserved populations, such as women or youth;
- Help **build a brand** or take advantage of a successful brand (e.g., expanding a well-regarded family health brand to include and promote modern family planning);
- Give more **visibility** to topics whose SBCC efforts have historically been under-funded;
- **Leverage resources and improve effectiveness** by sharing costs and resources, and reducing duplication of efforts;
- Support **integrated service delivery**
- Help realize **national goals** related to harmonization, coordination, collaboration and integration;
- **Strengthen the capacity** of staff and the local community or government to better manage programs across topics or sectors;
- **Enhance the sustainability** of interventions by establishing and institutionalizing their interdependence; or
- **Improve the satisfaction of providers or clients** (e.g., beneficiaries being able to receive all relevant services at one time in one place).

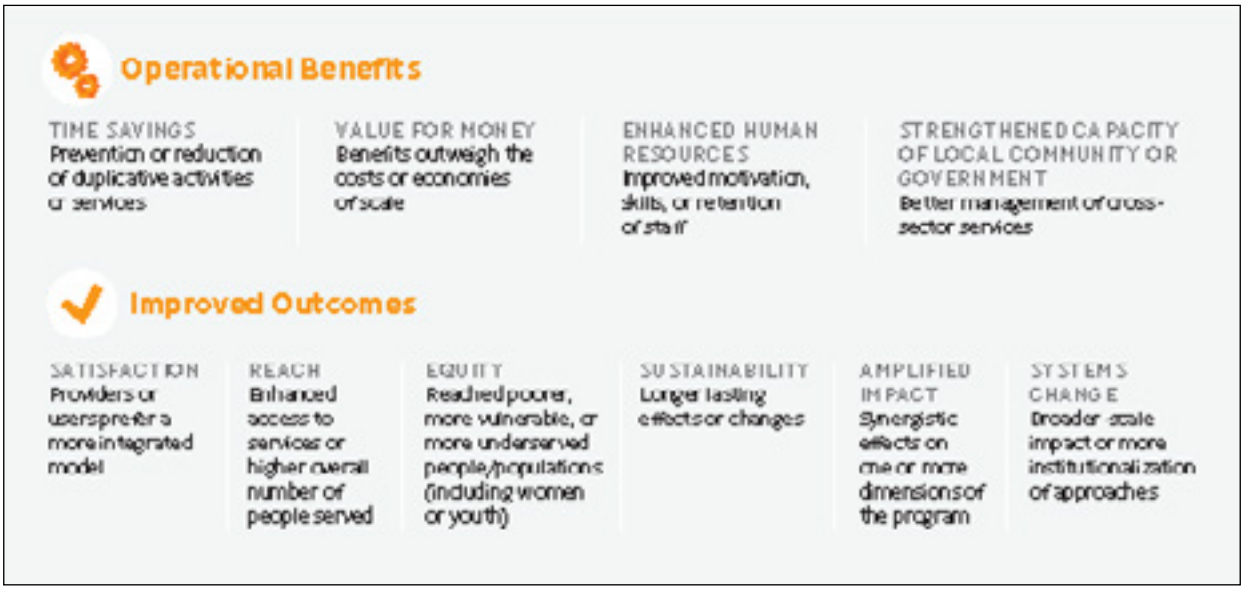
DEFINITION

The World Health Organization (WHO) defines **integrated service delivery** as "the management and delivery of health services so that clients receive a continuum of preventive and curative services, according to their needs over time and across different levels of the health system" (WHO, 2008).

Please refer to the Glossary for other terms.

TIP

In the Guidance for Evaluating Integrated Development Programs, FHI360 categorizes the potential advantages of integration into **operational benefits** and **improved outcomes**. While this framework is not related to SBCC specifically, it is useful for thinking through the possible reasons for integration.



PROGRAM EXPERIENCE: TARGET AUDIENCE

At the start of the Nuru integrated poverty reduction program in Kenya, the agriculture program targeted farmers, the financial inclusion program targeted entrepreneurs and the WASH, healthcare and education programs targeted the entire community. This caused Nuru to question how this assortment of programs focused in the same community was getting at people of extreme poverty faster, cheaper and more effectively than any one of the interventions alone. As a result, they changed their unit of impact to the farmer and their household, with all outcomes focused at aggregated up to that level (Changala, 2014).

DISADVANTAGES

Programs may also have reasons not to integrate SBCC. Consider the following potential **disadvantages** and challenges to SBCC integration:

- It might **overload the audience** or the delivery channel (e.g., community health workers).
- It can be **more complicated** than focusing on a single issue from both a programmatic and audience point of view.
- It often requires **more coordination and longer timelines** than single-issue SBCC programs.
- Bringing together donors or partners might require **more time or money** than the programs can afford, given their deliverables, timelines and budgets.
- It can require an **up-front investment in partnership building** that might not otherwise be needed.
- **A lack of cooperation** among or buy-in within the divisions of a donor agency involved in the integrated program might lower the program's chances of success.

- **Competition among donors** or potential partners might make integration more difficult than the results would merit. It can be difficult to garner the political will and understanding needed for effective integration.
- **Measurement is difficult** – measuring multiple outcomes as well as measuring the effect of integration can be very challenging.

KEY QUESTIONS

Any program considering SBCC integration will likely identify additional advantages and disadvantages specific to their context. Remember that there are varying degrees of integration, and many decisions to be made regarding how many and which technical areas to include, and the weight to give to each. Weigh all of the competing factors and make the best decision for the target audiences and the program. If you are an implementing partner, and the decision has already been made by the donor, find ways to maximize the advantages of integrated SBCC and to reduce the risks, including ensuring there is adequate funding for building and maintaining effective partnerships.

Key questions to consider before deciding to integrate different health topics:

- What are the pros and cons for SBCC integration in the program's context?
- What existing SBCC platforms and policies are already in place? Are they supportive of integration? Whose buy-in is needed?
- Is there enough time in the project's lifespan to design, implement, monitor and evaluate an integrated program?
- Is there enough evidence to make an effective case for integration?
- Is enough funding available to support both the strategy and the required coordination?
- Can the staff, volunteers and communication channels handle the implicit complexity of integration?
- How many and which topics/behaviors should the integrated strategy include, given the resources available (i.e., human, financial, time, etc.) and the coordination effort required?

ADDITIONAL RESOURCES

- Implementation Kits
- Social and Behavior Change Communication in Integrated Health Programs: A Scoping and Rapid Review
- SBCC How-To Guides

PART 2: LAYING THE FOUNDATION

Before designing an integrated SBCC program, it is critical to understand the enabling environment for the program. How might support for the project be strengthened? What actions can be taken to lay the foundation for an ultimately successful integrated program? While some actions may be implemented prior to the actual program design and implementation, reinforcing the supportive environment will be an on-going activity throughout the life of the program. This section reviews how to map the landscape for SBCC integration, how to engage the necessary support for an integrated program and how to prepare for implementation.

MAPPING THE LANDSCAPE FOR INTEGRATED SBCC

To gain an in-depth understanding of the landscape, start with stakeholder and environmental analyses. This section provides guidelines for conducting those analyses. The Mapping the Landscape for SBCC Integration Analysis Toolkit also provides a series of analysis templates to assist in this process.

> **TIP**
>
> Keep in mind that the complexity of the landscape for an integrated SBCC program increases with the number of topics and/or behaviors that are included, the number of sectors involved (e.g., health, agriculture and education) and the extent of decentralization in those sectors (e.g., operating at national, regional, district and/or village levels).

Stakeholder Analysis

Integrated programs are likely to involve a significant number of **stakeholders** from a wide variety of sectors. Such sectors may include health, education, agriculture, technology, communication or others. Start by identifying all stakeholders, and then spend time exploring each of them to gain a deeper understanding of their mission, approaches and needs.

Stakeholder Identification

Your first task is to identify the stakeholders for each health topic and behavior. Cast the net widely to be sure you capture all of the current and potential players in the field, both big and small. These may include government Ministries (e.g., the MOH and the Ministry of Education), different divisions within a given Ministry (e.g., the Reproductive and Child Health Section, the National AIDS Control Program or the Health Promotion Unit within the MOH), donors, multi-sectoral bodies, civil society organizations, faith-based organizations, NGOs, service delivery partners, SBCC partners, social marketing organizations, systems strengthening partners, universities or media organizations. Program beneficiaries are also key stakeholders.

Understanding Stakeholders

Once you have identified your stakeholders, learn about the goals and objectives of each potential stakeholder, how each stakeholder might benefit from integrated SBCC and what each stakeholder can bring to the SBCC integration effort. Be sure to understand any concerns, competing demands or agendas. Investigate what each stakeholder understands about the integration. Some may think integration means concurrent programs under one funding mechanism, rather than cohesive and logically packaged interventions that unite divergent health areas.

Collecting Information

Collect the following information on the donors, local government and partners to help you identify gaps, challenges and opportunities for effective and efficient SBCC integration.

> **RESOURCES**
>
> Worksheet 1: Stakeholder Identification for Integrated SBCC Programs provides a template to guide your stakeholder identification process.
>
> See Worksheet 2: Integrated SBCC Program Stakeholder Interview Guide for a sample stakeholder interview guide for integrated SBCC programs.
>
> *(continued)*

Donor and Government

- **The extent to which the government and donors understand integrated rather than concurrent programming.** It may be helpful to investigate any previous experience with integrated programs.
- **The extent to which various divisions of the donor or departments within the host country ministry (MOH or other) support an integrated SBCC approach.** Even though a donor may have issued an award for implementation of an integrated program, the individuals in that agency responsible for the various health or development topics may not be equally invested in the integration. Similarly, an integrated project may have high-level governmental approval that allowed it to be awarded, but lack buy-in from the individual programs implicated in the project. Integration comes with some loss of control over the outcomes for each topic and this may be uncomfortable for those responsible for those areas.
- **The potential to align reporting structures.** Governments and donors often have well-established programmatic and financial reporting structures that may be less flexible or amenable to an integrated program. Get a good understanding of what indicators are reported for each health topic, and how. Are there similarities and differences? What is the timeframe for reporting? Are fiscal years aligned? How amenable are these programmatic and financial reporting systems to change?
- **In the case of multiple donors, the degree of alignment among the donors on the need for SBCC integration and on the priority topics to integrate.** It is also helpful to understand the process by which the various funders expect the integration to take place.
- **The quality of the working relationship between the donor and government.** Effective coordination in an integrated program is key to its success. The project will likely invest significant time in ensuring and strengthening coordination. Be sure to have a clear understanding of relationships among divisions *within* the donor and government ministry/ministries, but also between the donor and government.
- **The potential for prioritizing topics in a way the donors and ministries can accept and support.** Given that funding for each topic may not be equivalent, it is critical that, as the implementer, you have flexibility in the design of the program to prioritize topics in a way that benefits the overall integration, rather than only benefitting each topic separately. For example, in an integrated maternal, child health and malaria project, it may make sense chronologically to begin with messaging on early ANC attendance, even if the malaria funding accounts for a larger percent of the project. Ensure that those responsible for malaria in the donor/government agencies understand the rationale for that prioritization and agree with the decision.

Partners

- **The extent to which partners understand complete integration.** It may be helpful to investigate any previous experience with integrated programs and ensure integration is not confused with concurrent programming.
- **Partners' understanding and perception of SBCC and approaches toward communication for change.** Are partners already familiar with SBCC, or is it a fairly new concept? Are they proponents of communication, or is advocacy needed? How advanced are the partners in their SBCC thinking, strategies and approaches? What degree of SBCC capacity building might be needed? If they are already implementing SBCC programs, what channels and intervention types are being used? What is the relationship between their messages? How consistent are the messages?

RESOURCES *(continued)*

Once you have collected all of this information, organize stakeholder information into matrices as shown in the examples found in Worksheets 3A: Stakeholder Capacity Matrix and 3B: Implementing Stakeholder Matrix. Compile your findings into a consolidated format (see example in Worksheet 3C) for easy reference. a template to guide your stakeholder identification process.

- **Partners' level of expertise in SBCC and the health areas of interest.** What are their strengths and gaps as related to SBCC and the topics/behaviors at hand? Do they have technical experts in content areas, such as HIV, family planning and malaria? What is their level of expertise in skill areas such as community engagement, training, media buying and radio production? What types of capacity strengthening might be needed?
- **The audiences reached by each partner.** Where is there audience overlap among partners? Are important audiences not being reached by existing partners?
- **Geographic areas of operation.** Are any partners working in the same states, regions, districts or villages? In the same health facilities? Do any partners have zonal, regional or other sub-national offices in similar locations? Are there opportunities for co-location?
- **Local partners.** Are national-level stakeholders working with local NGOs or Civil Society Organizations on the ground? If so, which ones? Are any partners working with the same local organizations, service providers or community health workers? What are the opportunities for synergy? How might these interactions be streamlined?
- **Availability and flexibility of resources.** What are the funding levels available for the integrated SBCC activity? What are the sources of funding, and what are the requirements and expectations of the donor for its use? What non-financial resources can partners contribute? Are existing financial tracking systems able to handle integration?
- **Project timelines.** How do stakeholders' project timelines align? How do the timelines of other projects align with the integrated initiative? What opportunities and challenges might varying timelines present?
- **Data collection and use.** What monitoring and evaluation systems are already in place? What type of data is being collected on each health or development area, at what frequency and through what structures? Is data collected using paper-based or electronic systems?

Identify areas of overlap, potential synergies and any gaps unaccounted for by any stakeholder. Are any of the audiences, messages or interventions known to significantly contribute to behavior change in the desired areas that are not currently addressed? Take this information into account when planning and implementing activities.

Environmental Analysis

In addition to understanding stakeholders, you also need to assess the existing structures and availability of resources for integration.

ENVIRONMENTAL ANALYSIS ELEMENTS AND QUESTIONS TO ASK
Existence of national-level strategies, policy documents or action plans for SBCC integration. Has integration been prioritized and formalized in the form of national-level documents?
Extent to which relevant health and development programs are already integrated. Have any existing strategies or policies on integration been implemented in practice? What topics have been integrated? What lessons, including specific challenges or success factors, can be learned from this experience?
Existence of national-level SBCC coordinating bodies. Is there a MOH Health Promotion Unit or equivalent structure currently coordinating SBCC? Do vertical programs within the MOH, such as the National Malaria Control Program or Reproductive and Child Health Section, have their own staff dedicated to SBCC outside of the Health Promotion Unit? Have any SBCC task forces or working groups been formed that span across different sections within the MOH? What is the SBCC technical capacity of these groups? How active and well-resourced are these coordinating bodies? Can any of the existing coordinating bodies serve as the coordinating mechanism for the integration effort, or is a new coordination mechanism needed?

Human resources for SBCC at decentralized levels. Are there point people responsible for SBCC in place at sub-national levels (e.g., Regional or District Health Promotion Coordinators or Community Health Focal Persons)? What is the SBCC capacity of these individuals? Is health promotion their only responsibility, or are they in charge of other areas as well (e.g., family planning coordinator)? If they are simultaneously coordinating other areas, how might that help or hinder their focus on SBCC and integration?
Extent to which the relevant services are available and integrated. Which services are available at which level of health facility? Are some services integrated? How are they integrated, and how well is it working? Is this standard practice in all of the health facilities? Are there plans to scale-up this type of integration?
Health providers' ability to accommodate the number of topics expected to be included. What cadres of health providers are implicated in the integration? Is it realistic to expect health providers to take on the number of health topics included in your program? What additional training will be required in order to achieve this?
Presence and roles of community health workers (CHWs). Is there a formal, institutionalized CHW cadre at the national level, or do different programs (either MOH units or donor-funded projects) recruit and train their own CHWs in different health areas? How extensive and decentralized is the network of CHWs? What qualifications are required to become a CHW? What health topics are included in the CHW training? How are these topics integrated, if at all? What methodologies are used in the training (e.g., didactic lectures or participatory approaches), and what types of activities are CHWs expected to carry out at the community level? Does their training have an SBCC component? Can the CHWs accommodate the number of health topics expected to be included? Who supervises the CHWs? How are CHWs compensated or incentivized?
Existing referral mechanisms. How are clients currently referred from the community level to the health facility, to different services within the same health facility and between health facilities? Are there standardized referral systems, or do different programs, projects and/or health areas have their own mechanisms?
Existing media that could be adapted to accommodate integrated SBCC. If the new initiative will have a mass media component, investigate whether there are any existing radio or television programs, magazines, newspaper sections, websites or social media sites focused on health or development. What do they currently address, and how? Could any existing hotlines or short message service (SMS) platforms be utilized for integrated SBCC? Could any of the available media channels be easily added to or adapted to include additional topics?

ENGAGING SUPPORT

Now that you have a clear understanding of the relevant stakeholders, structures and resources available for integration, you are ready to engage stakeholders in the design, implementation and evaluation of the program. Setting up structures and mechanisms for continuous engagement prior to design and implementation will help ensure a more successful program.

Encouraging Buy-in

The stakeholder analysis should give you an understanding of the varying levels of support for the integrated SBCC program. Stakeholders will likely fit into one of four categories. Those who:

- Believe strongly in the need for integration and are committed to bringing it to fruition;
- Accept the idea of integration in principle but fail to demonstrate it in practice;
- Express doubts about integration and are not yet fully bought in; or
- Adamantly oppose the integration.

TIP

Two types of advocacy may be necessary: advocacy for integration, and advocacy for SBCC. This I-Kit focuses on advocacy for integration. Please see the **Resources** section for tools that can help you make the case for SBCC.

It may be necessary to advocate for an integrated SBCC approach to ensure broad support for your project. Clearly demonstrating the potential benefits of integration *before* the design and implementation of the project can help ensure a more successful project and decrease the need to continually make the case for integration throughout the project.

Here are some strategies that can be used to advocate for integrated SBCC:

TIP

Programs can offer high-level training to motivate leaders and decision-makers to embrace SBCC and integration, and build their capacity to lead, manage or oversee the effort. The Johns Hopkins Center for Communication Program's Leadership in Strategic Communication training is one example.

- Highlight any government or donor strategies, policy documents or action plans that reference integration to provide a framework for collaboration.
- Emphasize the benefits of integration outlined in **Part 1: The Decision to Integrate SBCC**.
- Demonstrate how integrating efforts can prove more cost effective by leveraging resources to increase scale and impact.
- Present evidence from similar integrated SBCC projects that have shown positive results.
- Underscore incentives for collaboration, such as additional training, capacity strengthening, or international recognition through presentations, publications and conferences.
- If integration of any of the topics or behaviors has the potential for controversy in certain cultures or contexts, bring religious, traditional and/or political leaders on board early.

Establish a Neutral Coordinating Body

If the integrated SBCC effort involves several partners or crosses programs or sectors, a coordinating body will be essential to facilitate the work of the partners at national (and perhaps local) level. During the environmental analysis, if you discovered that a coordinating body for SBCC exists, it may be possible to take advantage of that body. This will depend on the purpose of that body, meeting frequency and amenability. Consider forming a sub-group of the existing coordinating body to manage the integrated program. Otherwise, it will be necessary to form a new group.

What is a Coordinating Body?

A **coordinating body** has the mandate and the authority to align the work of different implementing agencies towards a common strategy. This body may come in the form of a health or multi-sectoral partnership that includes relevant government agencies, donors, implementers and others.

What are the Roles of a Coordinating Body?

In general, a coordinating body's purpose is to harmonize efforts, avoid overlap and ensure everyone shares a similar understanding and is progressing toward the same shared SBCC and health/development goals. The coordinating body's level of authority may vary depending on context. Will your coordinating body have oversight, advisory, voting, decision-making and/or approval responsibilities?

Consider the following functions when determining what your coordinating body will need to do:

Ensure Quality

- Ensure strategies and activities are technically sound and align with national-level policies and documents
- Provide strategic guidance and/or technical input for integrated SBCC
- Establish or standardize processes and systems to support integration (e.g., finance, human resources and program data)
- Approve communication strategies, materials and performance monitoring plans, etc.
- Regularly review the project's progress, share updates and course-correct when necessary

Knowledge Management

- Coordinate and facilitate the exchange of strategies, methodologies and formative research among partners
- Encourage a pluralistic and holistic perspective of audiences, topics and behaviors
- Hold partners accountable for sharing work plans and data
- Share updates and information with the wider group of stakeholders
- Document the SBCC integration process, challenges and successes
- Represent SBCC issues in broader coordination meetings

Ensure Proper Resource Utilization

- Ensure that the comparative advantages of each stakeholder are maximized at all levels
- Ensure that resources are appropriately leveraged

Coordinate Implementation

- Ensure strategic coordination and multi-level planning that integrates work at the national, regional, municipal and community levels
- Coordinate the development of messages and materials to ensure message synergy and reduce conflicting or inconsistent messaging
- Develop joint initiatives to avoid duplication of effort and increase cost-efficiency
- Coordinate joint work plans, budgets and implementation across partners
- Set expectations and create a shared vision for integrated SBCC

PROGRAM EXPERIENCE

The **Communication for Health Communities** (CHC) project in Uganda coordinated national-level processes through the national Behavior Change Communication Working Group, which was led by the MOH with representation from implementing partners. It coordinated district and community-level activities through seven regional offices located in central Kampala, South Western, Eastern, Northern, Western, West Nile and Karamoja.

How Do You Establish a Coordinating Body?

The environmental analysis should give you information about any coordinating bodies already in existence. In the event that a coordinating body (or bodies) for SBCC already exists, you may need to strengthen or adapt it to meet your needs. In other cases, a coordinating body may need to be created.

Here are the recommended steps to take when establishing a coordinating body:

1. Identify an entity with convening authority to lead the coordinating body. This is usually a government entity. The Health Promotion Unit or its equivalent is often a logical choice. In some cases, a particular health technical unit within the MOH may be more appropriate. You may want to consider including units as co-chairs, with rotating leadership or with one as lead and one as secretariat.

2. Identify a focal point person who will be responsible for coordinating efforts. Ideally, this person will be senior enough to command the respect of the highest-ranking members of the MOH, as well as of regional and district authorities implementing the program on the ground. They should be familiar with SBCC as well as the relevant health or development areas. This may or may not be the same person who convenes the coordinating body.

3. Identify key organizations and/or individuals to be members of the coordinating body. Refer to your stakeholder analysis to determine who should be on the coordinating body. Each partner or stakeholder group should designate a representative who can make recommendations and decisions for their group.

4. In collaboration with the government focal person, set the objectives and agenda for the first integrated SBCC coordination meeting. Agree on the purpose of the meeting and develop the agenda for the first meeting together with the MOH. A sample agenda might include: a welcome and introductions; an overview of the proposed integrated SBCC program; the rationale and evidence for integrated SBCC; the purpose of the coordinating body; setting expectations; and developing a Terms of Reference (TOR).

TIP

In addition to national-level coordination, it is important to consider how coordination will remain strong at sub-national levels. What are the different sectoral entry points at the local level? What coordinating bodies exist or should be put in place at the regional level, district level or below? How can you build upon those networks to ensure coordination?

5. Determine the date and venue for the initial coordination meeting and send invitations to coordinating body members. A high-ranking government official, who is also (ideally) the focal person for coordinating efforts, should author the invitation. Include the agenda with the invitation so recipients understand the purpose and importance of the meeting. Emphasize in the initial invitation that consistency in attendance will be important and that the individual(s) selected to represent the organization should be able to fully commit their time and attention to the mission of the coordinating body.

PROGRAM EXPERIENCE: HOW TO ESTABLISH A COORDINATING BODY

The **Management Advisory Group** (MAG) served as the coordinating body for the three SSDI projects in Malawi – SSDI-Services, SSDI-Communication and SSDI-Systems. Initially, the MAG was comprised of the senior and technical project staff of the three activities and was chaired by the SSDI-Services Chief of Party (COP) with the objective of strengthening coordination amongst the three activities. Once implementation began, the composition of the MAG was expanded to include the USAID Health Office, including the Agreement Officer's Representatives (AORs) and all technical staff. The MAG was instrumental in providing guidance as a management body.

The frequency of coordination meetings will depend on the complexity of the project. Monthly or quarterly meetings are usually best, but there may be points in the project that require more frequent meetings, particularly during implementation and start-up.

Detailed guidance on organizing and conducting stakeholder workshops can be found here.

IN THEIR WORDS

"We had a main counterpart in the [MOH]. She was the mover and shaker of the project. If anything didn't work, we went to her and she would help us. We held monthly meetings. She was quite approachable. She was a senior government official, so having her blessing was quite important. At the same time, she would go to districts. Her correspondence there was quite important as well. She was helpful at both the central and district levels."

– Fayyaz Khan, former Chief of Party for Malawi SSDI-Communication

Who Should be a Member of the Coordinating Body?

Selecting the right members for the coordinating body is the first step to ensuring its success. It is important to be certain the coordinating body is properly constituted from the beginning, and that members consistently attend. Identify champions in each of the sectors or programs. Champions should be ready, willing and able to represent their topic and constituents well, and to identify solutions that further the shared vision.

The size of the coordinating body will depend on the number of topics in the SBCC initiative, and the number of stakeholders working in the various areas. It is not uncommon to have six or more organizations represented in a coordinating body for an integrated SBCC program. Consider the size that will allow the coordinating body to function most effectively. If it has too many members, the process may become unwieldy. Too few members will result in key gaps, and opportunities may be overlooked. Membership is rarely more than 25, and might include communication experts, representatives from each health area, implementing partners and the media.

As previously mentioned, ensure a high-ranking person convenes the partnership, and holds meetings at government offices whenever possible. Appoint an organization, individual or small team to serve as the secretariat. The secretariat is often the implementing partner leading the integrated SBCC initiative. The secretariat should be responsible for developing meeting agendas and content that efficiently uses participants' time, and for keeping partners informed through regular reports between meetings.

Step-by-step guidance on how to develop and measure coordination and stakeholder support can be found here.

Setting Expectations

Integrated programs operate differently than vertical programs in many ways. Those used to vertical programs may not be familiar with some of the realities and requirements unique to integrated programs. Set expectations early – ideally at the opening meeting of the coordinating body, or even before – to avoid conflict at a later point in time. A Memorandum of Understanding (MOU), TOR or another type of joint statement is useful to specify the purpose of the coordinating body, list its members and delineate the body's roles and responsibilities. All members should sign the statement once finalized to confirm their commitment. Circulate copies of the signed statement to members and organization heads.

Expectations may include:

- **Focus:** Integrated programs cannot cover the full range of knowledge, attitudes and behaviors that are part of a single-issue initiative. Too many behaviors or messages may overwhelm and confuse the audience, as well as those responsible for delivering the program (e.g., CHWs). Each technical health area may have to focus on one or two doable actions.
- **Flexibility:** With multiple topics and potentially competing agendas, remain open to a wide range of possibilities for program roll out. The amount of attention a particular topic or behavior receives may or may not be directly proportional to the amount of funding it receives. Certain topics may be prioritized over others, in terms of quantity or chronology. Be willing to work with the other stakeholders to search for common ground. For example, everyone may agree on the same audience, such as unmarried youth.
- **Mutual Trust:** Trust is especially critical in integrated SBCC programs that cover topics funded or managed by multiple technical programs. Integration can require giving up some control. It is critical to reassure the stakeholders involved that every issue will get the attention promised, and to deliver on that promise. Foster trust amongst stakeholders through open dialogue and follow-through. Listen to what they need and try to address their concerns.
- **Transparency:** Stakeholders in an integrated SBCC program may be both partners and competitors. With the competition inevitably comes a certain reluctance to freely share information. Integrated programs, however, require a higher degree of transparency between stakeholders than might be required in vertical programs in order to streamline processes, ensure efficiency, reduce redundancies and plan, implement, monitor and evaluate effectively. Sharing of budgets, data, processes, tools and work plans, for instance, might be expected.
- **Patience:** Integrated programs typically take longer to coordinate, design, implement and evaluate than vertical programs. Everyone involved should recognize and be comfortable with the amount of time needed to plan, implement all of the topics and interventions and achieve meaningful results. Donors,

in particular, should know when to expect action on their topic(s) and how progress on the other topics supports progress on theirs. Be sure to keep donors, government and others aware of progress and any delays.

- **Reporting:** Explore with donors whether there is flexibility in financial and programmatic reporting for integrated programs, and whether reporting can be done across health topics. Typically, financial reporting structures may be less flexible than programmatic reporting requirements. However, it is worth asking the donor if there is any possibility of combining the financial reporting requirements of various health topics to make it more amenable to an integrated program. Donor engagement and cooperation across their different departments is key in order for this to happen.

Establishing a Shared Vision

Establishing a shared vision is critical. Integration ultimately means less individual program autonomy, but focusing on the greater vision and how each partner can help achieve that vision in an integrated model can help overcome this hurdle.

The vision should be broad, bold and reach beyond the life of the particular project or what any individual program's efforts can accomplish. Reaching that shared vision should require progress on all of the topics included. Develop the vision with the coordinating body, or hold a larger stakeholder workshop that includes a wider array of stakeholders so as to ensure greater buy-in. You may want to include service providers, community representatives, opinion leaders, audience members and other non-health/professional representatives in developing the vision.

What Other Types of Coordination May Be Necessary?

It is often useful for the donor to establish its own internal coordinating body tasked with keeping all funding activity managers informed on project progress. The donor should identify a focal person to oversee integration within the donor community. This should be a senior individual in the donor agency with an understanding of SBCC and the various technical content areas. The MOH and government focal persons should remain in regular contact to ensure goals and progress remain in sync.

As you move forward, you may find a need for "sub-groups" within the coordinating body, including, for example, working groups or task forces responsible for producing a specific output, such as a campaign strategy or launch event. A sub-group will likely consist of some members from the coordinating body, and may also bring in external persons with relevant expertise to a specific task. A representative from the sub-group who also sits on the coordinating body should regularly update the coordinating body on the sub-group's activities.

While donor coordination is needed from the very beginning, task forces and working groups are usually formed later in the program, during the design and/or implementation phases. See **Design** and **Implement** for more.

PROGRAM EXPERIENCE: SAMPLE VISION STATEMENT

Sample Vision Statement: Health Communication Component (HCC) envisions a Pakistan where individuals, families and communities advocate for their own health, practice positive health behaviors (e.g., timely use of maternal, newborn and child health [MNCH] and family planning/reproductive health services) and engage with a responsive health care system (HCC, 2015).

PROGRAM EXPERIENCE: THREE PROJECTS, ONE SHARED VISION

Through the USAID **SSDI initiative** in Malawi, activities were awarded and implemented through three separate Cooperative Agreements: SSDI-Services, SSDI-Communication and SSDI-Systems. All three SSDI projects targeted the same 15 districts and were expected to collaborate and work together throughout the life of the project. Each implementing partner had a distinct scope of work and mandate, but one shared vision. The goal of all three Cooperative Agreements was to contribute to progress in three critical areas:

1. Reduce **fertility and population growth**, which are essential for attaining broad-based economic growth;
2. lower the risk of **HIV/AIDS** to mitigate the enormous impact on human resources and productivity; and
3. lower **maternal and infant and under-five mortality** rates.

Aware of the fact that they all had the same end goal, the projects did their best to collaborate and coordinate among themselves to maximize impact.

(Adapted from the *USAID/Malawi Support for Service Delivery – Integration Performance Evaluation* by Pinar Senlet, Chifundo Kachiza, Jennifer Katekaine and Jennifer Peters [2014])

PROGRAM EXPERIENCE: DONOR AND GOVERNMENT LEADERSHIP ROLE

Donors and government have key roles to play in advocacy, coordination and expectation setting with partners and within their own institutions. These leadership structures are often best placed to facilitate integration. It is usually much more effective to have the call for coordination come from the government and the funding agency than an implementing partner. In Guatemala, for example, the USAID Feed the Future portfolio was integrated across health, nutrition, education, economic growth, food security and climate change. More than 12 projects funded by USAID were given a similar goal: to contribute to the reduction in chronic malnutrition. With a huge need to integrate messaging, USAID invited HC3 to harmonize the many messages cutting across the different projects, partners and sectors, and made explicit to partners their desire for communication to support this integration effort. With this expectation set and reinforced by USAID, partners were better able to see the advantages of message harmonization and close collaboration to increase the impact of their work.

PREPARING FOR DESIGN AND IMPLEMENTATION

Once the coordinating body has been established and stakeholders are on board, take the following steps to prepare your program for design and implementation.

Agree on the Project Scope

Sometimes the donor pre-determines the geographic scope of the project, or sets certain parameters that implementers must work within (e.g., mandates that the program work in regions with the highest rates of malnutrition, but does not stipulate how many regions or which sub-regional areas to work in). Most programs state their geographic scope in their funding proposal. Now that you have a deeper understanding

of the landscape through the mapping exercise, have built consensus for the integrated program and have established a coordinating body, use your stakeholder analysis and work with your coordinating body to further refine the program's geographic scope. Who will be responsible for what, where and when? How can you ensure the project operates at scale, maximizes everyone's resources and is not stretched too thin?

Staff the Integrated SBCC Program

You likely proposed a particular staffing structure at the proposal stage. Given all that you now know from the stakeholder and environment analyses, is this structure still ideal for your integrated SBCC initiative? Consider designating staff members for each topical area (e.g., HIV, family planning and maternal and child health [MCH]), organizing it by skill area or function (e.g., media, community mobilization and training) or using a combination of those two approaches. Below are further details as to what these structures might look like:

- **Structuring by Content Area:** You may choose to designate a point person for each health or development topical area (e.g., HIV, family planning and MCH). If so, this person will be responsible for overseeing and championing all aspects of that intervention, including coordination and relationship management, strategy and messaging, media campaign development and implementation, community-level activities, budgeting and financial management, monitoring and evaluation and reporting. It will be this person's responsibility to ensure technical accuracy in that particular topic, engage regularly with the relevant government, donor and partner counterparts, and update necessary parties on progress or challenges.
- **Structuring by Function:** Alternatively, it may make more sense to organize your staff structure by skill area or function, such as media, community mobilization or training. If someone excels in a particular SBCC competency area, such as the development of participatory, interactive community outreach activities, that skill often translates across different topics. The media point person, for instance, would be responsible for overseeing the development of the media strategy, the production of radio and TV spots, media placement and media monitoring for all health or development topics of the program.
- **Combination Approach:** A third possibility is to combine the two approaches, and have both health area and SBCC component leads. Carefully consider how these staff will interact and clearly define their roles to avoid duplication of effort.

Additional human resource considerations include the following:

- How might you assemble a diverse mix of people to cross-pollinate ideas? You may be on the lookout for creative thinkers, "dot-connectors" who are able to see strategic linkages, health content experts, gender specialists, SBCC professionals, graphic artists, TV/radio production gurus, researchers or people with excellent relationships with a particular government ministry, who could forge and nurture relationships in that area.
- If your project is decentralized, at what level(s) (e.g., zonal, regional, district or village level) will your field staff be placed? Which positions will be most critical for successful implementation? Does it make sense to co-locate offices or place staff with other partners or stakeholders?
- Is it possible to create an integrated organogram that includes all organizations and stakeholders involved in the SBCC integration?

Budget for the Integrated SBCC Program

Several budgeting and financial considerations are unique to integrated SBCC programs. Think through all of the cost implications of integrated SBCC programs, and be sure to budget for them appropriately from the beginning.

Bear the following in mind when preparing budgets, establishing financial systems and tracking expenditures:

- Integrated programs typically require additional inputs (e.g., human resources, funding, processes and time) for effective management, coordination and implementation. As such, costs are often

frontloaded more so than in vertical programs, requiring you to **budget for higher start-up costs** than normal. Because coordination is so critical in integrated programming, be sure to dedicate adequate resources for the continuous engagement of stakeholders at multiple levels. The cost efficiencies due to integration, versus the redundant effort required common for vertical programs, can potentially make up for these added costs of coordination at a later point.

- The donor may require you to separate out costs by health area or activity. This can be particularly difficult for integrated programs, which, by definition, address more than one health or development topic at a time. Work with your donor to **set realistic expectations on the degree to which costs can be accurately disaggregated** and agree on how costs will be reported.
- In order to accommodate donor requests for disaggregated cost data to the extent possible, programs might need to **experiment with ways to track budgets for reporting purposes**, such as expenditure tracking by topic area. Keeping a potentially complicated intervention schedule on track through timely reporting becomes even more crucial with integrated programs.
- In most cases, the topics included in your program will have **varying levels of funding**. To further complicate matters, the levels of funding may vary from year to year. Funding for topics the program started with may be cut in later years, or new topics may be introduced as the program goes on. Regardless, donors and/or activity managers often want to see activities, results and indicators that match their funding commitments. Does an activity level proportional to the annual amount of funding for each topic make strategic sense for your program? Be prepared to justify and advocate for the most strategic allocation.
- Determine if your program can successfully make the case for **basket funding that allocates the budget according to strategic needs and requirements**. For example, can a proportion of the funding be used for overall or combined costs, such as coordinating body meetings, formative research, the launch of an overarching umbrella campaign, integrated SBCC capacity building interventions or staff time?
- Integration may be established prior to project start-up by the RFA/RFP, or may come about during the proposal or strategic design stages. **Budgets that are tied to deliverables or timelines set before the decision to integrate might warrant renegotiation** with the donor. Otherwise, funding, rather than formative research and logic, might dictate the phasing or priority of topics.
- **Funding timelines may differ** between partners, donors, projects and/or the government (e.g., start dates, end dates and fiscal years). It is critical to take those specific funding timelines into consideration as you plan activities and the disbursement of funds. It may help to set up a tracking system to help manage these timelines and plan ahead.

IN THEIR WORDS

"In integrated SBCC programs, underfunded activities often get a higher return on their investment. Under the Tanzania Capacity and Communication Project (TCCP), for example, our [MCH] funding was very little compared to our PEPFAR (U.S. President's Emergency Plan for AIDS Relief), PMI (U.S. President's Malaria Initiative) and Population funding. MCH, however, was the 'link' that tied all of these areas together. A campaign grounded in healthy pregnancy, safe delivery and the first year of a child's life would also help us address PMTCT, the prevention of malaria in pregnancy and post-partum family planning, together with early and complete ANC attendance, individual birth planning, delivery at a health facility and several other aspects of MCH. We ended up developing Wazazi Nipendeni (Love me, parents) – a huge, integrated national campaign that had a sizeable focus on MCH – with very few actual MCH dollars.""

– Robert Karam, Chief of Party for TCCP

Align Reporting Requirements

If the SBCC program is integrated, programmatic and financial reporting should be integrated as well. Such reporting may be difficult given the greater number and variety of activities being implemented, the potential increase in the number of donors/stakeholders to report to and the likely differences in their reporting requirements. If multiple donors or programs are involved, creating expectations for reporting requirements that support integration will help prevent the need for multiple versions of reports. It is helpful to set up

expectations and structures for integrated reporting before the program begins or, for example, in an early coordination meeting.

One option is to create a matrix of programmatic reporting requirements from each donor or agency, and identify where those requirements overlap. For example, some reports may use different terminology but require the same content. Discuss how to handle content required by only one or a few donors with partners and donors. Ask the donors what they can give up, and what absolutely must be collected, even if it is for only one donor. Then, create or adapt your mechanisms for collecting data and reporting on the agreed topics and indicators. The **Research, Monitoring and Evaluation** (RM&E) section provides more information on RM&E coordination, harmonizing indicators and data collection, analysis and reporting.

> **TIP**
>
> Where possible, let the RM&E plan (once it has been agreed upon) drive reporting.

Donors may also have different financial reporting requirements. Discuss this issue with your donors and come to an understanding about what can be standardized across donors. Explore the possibility of replacing the health-topic-wise reporting system with a system that tracks spending across health areas, and is better aligned with the manner in which an integrated program may plan activities addressing more than one health area while having different funding sources for each health area.

Assess Capacity

Integrated SBCC requires the assimilation of not only new but also more varied information and potentially new ways of communicating for both program implementers and providers (e.g., information communication technology [ICT] or improved IPC). Identify capacity-strengthening needs through working group discussions, needs assessment surveys and during SBCC strategy development.

Because integrated SBCC typically requires health workers, community health agents and others to explain and answer questions about new and varied topics, capacity-strengthening needs might be amplified as compared to single-focus SBCC. Where necessary, staff may need high-quality training and skills building in topics outside of their original area of expertise. When designing your program, plan for frequent supportive supervision that includes observation, customized on-the-job training and regular follow-up group training to strengthen generally weak areas. If agents use tablets or other digital technology to access relevant messages and information, training should include how to quickly find the needed information while remaining largely focused on the client, and supervision should verify agents' ability to use the technology effectively. Supervision guidelines and tools (e.g., checklists) should reflect integration, such as looking at how effectively providers integrate new content into their interactions with clients. As with many SBCC interventions, including frontline workers in training will not only help prepare them to provide the needed services but also help gain their buy-in.

> **RESOURCES**
>
> Both vertical and integrated projects often have a need for SBCC capacity strengthening. See the **SBCC Capacity Ecosystem** for more information on how to build capacity for SBCC programming.

Considerations for Community Agents and Providers:

- What is their capacity for integrating the additional information and skills;
- How do community agents and providers from the different programs/sectors intersect in the community (Are they working with the same people? Will all agents need to communicate about all of the topics?);
- Do efforts need to be redistributed to avoid overlap or gaps?
- Do the agents and/or providers need to learn new ways of sharing information?
- What are the implications for supervision?

ADDITIONAL RESOURCES

Making the Case for SBCC

- What is SBCC (Video)
- What is SBCC (Infographic)
- HIV Evidence Package
- Evidence Infographic - Youth Reproductive Health
- Urban Youth Evidence Database
- Health Communication and the HIV Continuum of Care: JAIDS Supplement

Miscellaneous

- Population-Level Behavior Change to Enhance Child Survival and Development in Low- and Middle-Income Countries: A Review of the Evidence
- How to Conduct a Situation Analysis
- Mapping the Landscape for SBCC Integration Analysis Toolkit
- How to Conduct a Stakeholder Workshop
- Leadership in Strategic Communication (Training)
- Stakeholder Management: Planning Stakeholder Communication

PART 3: STRATEGIC DESIGN OF INTEGRATED SBCC PROGRAMS

There are important considerations throughout the integrated design process that may differ in detail from a vertical program. This section highlights those considerations and addresses key concepts, including formative research, program goals and objectives, target audience(s), message design and communication approaches and channels that may be unique to an integrated SBCC program.

CONSIDERATIONS FOR THE STRATEGIC DESIGN PROCESS

Take the following factors into consideration **before** starting the strategy development process.

Alignment with National Strategies and Policies

Your environmental analysis should have identified any national-level strategies, policy documents or action plans for SBCC integration. Review these documents and their priorities, and factor them into your strategic design. Your integrated SBCC strategy needs to align with the country's strategic direction and clearly demonstrate how it is contributing to national goals and targets. To help you determine how best to align with national priorities, think about the following questions:

- Are there vertical communication strategies for the different topic areas (e.g., a National Communication Strategy for Malaria Control or a National Family Planning Costed Implementation Plan)?
- Where are the areas of synergy in these strategies?
- Do some target the same audiences, or use the same communication channels?
- How might you blend these in your strategy?

PROGRAM EXPERIENCE: NATIONAL STRATEGIES GUIDE DESIGN

Several national strategies and guidelines were instrumental in guiding the strategic design of **Tanzania's *Wazazi Nipendeni* campaign**, which integrated MCH, PMTCT, malaria prevention, family planning and nutrition into an overarching safe motherhood campaign. Most notably, the campaign aimed to operationalize the Campaign on Accelerated Reduction of Maternal Mortality in Africa in Tanzania (CARMMA/Tz) and the National Road Map Strategic Plan to Accelerate Reduction of Maternal, Newborn and Child Deaths in Tanzania 2010-2015 (One Plan).

Stakeholder Engagement and Coordination

During the strategic design process you will make key decisions about content, order and priorities. For integrated SBCC to retain buy-in from stakeholders, they must be actively engaged in this decision-making process. It is likely there will be trade-offs between topics, audiences, level of detail and other aspects of programming. Stakeholder involvement will help ensure they have a chance to deepen their understanding of their audiences' needs, and the opportunity to provide input into how and when their issue will be covered.

TIP

Advocacy for the strategy is as important as the strategy itself. Advocate within the partnership to continually strengthen the strategy. Also advocate with communities by engaging traditional and religious leaders and other gatekeepers (e.g., in-laws and community groups) on the topics before and during implementation to get their support and participation.

In addition to the **coordinating body**, this phase of integrated SBCC programming is likely to involve the formation of smaller working groups or task forces. There may be sub-groups tasked to develop the initial draft of the strategy for the coordination body's review, to work on developing creative concepts or to develop communication

materials. You may hold strategy design, campaign design or materials development workshops for these purposes (see How to Conduct a Stakeholder Workshop for more information).

This is also an ideal time to involve the target audience in the process in order to co-create the strategy, concepts and materials with the people or groups they are meant to benefit, and help to ensure their relevance and success. Be sure to factor in the additional time and resources required for stakeholder coordination during this strategic design phase.

TIP

If faced with challenges on what to prioritize, return to the shared vision and common goals set at the beginning of the project to determine the best course of action. They can act as a "compass" for navigating the design process, and help ensure the main objectives are at the heart of each activity (Edmond, et al., 2013).

IN THEIR WORDS

"Local input during the design process ensures better long-term solutions. The co-creation process is critical to restore agency and transfer responsibility, ownership and decision-making to enable exit. Developing and equipping local and national servant leaders to be able to design, manage and scale solutions is the key to long-term success in the fight to end extreme poverty. Using a co-creation design process for programs puts potential solutions through a rigorous vetting process to determine their suitability in any given project's context for maximum impact."

– (Changala, 2014)

Materials Inventory

When designing an integrated SBCC project, chances are that you will not be the first to develop communication materials on each of the various topics. Rather than re-invent the wheel, see what others have already produced in the areas of interest. Collect and catalogue existing materials and resources from partners to use later during the message design and materials development processes. Obtain both electronic and hard copies wherever possible to facilitate adaptation.

PROGRAM EXPERIENCE: COLLABORATIVE DESIGN

Where partners have communication staff, an SBCC working group to develop and collaborate on implementing the integrated SBCC strategy can further increase buy-in and build SBCC capacity. In Guatemala, for example, HC3 organized meetings, workshops and consultations with communication staff of the **Western Highlands Integrated Program** (WHIP) implementing partners. Workshops were used to share a message consistency analysis and situation analysis, build capacity for formative research and use of data for decision-making, develop the integrated SBCC strategy and develop a radio campaign, among other things.

FORMATIVE RESEARCH

Formative research is essential to effective strategy design in any SBCC project. However, integrated SBCC programs must take into account additional nuances and considerations. Before designing your integrated SBCC strategy, you need to conduct some level of formative research to better understand your audiences and the health topics and behaviors you plan to address. Your findings from this research will be used to inform the development of your strategy.

In general, formative research should uncover what people currently know, think, feel and do about the

relevant topics and behaviors, and to understand their motivations and barriers to changing or adopting new behaviors. In integrated SBCC programs, the formative research should also help determine whether and how different topics and behaviors relate to one another. Both types of information will help the program and partners determine what to include in an integrated SBCC strategy, and provide insight on how best to do it. Engage a wide representation of stakeholders at all levels (e.g., communities, leaders and other stakeholders) when identifying which issues to address. hen designing an integrated SBCC project, chances are that you will not be the first to develop communication materials on each of the various topics. Rather than re-invent the wheel, see what others have already produced in the areas of interest. Collect and catalogue existing materials and resources from partners to use later during the message design and materials development processes. Obtain both electronic and hard copies wherever possible to facilitate adaptation.

TIP

Some influential stakeholders might want to exert influence that conflicts with what community stakeholders want or need, or what the research says should be done, such as targeting inappropriate audiences or prioritizing irrelevant health topics. Continuously reinforce the need for the SBCC effort to go where the formative research directs might help.

Objectives of formative research for integrated SBCC programs:

- gather information about the extent to which audiences (including providers) perceive or experience the topics or behaviors as related, and how they are related;
- identify influencing factors and behavioral determinants common to the behaviors in question;
- provide insights on how to prioritize topics or behaviors in the implementation phase;
- identify **clustered behaviors**, **gateway behaviors** and patterns of household/community communication that foster change;
- observe communication across behaviorally related areas to understand the shared goals that unify seemingly diverse behaviors (e.g., parental investment as a unifying goal);
- identify ways to gain maximum synergy and added value from integration;
- reveal the extent to which audiences are already touched by or interacting with integrated SBCC or integrated services;
- observe communication cascades (e.g., word-of-mouth, discussion-partners, spousal communication and provider/client interactions) around different issues to understand how communication shapes decision-making and action;
- inform an integrated theory of change;
- identify how to segment and appeal to audiences in the context of integration, including understanding people's desires, articulated and unmet needs;
- identify potential conflicts and unintended consequences of integrated SBCC;
- suggest monitoring and evaluation (M&E) indicators specific to integrated programs; and
- develop clear integration-specific (and other) research questions.

Formative Research Methodologies may include more traditional approaches, such as focus group discussions (FGDs) or in-depth interviews (IDIs). Less traditional, user-centered ethnographic techniques include direct observation, immersion, mystery client experiences, interactions with spaces, customer journey mapping, photo diaries, photo elicitation and card sorts. These less conventional methodologies can help provide more well-rounded perspectives of the target audience's understanding and experience with your topic areas, and yield unexpected, actionable insights. For more information on how to conduct formative research, review the **Resources** at the end of this section, including How to Conduct Qualitative Formative Research, the Total Market Approach, Trials of Improved Practices and **human-centered design** research techniques.

In integrated SBCC programming, it is especially important to seek sources of information beyond your beneficiaries to inform your programming. Interview topical, behavioral and/or integration experts, for example, to gather important lessons learned and to gain new perspectives on your topics and how they might be linked. Conduct literature reviews on similar integrated interventions that have been implemented elsewhere for important guidance on program design, including both peer-reviewed articles and gray literature. The stakeholder and environmental analyses in **Laying the Foundation** are also types of formative research meant to inform program design and implementation.

PROGRAM EXPERIENCE: FORMATIVE RESEARCH METHODOLOGIES

In a recent interview, Fayyaz Khan shared that SSDI used FGDs, IDIs, a mapping process and extensive visuals in their formative research process (2017). He noted that they designed the research to address questions such as:

- What do people value?
- How do they perceive health?
- Is HIV more dangerous than malaria or not?
- How do they perceive the value of losing a child?
- What is the value of a woman?

The project went beyond traditional health topics to look more holistically at how different groups in communities view health (Khan, 2017).

COMPONENTS OF AN INTEGRATED SBCC STRATEGY

A communication strategy is a plan that outlines how an SBCC program plans to achieve its goals and vision. The structure and components of an integrated SBCC strategy do not differ from that of a vertical program. However, the content of each of the components may be quite different from vertical programs. In this section you will find special considerations for each of the components of an integrated SBCC strategy.

Find more information on SBCC strategy development in HC3's how-to guide and I-Kit.

TIP

Social norms are critical to integrated programs, but shifting them can take a long time. Given the breadth of integrated programming, carefully consider how best (and how much) to emphasize social change. It can be helpful to identify norms that are shared across health topics and then determine which are most critical to address. Programs might have to rely on changes in attitude and/or on individual behavior change as shorter-term proxies for social change.

Goals and Objectives

Goals and objectives are designed to state the intended impact of the communication program. The goals of an integrated SBCC program should flow from the shared vision agreed on by stakeholders. The goals should be bigger than what a single-focus SBCC effort could accomplish and answer the question: "If major progress is made on all of the issues/behaviors addressed through this program, what will be the result?" In addition, the objectives should implicitly or explicitly cover all of the health or development topics and behaviors included in the integrated effort. Ideally, the objectives will reinforce each other.

IN THEIR WORDS

"The development process and final strategic document is noteworthy. At the outset of the SSD-I activity, there were a myriad of health communication strategies without an overarching document covering all of the [EHP] areas. The Health Education Unit (HEU) did not have the human or other resources required to pull these together into one unifying package. In addition, it was beyond the mandate of SSDI-Communications to undertake this task. To address this challenge, the activity worked closely with the HEU to develop a strategic document for the activity's six focal areas, and ensured that HEU skill sets and capacity were strengthened. As a result, HEU personnel were able to utilize this experience and the initial strategic document to guide them in developing a national strategic plan covering all of the EHP areas."

– (Senlet, Kachiza, Katekaine & Peters, 2014)

PROGRAM EXPERIENCE: Sample Integrated Project Goals and Objectives

Project: USAID-funded World Relief/Burundi Ramba Kibongo (Live Long Child) Program

Goal: To reduce the morbidity and mortality among children under five years of age and women of reproductive age.

Areas covered: Nutrition, malaria, diarrhea, immunization and family planning

Objectives: Improved linkages between households, communities and the formal health system; improved availability and access to essential health commodities at the community level; and increased knowledge and adoption of key family practices for child health by child caregivers with support from community leaders and health providers

Theory and Frameworks

The Importance of Theory

Grounding any SBCC strategy in a **theoretical model** is important but it can be even more so for an integrated program. A theoretical model lays out a "map" of how and why you expect change to happen. It helps to focus and guide every aspect of the program – from design to implementation and M&E. Given the complexity of an integrated SBCC program, a sound theoretical model can help stakeholders understand the logic behind program decisions and how each partner fits into the overall strategy.

See **Annexes A-I** (pages 61-75) for a selection of theoretical models that have been applied to integrated SBCC programs.

Approaches to Integrated SBCC

While the theory helps you explain why and how your program should work, the approach provides an overarching method for carrying out your integrated program. The field of integrated SBCC is evolving and new approaches are continually emerging. Below are some approaches that have been implemented successfully.

Life Stages Approach

In this approach, programs reach audiences (see Figure 6 on the next page) with information and skills that are relevant to their stage in life, in the belief that providing audiences with information they need when they need it increases the likelihood of its use. The Life Stage approach segments the family and society as a whole according to the age- or stage-appropriate needs of each member, addressing the household as a key decision-making unit. This approach acknowledges that each life stage, while transitional, has its own specific behavioral objectives and health needs. Promoting positive health behavior at early stages represents a positive health investment and will have a cumulative, sustainable impact on future health behavior.

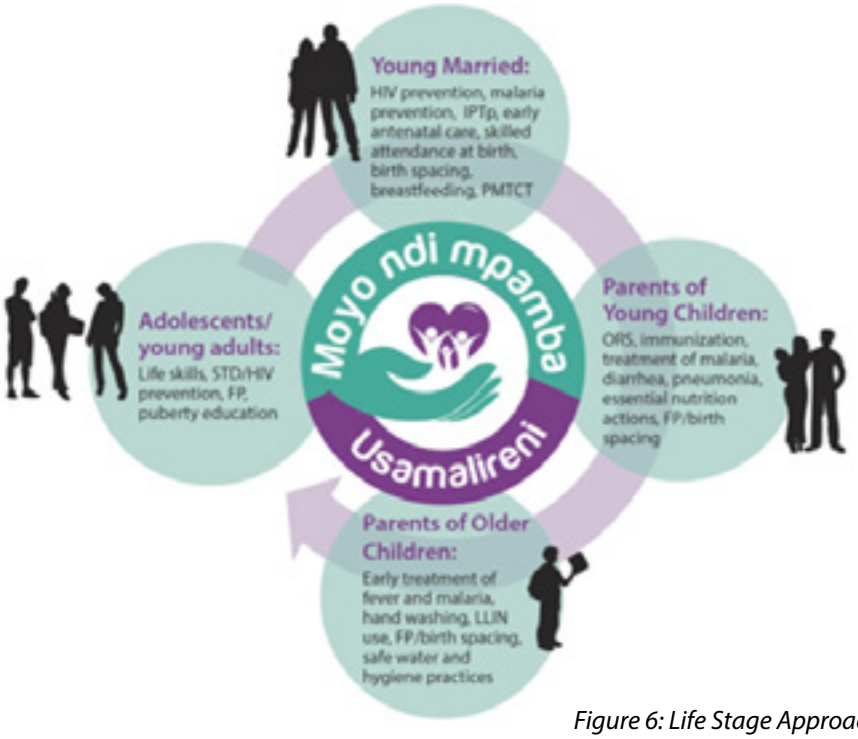


Figure 6: Life Stage Approach: Audiences

PROGRAM EXPERIENCE: LIFE STAGE APPROACH

In Malawi, for example, **SSDI** developed their communication strategy around four key life stages: young married couples, parents with children under five, parents with older children and adolescents. The four life stages were adopted by all three SSDI projects – SSDI-Communication, SSDI-Services and SSDI-Systems (HC3, 2016).

Communication for Healthy Living (CHL) in Egypt also used a Life Stages approach to address family members from birth through old age, with a special focus on newly married and young couples. CHL aimed to address a wide range of health areas using the Life Stages approach, including family planning, reproductive health, MCH, infectious diseases (including HIV) and healthy lifestyles and practices.

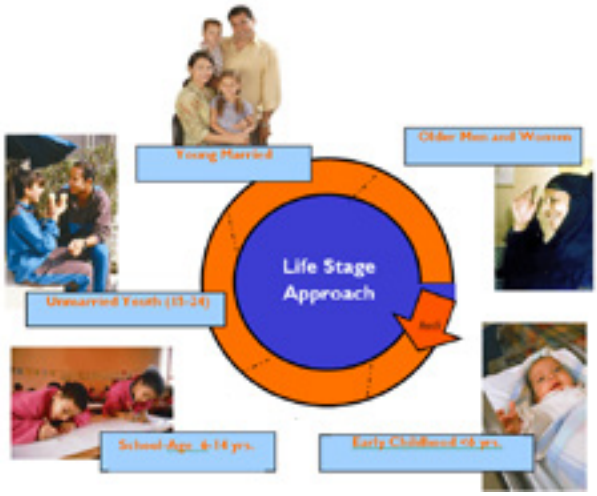


Figure 7: Life Stage Approach Age Cohorts (HC3, 2016)

Communication for Healthy Communities (CHC) in Uganda was based on the Life Cycle/Life Stage approach. Due to its personal touch, the approach triggered rapport, honest dialogue and self-reflection and provided knowledge, motivation and skills on HIV prevention, HIV care and treatment, MCH, nutrition, family planning, malaria and TB. The interventions were aimed at shifting gender and social norms and providing supportive environments for adopting recommended heath actions/behaviors. They were implemented through targeted interpersonal communication (IPC), community mobilization interventions, mass media and social media as well as print and outdoor media.

Gateway Behavior Approach

In the Gateway Behavior or Moment Approach, "Gateway" refers to a positive health behavior or to a facilitating factor that may trigger or facilitate other positive health behaviors, both simultaneously and across the family life cycle. For example, getting women to attend ANC can then lead to IPTp uptake, HIV testing, birth planning and other healthy behaviors.

PROGRAM EXPERIENCE: GATEWAY BEHAVIOR OR MOMENT APPROACH

Examples:

In Bangladesh, Alive and Thrive has worked to integrated maternal nutrition into a large-scale MNCH program with the idea that maternal nutrition is a gateway to positive infant and young child feeding outcomes.

The Nigeria Urban Reproductive Health Initiative (NURHI) used a **gateway behavior approach** to promote two key behaviors – completion of all recommended ANC visits and IPC on family health matters – with the hypothesis that adoption of these behaviors had significant potential to then facilitate the adoption of other health behaviors, including family planning, exclusive breastfeeding and immunization.

Behavioral Attributes Approach

The behavioral attributes approach takes into account that behaviors from different health or development topics may have more in common than behaviors from the same health area. For example, messaging about daily adherence to both antiretrovirals (ARVs) (HIV) and oral contraceptive pills (family planning) might be more similar than messages about ARV adherence and CD4 testing, which are both part of an HIV program.

To determine which behaviors might be promoted together, examine their attributes (i.e., the characteristics that define the behavior). Analyze the similarities and differences across the health areas and behaviors in your intended program to determine if there are ways to combine and package content that will improve impact, economies of scale, cost-effectiveness or program efficiency. Consider these potential points of convergence or divergence when determining which health areas and/or behaviors to package together.

Points to consider:

- What is the **frequency** of the behaviors you are looking to influence – daily, weekly, monthly or yearly? Are they one-time behaviors (e.g., voluntary medical male circumcision), behaviors enacted for a certain period of time (e.g., exclusive breastfeeding for six months) or practices the audience is familiar with? Are the behaviors habitual, or do they require a deliberative process? Are you aiming to increase the behaviors (e.g., exercise), decrease the behaviors (e.g., reduce sugar consumption) or stop a behavior completely (e.g., smoking)? What time of the day do the behaviors happen (e.g., morning, evening or at multiple time points)?
- What are the **financial, logistical and social costs** of the behaviors? Are they costly? Cheap? Free? How easy or complicated are the behaviors? Are they stigmatizing or pride-inducing?

- Do similar **structural** (e.g., distance to the health facility, infrastructure, law or policy) or **ideational** (e.g., attitudes, couple communication, self-efficacy or social ties) factors affect the behavior?
- Are the behaviors done **publicly** or in **private**? Do the behaviors require the agreement or support of others, or can they be done alone? Are there any concerns around anonymity (e.g., HIV testing and counseling)?
- Are the behaviors **shaped by gender norms, inequality or other social factors**? Is the behavior of high cultural significance (e.g., traditional male circumcision)?
- If behaviors require **interaction with a health provider**, what needs to happen before, during and after the client-provider interaction (e.g., demand creation, quality counseling and adherence, respectively)?

These behavioral attributes can affect messaging, timing, phasing, channel selection and other parts of the strategy (Source: Rajiv Rimal, "Social and Behavior Change Communication at the Crossroads (and Crosshairs): What's Next?" Plenary Presentation at the International SBCC Summit 2016: Elevating the Science and Art of SBCC, Addis Ethiopia, February 2016).

PROGRAM EXPERIENCE: BEHAVIORAL ATTRIBUTES APPROACH

In Tanzania, the *Wazazi Nipendeni* safe motherhood campaign used the Fogg Behavioral Model to inform its design. The Fogg model posits that there are three different durations of behaviors – one-time, over a limited period of time and indefinitely – and five different behavioral categories (a new/unfamiliar behavior, a familiar behavior, increasing behavior, decreasing behavior and ceasing behavior). This results in a grid of 15 possible types of behaviors (Figure 9, right). The design team mapped each of the campaign's desired behaviors onto the grid in order to better understand their attributes, and, in turn, how to best address the target audience and trigger change (Source: Fogg, 2010).

Fogg Behavior Grid *with Examples*

	Green behavior	Blue behavior	Purple behavior	Gray behaviors	Black behavior
	Do NEW behavior, one that is unfamiliar	Do FAMILIAR behavior	INCREASE behavior intensity or duration	DECREASE behavior intensity or duration	STOP doing a behavior
Dot behavior is done ONE-TIME	GreenDot Do NEW behavior one time *Install solar panels on house*	BlueDot Do FAMILIAR behavior one time *Tell a sister about eco-friendly soap*	PurpleDot INCREASE behavior one time *Plant more trees and native plants*	GrayDot DECREASE behavior one time *Buy fewer cases of bottled water today*	BlackDot STOP doing a behavior one time *Turn off space heater for tonight*
Span behavior has a DURATION, such as 45 days	GreenSpan Do NEW behavior for a period of time *Try carpooling to work for three weeks*	BlueSpan Do FAMILIAR behavior for a period of time *Bike to work for two months*	PurpleSpan INCREASE behavior for a period of time *Recycle more of household waste for one month*	GraySpan DECREASE behavior for a period of time *Take shorter showers this week*	BlackSpan STOP a behavior for a period of time *Don't water lawn during summer*
Path behavior is done FROM NOW ON, a lasting change	GreenPath Do NEW behavior from now on *Start growing own vegetables*	BluePath Do FAMILIAR behavior from now on *Turn off lights when leaving room*	PurplePath INCREASE behavior from now on *Buy more local produce*	GrayPath DECREASE behavior from now on *Eat less meat from now on*	BlackPath STOP a behavior from now on *Never litter again*

Figure 9: Fogg Behavior Grid

Co-Occurring Behaviors

Some integrated SBCC efforts focus on targeting behaviors that tend to occur together. Common examples include HIV and TB prevention and control, and HIV and substance abuse prevention. SBCC efforts often seek to address common drivers of co-existing behaviors, use entry points accessed for one issue to address the other issue(s) and link the issues/behaviors in the minds of the audiences.

Progressive Integration Approach

Often, programs seek to broaden a behavior change effort by adding new health areas onto an existing health program. This allows the program to take advantage of existing buy-in, structures and platforms. Examples include integrating family planning into immunization and other child health programs, integrating HIV into family planning or vice versa, and integrating maternal and child nutrition into child health programs.

These approaches are in no way mutually exclusive. An integrated program may use some or all of these approaches – for example, brand the campaign under one common umbrella, use a life stage approach, employ gateway behaviors and adopt co-existing or progressive integration. The integration approach(es) selected will impact many decisions about project design.

Target Audience

Integrating SBCC can complicate audience identification and segmentation. It might also reveal overlooked audiences. It is important to use what is known in the literature and discovered during formative research to identify and prioritize audiences, understanding that priority and influencing audiences might differ according to the topic or behavior.

If using an **umbrella approach**, you may find there is a core audience for the overarching brand, and more specific, segmented audiences for each technical intervention. Ghana's GoodLife "umbrella" brand, for example, targeted young families. The specific target audience would then vary slightly for each different health campaign. For example, pregnant women were a primary target audience and mothers/mother-in-laws were a secondary target audience for the IPTp campaign.

Integrated SBCC may be particularly relevant for certain audiences, such as adolescents as the focus of a reproductive health project, who would need (and likely welcome) information not only about contraceptives but also about sexual debut, marriage, education, livelihoods, HIV and more.

Consider what types of audience segmentation might make sense for your integrated SBCC program. If you are using a Life Stages approach, you may segment by key life stages, such as adolescence, marriage, pregnancy and parenthood. Some of these stages can be broken down even further, depending on the program's needs. Parenthood, for instance, may include the pregnancy period, parents of newborns, parents of infants and parents of children ages two to five -years old. If your program is grounded in the Stages of Change, you may look to segment by readiness to adopt a behavior. As multiple behaviors are implicated in integrated programs, a "readiness index" that assesses the stage of change across all behaviors might be

PROGRAM EXPERIENCE: TARGET AUDIENCE

At the start of the Nuru integrated poverty reduction program in Kenya, the agriculture program targeted farmers, the financial inclusion program targeted entrepreneurs and the WASH, healthcare and education programs targeted the entire community. This caused Nuru to question how this assortment of programs focused in the same community was getting at people of extreme poverty faster, cheaper and more effectively than any one of the interventions alone. As a result, they changed their unit of impact to the farmer and their household, with all outcomes focused at aggregated up to that level (Changala, 2014).

appropriate. Possibilities for audience segmentation are nearly endless. See How to Do an Audience Analysis and How to Do Audience Segmentation for more information.

On the other hand, you may find a need to collapse target audiences into broader categories in order to achieve efficiencies. Be prepared to lose the specificity of your target audience in order to gain effectiveness.

Content and Messaging

When developing content for an integrated program, it is particularly important to think about how you will prioritize and package the content. In other words,

PROGRAM EXPERIENCE: CONTENT AND MESSAGING

In Uganda, the CHC project focused on engaging in dialogue with their audiences to determine content and messaging. Instead of the traditional, prescriptive health messages that tell audiences what to do, the project engaged people in a conversation, found out what was important to them and positioned relevant health actions in that context.

1. **Prioritize:** Which health topics or behavioral messages will be rolled out first? Which will be rolled out last? How much time will be given to each topic area? Which content is most important and absolutely must be included in the program? Which content might be cut?
2. **Package:** Which health topics will be bundled together? Which behavioral actions might be combined within one message?

TIP

When it comes to SBCC integration, focus demands sacrifice - even more so than in vertical programs. In deciding how many messages to convey in a single intervention, such as a counseling session or radio drama, consider both the audience and the channel. Some research shows people can retain just three key messages discussed in a 15-minute session.

How to Prioritize and Package Content

Deciding how to prioritize or package content for an integrated SBCC program can be complicated. Which content do you keep? What do you sacrifice for the sake of focus? What do you focus on first? Do certain topics or behaviors deserve more attention than others? How do you ensure your messages are well-balanced, coherent, logically packaged and rolled out in an understandable way?

Programs have used a variety of approaches for prioritizing and packaging content in integrated strategies. As noted above, some use a phased approach, which helps balance the amount of information being conveyed at once. For example, a phased approach can start with messages about behaviors considered to be relatively easy to adopt (i.e., "low-hanging fruit" or small, doable actions), as determined by formative research, or with the topic whose funding ends first/earliest. If possible, plan to repeat the cycle of messages to reinforce them. Unfortunately, in situations where multiple donors or vertical programs are involved, phasing can be difficult.

Ultimately, you are aiming to create synergy by addressing related topics together. Consider the following methods of combining or prioritizing SBCC content.

Behavioral Considerations

- What are the **behavioral determinants** that influence the adoption of each behavior, and how might you focus messaging on these?
- How **simple or complex** are the different behaviors? Complex behaviors may need more in-depth messaging or attention.
- What are the other **attributes** of your behaviors? How might this influence messaging? (See Behavioral Attributes Approach on page 28)
- What are the **causal pathways** of your behaviors? What **gateway behavior(s)** lead to others?

Client Considerations

- How might you use participatory methods such as **human-centered design** or the **Action Media methodology** to determine what information **end users** want to receive, how they want to receive it and in which order?
- What are the **client's most immediate needs**? For example, if a client comes for family planning, start with family planning, then move to other issues of concern such as HIV testing, post-natal care or immunization.
- What topics or behaviors could be addressed during key "**teachable moments**" in a family's life?

Coordinate Implementation

- What are the **health or development outcome priorities** of the host country and the donor?
- What is the level of **funding** for each topic?

Other Considerations

- How do your topics or behaviors relate to one another **epidemiologically**? In the **minds and lives of the audience**? In the **delivery of products and/or services**?
- What is the **availability of relevant products, services and/or support structures**? Encouraging behaviors that cannot be practiced can create frustration.
- What is the **capacity of the health provider or community health worker** to address these topics? You may want to start with familiar topics or messages and build from there.

IN THEIR WORDS

"Guidelines from the Africa Biodiversity Collaborative Group on freshwater conservation and WASH integration recommended the following widely applicable lesson: "Resist the urge to design a 50/50 project between WASH and freshwater conservation activities and do not be afraid to rule things out. Projects are context specific. Not all implementation elements can be incorporated for many reasons including lack of financial resources, capacity, community ownership or other constraints. No project can do everything, what matters most is that the project achieves the agreed upon goals."

– (Edmond et al., 2013)

Message Harmonization

While messages are an integral part of your communication strategy and will be addressed during the strategy design, you may find you need to dedicate extra time to this component.

PROGRAM EXPERIENCE: MESSAGE HARMONIZATION

Ghana BCS formed content design teams for each of its health areas (e.g., malaria, family planning, nutrition and WASH). Each team was a small group with representation from approximately five organizations, plus the relevant Ghana Health Service Unit.

Hold a message development workshop with partners and stakeholders to help ensure **messages are harmonized**, agreed upon and that partners feel their messages are represented well.

- Organizing this workshop may best be assigned to a working group, task force or other sub-group of the coordinating body.
- Be sure to include technical experts from each topical area in the workshop to help ensure technical accuracy.
- Consider developing a message guide or matrix to harmonize all messages moving forward.

See the HC3 guide on How to Design SBCC Messages. The list of **Resources** at the end of this section provides examples of how integrated SBCC projects have harmonized messages.

Channel Selection

As with any SBCC program, the choice of channel(s) should depend on the audiences, the purpose/desired outcome and the type of information being conveyed. Similarly, it is important to ensure message consistency across all channels. See HC3's guide on how to develop a channel mix plan here.

Below are additional points to keep in mind when selecting channel(s):

- Consider which channels lend themselves to certain audiences, types of content or communication objectives. IPC and community mobilization, for example, are often effective in addressing social norms. Experiential channels where the audience has the opportunity to try behaviors or skills, meanwhile, may be most appropriate for addressing habits. Mass media channels are often a good choice for planning or service-seeking behaviors.
- Consider formats that can easily include several issues, such as radio or TV serial dramas, magazine programs or distance learning programs.
- Balance the breadth, depth and intensity of messages across different media, so that channels will not be overburdened.
- Complement or supplement IPC channels (e.g., CHWS and facility-based providers) with other channels to avoid overloading personnel.
- Facilitate easy access to information for CHWs and facility-based providers to enable them to communicate effectively on the varied topics. Materials for clients and job aids – particularly ones that are easily accessible via cell phone or tablet – can help in this regard.
- Ensure effective IPC to help explore the variety of issues and links between them. Use other channels to generate demand and reinforce messages delivered through IPC.
- Utilize longer formats and more interactive channels for complex behaviors that are more difficult to change. Shorter format channels (e.g., radio or TV spots) may be more appropriate for simpler behaviors more in need of reminders.

TIP

Studies of integrated SBCC projects found IPC to be highly effective when communicating multiple messages. One key is to ensure that those delivering the messages exercise critical thinking skills and can tailor messages to the individuals with whom they interact or to each client, based on client needs.

PROGRAM EXPERIENCE: SERVICE INTEGRATION

As part of a Maternal and Child Health Integrated Project (MCHIP) program in Liberia, vaccinators asked mothers if they would also like to go for same-day, co-located family planning services to space their children (for rest and health) and mentioned that many other vaccinating mothers were doing it. This addressed the strong social stigma against resuming sex and using family planning before the baby walks (MCHIP, 2012).

FROM STRATEGY TO CREATIVE CONCEPTS AND MATERIALS

Once you have achieved consensus on the SBCC strategy, your project will develop and test creative concepts, then turn these concepts into executions (i.e., samples) to test with your target audience. While this process is similar to that for vertical programs, certain aspects require particular emphasis or nuance in integrated programming. This section will focus on those aspects.

Developing Creative Concepts

A creative concept is an overarching "big idea" or unifying theme that can be used across all campaign messages, calls to action, communication channels and audiences. Developing and testing creative concepts is particularly important for integrated SBCC campaigns that need to ensure the entire campaign is coherent across multiple topics, and resonates with all audiences. In integrated SBCC programs, it is usually a good idea to create an overarching, umbrella brand that encompasses multiple health topics. This helps unify SBCC efforts under a single brand, link issues in the minds of the audience, draw attention to lesser-known issues and act as a force for cohesiveness in messaging and other aspects of SBCC. The Ghana GoodLife program exemplifies the umbrella brand.

Take the following into consideration when developing creative concepts for an integrated SBCC program:

- **Consider how you will develop your creative concepts.** Through an internal creative team? With an advertising agency? Together with audiences through a human-centered design approach or in an Action Media workshop? If you decide to use an advertising agency, human-centered design firm or other outside organization, consider the pros and cons to having a single agency or multiple firms. Would a single firm be able to handle the workload? How might dividing the work impact uniformity?
- **Develop a wide range of concepts.** This will increase the chances of finding one that deeply resonates with your target audience. Consider basing your concepts around values, benefits, emotions, trends, cultural phenomena, symbols or other broad constructs that will encapsulate your integrated SBCC program's components.
- **Be sure that your creative concept is flexible.** Will it be able to accommodate other topics or behaviors that you might be asked to include at a later point in time?
- **Try developing a few sample executions** for your different topics for each creative concept to see if and how they work for different content areas.

Find more information on how to develop creative concepts here.

TIP

When multiple donors – or even multiple projects under a single donor or multiple activity managers within a single donor on a single project – favor integration but want a lot of control of treatment of their issue, an umbrella branding strategy might be a good option.

PROGRAM EXPERIENCE: A FLEXIBLE CREATIVE CONCEPT

Tanzania's *Wazazi Nipendeni* safe motherhood campaign initially covered the period from pregnancy to delivery. The campaign later extended to the first year of the child's life in a second phase, and brought in a number of additional health issues, such as early and exclusive breastfeeding, immunization and post-partum family planning. The flexible and inclusive nature of the creative concept allowed for its expansion.

Testing Creative Concepts

Once you have developed several creative concepts for your integrated campaign, you need to test them with your audience. Your objective when concept testing for integrated SBCC initiatives is to determine which concept the audience understands and relates to most strongly. An emphasis of concept testing in an integrated program is to gain insight into how the audience **views the links** between the various topics and whether your **concepts represent those linkages** in a way the audience connects with. Follow this guidance:

- Starting with your first concept, test each concept by itself first, and then show sample executions of the concept that demonstrate how different topics would roll out under this umbrella. Repeat with the other concepts.
- In addition to questions about attention, comprehension, motivation, personal relevance and cultural appropriateness, dive deeper into questions that ask how the audience understands the link of the topics within the concept.
- After showing each concept individually, ask the audience to compare and rank them. Which do they prefer and why? Is the concept selected still in line with your strategy?

Find more information on how to test creative concepts here.

TIP

Examples of Integrated SBCC Concepts:

Uganda: "How is life?"

Ghana: "What is your good life?"

Egypt: "Your health, your wealth."

Malawi: "Life is precious."

Tanzania: "Love me, parents."

Jordan: "Our Health, Our Responsibility."

PROGRAM EXPERIENCE: INTEGRATED SBCC CONCEPTS AND LIFE STAGES

In Uganda, FHI360 developed the Obulamu ("How is life?") umbrella campaign. The concept was flexible enough to adapt to different life stage audiences. For young couples, it turned into "How's your love life?" For pregnant women and partners, "How's your pregnancy?" For young families, "How's Baby Opjo?" and for adolescent boys and girls, "What's up?"

Developing SBCC Materials

After deciding on the creative concept, it is time to design and pre-test the actual integrated SBCC materials. Consider holding a materials review and adaptation workshop, using the materials acquired during your materials inventory as a starting point. Reviewing and updating, improving, re-branding or otherwise adjusting accurate, already approved materials helps save time during the approval process. To ensure they fit with your strategy and link with new topics, you may need to add elements from your creative concept, update some language or include a new tagline or slogan.

HC3 resources provide more information on how to develop and adapt SBCC materials. Some examples of integrated SBCC materials are provided in the **Project Examples** at the end of this section.

Pretesting SBCC Materials

To the extent possible, pretest methods should match the method(s) being used for message delivery. For example, if topics will be phased, the messages and materials for each topic can be pretested separately. But if the messages/materials for topics will be conveyed concurrently, they should be pretested together.

Pretesting can also inquire about the acceptability and feasibility of integrated communication. If possible, have providers pilot-test and give the program feedback on new tools and practices so they can be adjusted as needed before full program implementation. For example, in Liberia, the project tested the amount of time it would take for vaccinators to use an integrated family planning and immunization job aid with a client in a clinic setting. This was important in assessing the feasibility of introducing the new step in each of their client visits.

See the HC3 guide on how to conduct pretesting for more information.

DESIGNING LINKAGES BETWEEN SBCC AND SERVICE DELIVERY

Given the importance of quality service delivery to sustained behavior change on many health topics, it is important to think about how your integrated SBCC program connects to service delivery. As noted previously, SBCC programs can be considered integrated even when they are not integrated with or within service delivery. However, even when an integrated SBCC program is not formally mandated to integrate with service delivery, it is important to consider the implications of your program for service delivery. This is especially true when driving demand for multiple health areas.

Areas for Consideration

- **Engage relevant institutions and providers** in the early stages to gain buy-in for integration. Explore how to ensure service availability, and seek out input on and approval of key messages – especially information the program wants providers to deliver. Invite service delivery representatives to SBCC coordinating bodies or working groups if they are not already a part of these groups.
- **Determine the extent to which service delivery health programs are already integrated**. For example, how many health programs will the SBCC program have to link with? One integrated structure, or several vertical structures? How much extra effort will this require in terms of message approval, provider training, monitoring and other areas?
- **Map out all of the contact points with clients along the continuum of care** for the various health areas of focus. Think about how best to optimize each of those points, and ensure no opportunities are missed to provide necessary information and links to services at each point. At the health facility, for example, there are opportunities at ANC, intrapartum, postnatal care, immunization, family planning and well child visits, among others. Similarly, map out the timing of each of the CHW's home visits and consider other opportunities at these entry points. For more SBCC techniques to motivate health service-related behaviors among intended audiences across the continuum of care–Before, During and After services–see the Service Communication Implementation Kit.
- **Determine the capacity of the health system and providers** to meet an increased demand for services. What efforts will be necessary to ensure a quality supply of services? Do you need to consider a phased approach to allow supply to match demand?
- **Consider how to effectively engage and train service providers**. Service providers must be knowledgeable about and comfortable discussing the range of topics with clients. They must be able to provide the services or make effective referrals. They must also be willing and able to report on service delivery for monitoring purposes. All of these have implications for the design of your program. Will capacity strengthening be necessary? What job aids and other support will be required? What structures need to be put in place?

TIP

Integrated SBCC programs have found different ways to assist CHWs and facility-based providers in counseling and message prioritization for integrated SBCC through training and materials. Some possible approaches include: phased-in training, discussion cards organized by topic, multi-topic flip charts, pre-loaded tablets and mobile applications (apps) for basic or smart phones. Examples can be found in **Project Examples**.

ENGAGING AND PREPARING PROVIDERS

In an integrated SBCC program, service providers at the community and facility levels usually have a role to play in delivering and reinforcing key information. It is critical that they feel involved and capable of doing what is being asked of them. To ensure readiness and quality:

- Assess the capacity of the providers you plan to work with, then strengthen capacity where necessary. What IPC skills and practices do they possess? What do they already know about the health topics? How able are they to make connections between health topics? Build on what providers know and be sure not to add tasks or information too quickly.
- Build health worker capacity to communicate in interpersonal settings in a meaningful way. Ensure they are truly able to understand a client's needs and challenges, tailor communication to their needs, facilitate meaningful and participatory dialogue, and employ approaches that facilitate community-driven ownership and action.
- Determine the providers' workload. Design strategies for helping providers effectively integrate topics and meet multiple needs at once. Train providers to probe and make connections to maximize client benefit. Help providers see the benefits of integrated programming – particularly how it can help them. Sometimes it may be beneficial to consider opportunities for task shifting, or sharing certain elements of the service delivery process with other providers, volunteers or health champions.
- In collaboration with service delivery programs, help establish systems and structures for quality services. For example, how to provide referrals between and within the SBCC and service delivery programs; how to ensure effective coordination between community-level and facility-based providers; and policies or systems for enabling task shifting.

Integration requires providers to change behavior and confront potentially negative attitudes about the new health topics they are required to cover. In addition to training, programs may find it useful to conduct provider behavior change communication campaigns or activities. Find more information about IPC interventions here.

TIP

For integrated programs, providers especially need to be able to quickly get the client talking about her/his needs, issues and status to be able to cover the critical topics well, given the time available. Ensuring providers practice effective IPC can be key to helping clients adopt and maintain desired behaviors.

PROGRAM EXPERIENCE: MOTHERS2MOTHERS

Task shifting (specifically around counseling) might be required to ensure enough time to effectively communicate multiple messages. In Malawi, for example, Mothers2Mothers (M2M) provides HIV education, support and referrals on TB, infant and maternal nutrition, cervical cancer and malaria, so the provider only needs to verify the clients' understanding and needs. Additionally, group-based ANC has been a way to provide higher quality care to women in a more efficient manner.

CAPACITY

The capacity of program staff and project stakeholders to design integrated SBCC will influence the strategic design process and vice versa. Integrated SBCC requires the assimilation of not only new but also more varied information and potentially new ways of communicating for both program implementers and providers (e.g., information communication technology [ICT] or improved IPC).

Identify implementer capacity-strengthening needs through working group discussions, needs assessment surveys and during SBCC strategy development. In addition to information about the topics and behaviors to be addressed, implementers need to have a common understanding of SBCC, the project's selected theory of change, data collection and use (including formative research), supportive supervision, advocacy and a range of other topics, depending on the program.

Because integrated SBCC typically requires health workers, community health agents and others to explain and answer questions about new and varied topics, capacity-strengthening needs might be amplified as compared to single-focus SBCC. When designing your program, plan for frequent supportive supervision that includes observation, customized on-the-job training and regular follow-up group training to strengthen generally weak areas. If agents use tablets or other digital technology to access relevant messages and information, training should include how to quickly find the needed information while remaining largely focused on the client, and supervision should verify agents' ability to use the technology effectively. Supervision guidelines and tools (e.g., checklists) should reflect integration, such as looking at how effectively providers integrate new content into their interactions with clients. As with many SBCC interventions, including frontline workers in training will not only help prepare them to provide the needed services but also help gain their buy-in.

TIP

Strengthening capacity for integrated SBCC may involve the following:

- Extra time, repetition and support to effectively assimilate new information and practices
- Phasing in new topics over time
- Nonthreatening testing of providers to ensure correct knowledge
- Structured observation of providers to ensure correct use of skills
- Adaptation based on experience

RESOURCES

Both vertical and integrated projects often have a need for SBCC capacity strengthening. See the SBCC Capacity Ecosystem for more information on how to build capacity for SBCC programming.

Additional resources and examples for design are available here.

PART 4: INTEGRATED SBCC STRATEGY IMPLEMENTATION

Implementation of an integrated SBCC strategy is similar to implementation of a vertical SBCC strategy. However, several key considerations may improve the success of an integrated program.

COORDINATION

The **coordination mechanisms** established and reinforced during the previous phases must continue to be maintained during program implementation. This is critical both for the efficiency of the program as well as maintaining buy-in from ministries, partners, communities and other stakeholders. In the implementation phase, you may even need to increase the number and types of coordination mechanisms being utilized.

Hold Stakeholder Meetings

Given the complexity of integrated SBCC programs, it may be necessary to hold **stakeholder meetings** on a more regular basis than in a vertical program – on a quarterly basis at minimum, or more frequently, if needed. In these meetings, stakeholders should review the monitoring data to ensure the activities are implemented as planned, messages are harmonized across partners and the supply of products and services is aligned with SBCC activities. In addition, stakeholder meetings can be used to keep up the **momentum of the shared vision** established for the project.

Form Working Groups or Task Forces

You may **form more working groups or task forces** during implementation to take on key assignments, such as launches, events or materials distribution. These groups may need to meet multiple times per week during high-intensity implementation periods.

Reevaluate Partner Roles

In the previous phases of the program, you determined the role each partner would play based on their areas of expertise, interest and availability, as well as on economies of scale. However, during implementation, you may find areas that have not been clearly defined. You may also find instances of duplication of effort or concerns about who does what. Monitor this closely so you can resolve any conflicts, reduce redundancies and ensure smooth operations. Roles can be changed throughout the program to ensure proper implementation.

Credit Partners

Government, donor and partner branding of communication materials is often a highly political part of the SBCC implementation process. This may be even more so in integrated SBCC programs, where multiple donors, ministries and/or partners may be involved. Integrated programs often attempt to limit the number of logos in order to reduce distraction, yet there may also be advantages to including everyone's logo. For example, organizations (including partners and donors) are generally more likely to distribute, display and use materials that identify them as a contributor. However, displaying multiple logos may be easier on certain materials (e.g., logo strips on the bottom of posters or backs of brochures, and logo screens at the end of TV spots) than on others (e.g., radio spots, in which naming everyone involved would significantly cut into the time for the spot). Alternatively, you may consider tailoring the branding so that the stakeholder logos included vary according to the particular topic, geographic area of operation/distribution or other relevant variables.

ACTIVITY PLANNING

Activity planning for integrated SBCC programs can be considerably more complicated than for vertical programs. Depending on your approach, multiple activities for several topics may take place at the same time. Create a realistic and detailed **integrated SBCC timeline or implementation plan** clearly mapping out how the different activities relate to each other.

Considerations for Activity Planning

- How do the activities relate in time and space/communication channel, the relative intensity of each topic at any given time and the person or organization responsible for each activity?
- Which activities can you get started quickly to gain some "**quick wins**" and which will take longer to launch?
- Are certain **times of year or even specific days** ideal to focus on particular topics? For example, do you want to launch or increase the intensity of the HIV component of your integrated SBCC intervention around World AIDS Day, or might it get "lost" in the clutter with others doing the same? Do you want to time WASH interventions to correspond with rainy season, when childhood diarrhea is most prevalent?
- Will you **pilot** certain activities on a smaller scale or in a limited geographic area, or will you go to scale immediately? Will different components be given phased, geographic introductions?

Whether you build on existing programs, use a phased implementation approach, have an overarching umbrella campaign or use a combination of these approaches, be sure you have a complete picture of how everything fits together. During the implementation phase, it is critical that all activities make sense in the minds of project implementers, stakeholders and, most importantly, your target audience.

SAMPLE INTEGRATED SBCC PROGRAM ACTIVITIES

- Integrated one-on-one counseling between a client and a provider that addresses reproductive health, exercise and nutrition
- Group talks for young mothers at the health facility that address immunization, early childhood development, malaria prevention and nutrition
- Counseling materials for adolescent boys ages 15 to 19 covering voluntary medical male circumcision, HIV and STI prevention, reproductive health and family planning
- Community outreach programs emphasizing the nutritional and economic benefits of vegetable gardens
- An after-school program for secondary school students that ties together economic empowerment and sexual and reproductive health
- Community health fairs offering HIV testing and counseling, STI and cervical cancer screening, family planning services, blood pressure screening, insecticide-treated bed net (ITN) hanging demonstrations and nutritional cooking classes
- A mass media campaign with radio, television, outdoor, print and social media executions on couple communication, gender norms, family planning and couple HIV testing and counseling
- An entertainment-education TV serial drama that interweaves storylines on malaria prevention, voluntary medical male circumcision, concurrent sexual partnerships, family planning, and PMTCT

IMPLEMENTATION MODELS

There are several models for an integrated SBCC program to follow:

Add-On (Building on Existing Models)

Integrating new topics into an existing single-topic SBCC program builds on the existing program's infrastructure to reduce costs and achieve rapid results. Leveraging existing program resources, community agents and community structures that have already demonstrated success in effectively bringing people together facilitates the quick scale-up of an expanded program model. The target audience benefits from the cumulative effect of the integrated model and continued SBCC efforts.

Perhaps the primary consideration for adding new topics, behaviors or products to an existing brand is ensuring there will be **no conflict among brand elements** and that **existing elements are refreshed, if necessary**, to avoid losing traction as new elements are introduced.

PROGRAM EXPERIENCE: ADD-ON

As a quick win in year one, SSDI-Communication agreed with another USAID-funded project, BRIDGE II, to co-fund the established *Cheni Cheni Nchiti?* ("What Is Reality?") radio program, which previously focused only on HIV and AIDS. SSDI-Communication was able to take advantage of an existing platform with an existing audience ready for new content. The program was then repositioned to include other SSDI topics over time. Similarly, in Tanzania, the HIV-focused radio magazine programs initially started under the Strategic Radio Communication (STRADCOM) project were broadened under the TCCP follow-on to incorporate all of the integrated project's health areas.

Phased Implementation

Phasing in interventions over time can improve the likelihood of program success by presenting information in progressively manageable "chunks". By packaging messages in smaller, easily understood and doable pieces, the target audience is more likely to learn and succeed. Rather than exposing them to too much too soon, the audience can have time to digest the information, and then apply this learning to the next phase.

If the decision is made to introduce topics using a phased approach, programs can consider the following in order to prioritize audiences or sequence rollout of messages:

- Use the Community Action Cycle, a process developed by Save the Children, which mobilizes communities to plan together for collective action.
- Address the goals that can be achieved most easily ("low-hanging fruit"). Near-term gains ("quick wins") can improve the environment for other changes that will require more time and effort.
- Present the information in chronological order (e.g., discuss antenatal care before larger malaria topics in an integrated child health and malaria project).
- Follow what your selected integration model seems to logically dictate.

PROGRAM EXPERIENCE: PHASED IMPLEMENTATION

Tanzania's *Wazazi Nipendeni* campaign rolled out in two phases. The first phase focused on the period from pregnancy through delivery, while the second phase focused on the period from delivery through the first year of the child's life.

Overarching Umbrella Brand

In the roll out of an overarching umbrella brand, an integrated SBCC project generally uses an initial phase to first establish the brand in the minds of the audience. Consider whether your program will use this approach. Will you start with a teaser phase to heighten curiosity, encourage speculation, build anticipation and spark conversation? How long will this teaser phase last before the big reveal of the brand's actual purpose? What training or materials distribution needs to occur before officially launching the umbrella brand? What are some other creative ways to introduce the brand? No matter how you introduce the brand, each activity should be linked to the umbrella brand, whether through a logo, slogan, audio cue or a combination of these elements.

PROGRAM EXPERIENCE: UMBRELLA BRAND

Ghana's Good Life initiative provides an excellent example of phasing using a teaser. The teaser segment lasted about three weeks and was designed to generate curiosity and mystery. It simply asked of the audience: What is your Good Life? What do you enjoy and value in life? Health topics were not introduced at this stage so as not to risk losing the interest of the audience. Six Ghanaians representing a cross-section of the country's population were selected to tell personal stories about what they value in life and how health enabled them to achieve their good life. Their stories were produced for television, radio and print. See the full case study on how Ghana Good Life used umbrella branding.

INTEGRATED SBCC PLATFORMS

The merits of integrated SBCC platforms were included in the **Design** section of this I-Kit. Consider the various platforms you might use for your integrated campaign. Distinct from the overarching umbrella brand unifying the entire project, integrated platforms are discrete activities that unite topics. The following are examples of integrated SBCC platforms used under TCCP. These platforms addressed all or some of the following health areas: HIV prevention, HIV treatment, voluntary medical male circumcision, HIV testing and counseling, PMTCT, most vulnerable children, family planning, MCH and Malaria.

TV Serial Drama

Siri ya Mtungi ("Secrets of the African Pot") was a 26-episode TV serial drama that followed the ups and downs of a dynamic cast of characters as they managed relationships, work, health and life's joys and sorrows. This longer format entertainment-education approach modeled behavior change and all of its challenges in a compelling, believable way, allowing viewers to experience the journey alongside the characters. Supportive social media channels amassed hundreds of thousands of followers and engaged them in lively, thought-provoking conversations around Siri ya Mtungi's storylines.

TV and Radio Game Show

Aiisseee! ("I Say!") was a game show designed to improve couple communication and promote couple connectedness. Through a combined game show and documentary format, the show gave contestants, listeners and viewers the chance to discuss serious relationship issues in a humorous way, paving the way for continued dialogue. Social media platforms provided a further avenue for conversation.

Radio Distance Learning Program

Kamiligado ("Fully Equipped") provided remote training for community volunteers in community mobilization and TCCP health areas through 39 30-minute radio episodes. Each episode explored a different community mobilization topic and covered a particular health area. Registered listeners also received a set of tools to assist them in their community work, including a community mobilization guide and 16 information cards about the various health topics.

Radio Magazine Programs

Locally produced radio magazine programs utilized a number of approaches to address TCCP's health topics, including radio diaries, interview segments with experts and testimonials with service beneficiaries. TCCP made this platform available for partner and stakeholder use to provide expertise, address health challenges facing the community and encourage the community to utilize existing health services. The program worked primarily with radio stations, allowing for highly localized and targeted programming.

Community-Wide Events

Concerts, clinic shows, health fairs and other community-wide events provided rich opportunities for both demand creation and service provision for a range of health areas, all at the same time and in the same location. Voluntary counseling and testing (VCT), family planning and other services would be provided alongside communication activities.

Comprehensive Community Resource Kit

The *Sarafi ya Mafanikio* ("Journey of Success") community resource kit's unique and highly participatory methodology engaged participants through interactive storytelling, drama, games, metaphors, personal risk assessments and other innovative activities which inspired solution-seeking behaviors and shifted mental models around deeply held cultural beliefs. The modular nature of the kit allowed facilitators to design and implement sessions relevant to the circumstances of the target community, enabling them to choose the most relevant sessions for the disease burden in their area, and adapt lessons for different target audiences.

MEDIA BUYING

Media buying for integrated SBCC campaigns poses unique challenges and opportunities. In vertical programs, where different projects or partners run separate media campaigns on each topic, the campaigns may compete or even contradict each other. In an integrated project, however, you can plan the media buy in a way that ensures your topics and their placement are complementary and non-competing. You must be sure you have a clearly articulated media plan.

TIP

Take advantage of economies of scale and negotiate discounted media rates by purchasing airtime in bulk and up front. You are likely to get good broadcast rates if you are a big client across different health areas. TCCP, for example, bought all of its TV and radio spots, programs and DJ mentions for each of its health areas six months to one year at a time.

Considerations for Media Buying

- **Decide on the pattern of media scheduling**. For instance, you can schedule media in a cyclical pattern, in which messaging on one topic phases out (either drops down to a maintenance phase, or comes off the air completely) while another ramps up.
- **Consider how you can best place your media** to be sure your programs reach your specific target audience(s). For example, if you are targeting young people ages 18 to 24, for instance, what programs are they watching or listening to, on what stations and at what times of day?
- **Ensure you have a master media broadcast plan and a designated person to oversee the plan** who has an understanding of the media needs of each component of the integrated SBCC initiative. This person may be internal to the project or an external media buying partner.

Find more information on media selection here, and ICT and new media here.

MATERIALS PRODUCTION AND DISTRIBUTION

During implementation it is critical for all SBCC programs to ensure that materials:

- are produced in the right quantity;
- make it "the final mile" to their intended destination and/or target audience; and
- are used in the appropriate way, in the appropriate place and at the appropriate time.

Since integrated SBCC projects will likely have multiple types of materials – potentially implemented in phases or addressing different life stages, audiences or topics – the plan for materials production, distribution, orientation and tracking should be clear and user-friendly.

See **Project Examples** at the end of this section for more information on materials production and distribution.

PROGRAM EXPERIENCE: MATERIALS DISTRIBUTION

The Government of Egypt (GOE) disseminated CHL materials through their network of more than 5,000 MOH clinics and 62 State Information Service-local Information Centers through fiscal year 2009. Thereafter, CHL provided selected printings upon the GOE's special request, with approval from USAID. The print materials were distributed from the central level to the village Primary Health Care units (PHCs) following the MOH system of distributing commodities. The materials were also disseminated by NGO partners and the CHL private-sector program, including the AskConsult network of 30,000 pharmacies, AskConsult local gatherings, partner United Company of Pharmacies (UCP), trade magazine Pharma Today and major employers (CCP, 2011).

CAPACITY STRENGTHENING

Now it is time to implement your capacity strengthening plan. Plan for frequent on-the-job and need-based refresher training during the first several months or as new topics are rolled out.

The intensity of capacity strengthening with community agents and health providers will be more extensive for an integrated SBCC program than for a vertical one. They will need to master all of the new information and be able to tailor their counseling according to the client in front of them – not just go through the list of topics covered in the integrated strategy. Therefore, more time, financial resources and follow-up support will be needed to ensure agents and providers are properly trained on how to integrate messages. Frequent supportive supervision visits should be built into the program, especially during the initial roll out of the program. Supervisors should ensure that community agents and providers select and deliver integrated messages appropriately tailored to their audiences, and do not revert to delivering siloed topics and messages.

Providers

Providers will need to master all of the new information and be able to tailor their counseling according to the client in front of them – not just go through the list of topics covered in the integrated strategy. Providers should be trained on how to assess the overall needs of their clients based on their health needs, and understand which complementary products, services and behaviors should be discussed during counseling.

TIP

Mobile-based tools and applications can be particularly useful training approaches for integrated SBCC programs. Following an initial in-person training, the apps can be easily updated and expanded with additional content without the need to come face-to-face.

PROGRAM EXPERIENCE: CAPACITY STRENGTHENING

In Liberia, an integrated family planning and immunization program under the Maternal and Child Survival Project (MCSP) conducted a one-day orientation for all supervisors, followed by a three-day training for vaccinators and family planning providers together. The training included a practical component where providers tried out the new approach in a clinical setting. The program also found that including a values clarification component was critical, as many vaccinators were unfamiliar and inexperienced with family planning, and brought in varying levels of bias.

MONITORING

While monitoring should be built into all SBCC programs, integrated SBCC programs have some unique areas of emphasis. Since the program will be working across health topics, it is important for the monitoring to determine whether program messages are harmonized, community agents and providers are delivering appropriate messages, intended audiences comprehend the integrated messages and the program goals are being met. More specifically, monitoring data should be used to determine how audiences perceive the integration of topics, what content might be missing, whether audiences feel overburdened with information and how well the timing of activities and interventions is working. It is also important to understand how providers are adapting to the changes associated with integrated programming, including challenges, successes and suggestions for changes.

Different integration models will need to monitor different program aspects. For example, a program using a phased model might need to determine whether the timing for the phasing is effective or if it needs to be sped up or slowed down. A program building on an existing platform needs to monitor how the audience is receiving that change and whether the platform should continue to be used.

Routine monitoring of program outputs should be done on a monthly basis. Supportive supervision visits should be conducted with community agents and providers on a quarterly basis, or more frequently, if needed, to evaluate demand generation efforts and counseling skills. See **Research, Monitoring and Evaluation** for more detailed information on monitoring.

ADDITIONAL RESOURCES

- Community Action Cycle
- ICT and New Media Section: Demand Generation Implementation Kit
- Media Selection Section: Demand Generation Implementation Kit

Additional Example: Materials Production and Implementation

- Tajikistan: Guidelines and Tips on How to Organize IEC Material Distribution for Maximum Impact

PART 5: RESEARCH, MONITORING AND EVALUATION

Given their complex, varied and often dynamic nature, integrated SBCC programs require unique research, monitoring and evaluation approaches (RM&E). When designing RM&E components for an integrated program, take into consideration how specific SBCC program approaches address specific health topics, what needs to be measured to understand the linkages, the breadth of coverage, and proposed timelines for introducing topics. These considerations are relevant at every step of the RM&E process – from creating your logic models, to selecting indicators, choosing monitoring methods, and designing your evaluation framework and data collection tools.

COORDINATE

While the evidence base for integrated SBCC is growing, more evidence is needed to solidify its role and importance in development programs. In addition to a general need for more evidence SBCC program integration is worthwhile, there is a need for broader research that informs the design and implementation of future integrated SBCC programs and supports decisions about funding. Building this evidence base will help improve integrated SBCC programming and reduce negative unintended consequences, as well as build confidence in the use of integrated strategies. Some of this research can be folded into existing approaches to program impact evaluations, while other research may require stand alone studies, meta-analysis or comparative studies.

Areas needing research include:

- At what point does SBCC content become over-integrated to the point of harm to program effectiveness? Is there an ideal number of topics that can be integrated to achieve maximum impact under certain conditions?
- Does integrated programming improve outcomes equally well across the behaviors and services under an integration umbrella? For example, does service uptake tend to increase more in some health areas and less in others? If so, to what extent are these differences due to integration itself or to other aspects of the SBCC intervention(s)?
- Which approaches toward bundling objectives and messaging (e.g. by life stage, by audience, by behavioral attribute, by service point) work best under which conditions?
- What role does branding play, above and beyond operational integration?
- How much exposure or dosage is required to achieve different kinds of outcomes under an integrated approach? How much does it need to vary by type of behavior, by type of stakeholder, by context? Are there unique threshold or ceiling effects of messaging in integrated programs compared to vertical programs?
- What are the advantages and disadvantages of rolling out topics in phases? Does the order of rollout matter? When does it matter? How can topics be sequenced to build on each other most effectively?
- What improves the sustainability of integrated programs?

Coordination

Seeking stakeholder consensus for RM&E of an integrated SBCC program is important to set research priorities, allocate appropriate resources, select and harmonize indicators, facilitate sharing and utilization of data, agree on reporting mechanisms (including how to prevent double counting), and disseminate findings.

As this consensus is reached, all stakeholders should have a clear understanding of the implications of integration on what will be required to effectively monitor and evaluate the program. For example, an integrated program may need to track more indicators than a vertical program would, because it addresses a broader range of health issues. The data collection and analysis may also be more complex, requiring multiple data sources and, therefore, additional resources.

It is important to let partners know early what kinds of information will be needed and which partners may need to be responsible for each (e.g., service delivery partners for service statistics or referral data, media partners for message dissemination data, community outreach partners for activity and event data, private sector partners for sales data, and so on). Collecting referral and service delivery data could be more challenging for integrated SBCC efforts if different programs or organizations collect and manage different parts of the data needed. For example, the reproductive health program manages the family planning service data while the MNCH program manages the child health data. As integrated programs complicate the "chain of custody" of the data, partners must agree on who collects which data, how, and how often, as well as how to share, analyze, and report on it.

TIP

While the RM&E section is placed at the "end" of this I-Kit, thinking about it and planning it by no means should be left until the end of your program. RM&E begins at the earliest planning stage, and plays a critical role throughout the design and implementation stages. Because this integration of research into program activities is so critical, we have introduced much of this information in the previous sections. See **Design**, for example, for more information on formative **Research**.

Open access to data can help technical and managerial stakeholders track progress more easily, without having to always rely on their RM&E teams. This may take the form of a Routine Health Information System (RHIS), where SBCC, service utilization and other data is collected from health facilities and consortium partners on a routine basis and then aggregated into a single database. A dashboard function would allow stakeholders and technical and management staff to track progress and make course corrections, if necessary, as well as see how different program components are moving together. Such systems require significant buy-in from the government, and a high degree of ownership and coordination from various sectors.

RM&E should be on the agenda of all coordinating body meetings. There may also be a need to create additional working groups or task forces for RM&E. When creating such teams, involve those with quantitative as well as qualitative experience, those with expertise in the respective vertical health areas, as well as those with experience in program integration to the extent possible. Ensure all topical areas are represented, and clearly articulate roles and responsibilities.

RESOURCES

FHI360 has developed Guidance for Evaluating Integrated Global Development Programs. While this document is not specific to SBCC or health, its recommendations are useful for both. Many of the recommendations in this section have been adapted from this resource.

IN THEIR WORDS

"Making all programming data (not just sector-specific) available to technical and programmatic staff and organizing reporting of program-wide achievements can tease out some of the added value of integration… On a set schedule, program monitoring data should be presented and discussed among program staff and stakeholders. Discussions of the data with monitoring and program staff across integrated sectors or activities can illuminate further what has been found and what needs to be further measured. From these discussions and presentations, decisions can be made about the need for more qualitative lines of inquiry to discern sources of the problems or where best practices are found."

– (Source: FHI360)

CREATING AN INTEGRATED SBCC RM&E PLAN

The RM&E plan for your integrated SBCC program should cover the same basic elements as an RM&E plan for a vertical program, including: the program's theory of change and/or logic model that shows your program's resources and inputs, activities, outputs, outcomes, and intended impact; indicator definitions, data sources,

frequency and timing of data collection, and person responsible; a description of each staff member's role in RM&E data collection, analysis, and/or reporting; the necessary reporting templates; the plans for analysis; and a dissemination plan for how data will be shared both internally among staff for program improvement, and externally among donors, stakeholders, and project beneficiaries about program progress.

In addition to these basic elements, special considerations for integrated SBCC RM&E plans include the following:

- Different stakeholders may have different goals for SBCC integration (e.g. cost effectiveness, time savings, increased reach, amplified impact, improved quality of care, systems change, enhanced sustainability), which will influence the entire design and implementation of the RM&E plan. Clarify and clearly communicate the desired goal of SBCC integration in your theory of change/logic model, and ensure through your coordination mechanism(s) that all partners, donors, and stakeholders agree with this definition.
- A linear cause and effect logic model may not be able to accurately represent the complex interactions and outcomes of an integrated program. You may need to explore alternative or additional formats to enhance or supplement your model. FHI360 recommends that integrated programs align theories of change and logic models with other systems-related tools, such as **appreciative inquiry** or **ripple-effect mapping**. These will help stakeholders and evaluators account for complexity, identify emergent outcomes, relationships between activities, and best practices.
- Include indicators that allow for an assessment of the extent to which integration is taking place, and its effects on outcomes.
- Design ways to measure how health topics interact, reinforce and complement each other.
- Emphasize the regular use of data by stakeholders and partners to make decisions on whether and how to continue or improve integration.
- Generate documentation of lessons learned that can contribute to the knowledge base for integrated SBCC programming.

Harmonizing Indicators

One of the dangers of integrated SBCC programs that address multiple topics is pressure to include a long list of indicators. Including too many indicators, however, can overwhelm your RM&E staff, those responsible for data collection on the ground, and even your research subjects and beneficiaries and greatly increase the complexity of the analysis needed to explain outcomes and impact. Giving in to this pressure even may reduce the quality of the data collected. Select and prioritize your indicators carefully using these tips.

INTEGRATED SBCC INDICATOR TIPS (Adapted from FHI360 Guidelines)

- **Review existing indicators** from the topics involved in your program. Identify any areas of overlap and determine which indicators might be crosscutting and could be harmonized. Consider what information you most need to know to show impact. Remember to include indicators that quantify change as well as those that track the process.
- **Review the existing definitions** of any standard international, national, or donor indicators, such as those in Demographic and Health Surveys, HIV and Malaria Indicator Surveys, Service Performance Assessments, or those required by USAID, DfID, private funders, or other donors. Identify any differences between your indicators and standard indicators that may require duplication of effort during data collection or cause comparability problems during analysis. Regarding timing, if the start or end of a program coincides with a DHS wave, consider using those indicators for your baseline or endline instead of collecting them yourself (if they can be disaggregated at a level that is useful for the program).
- Request that stakeholders from each sector designate their respective indicators as either **required** or **recommended**, and as either primary or secondary data to condense the list of indicators. Decide which

are necessary for reporting and which are desirable for internal decision-making or causal analysis, but are not required by the donor. Also consider how easy it is to collect data for each indicator. Some indicators are easily obtained (e.g. medical records) while others are more time-intensive to collect.

- Consider using **proxy indicators** to harmonize indicators. Proxy indicators may use an alternative definition and/or be derived from a different data source to approximate an indicator of interest that is otherwise too difficult or expensive to collect.

Planning for Analysis

As you develop your RM&E plan, it is also important to consider and plan for how you will analyze your data. Strategically designed data analysis can help specify linkages between different aspects of your integrated SBCC program, help track and quantify what changes occur and where, and identify complementarity within the program.

Considerations for Data Analysis

- Develop your analysis tools early in collaboration with cross-sectoral stakeholders. Doing so will help identify the need to modify some indicators, definitions, methods, or frequencies so that they are complementary across sectors. Adjusting and standardizing these as early as possible will help with comparability of analyses over the life of the project.
- Design your analysis to examine the total number of beneficiaries served with how many beneficiaries are served by sector. FHI360 recommends counting the total number of beneficiaries served with any programming, and disaggregating by the type of services received (for example, for sector A, sector B, both sector A and B). Using this method can help you identify and account for both direct and indirect beneficiaries.
- Consider utilizing a unique identifier system that can link each service or SBCC activity to a specific individual across sectors.

See How to Develop a Monitoring and Evaluation Plan for additional guidance on how to develop a monitoring and evaluation plan.

PROGRAM EXPERIENCE: RM&E PLAN

Under the Combination Prevention Program for HIV in Central America, PASMO has used a combination prevention approach to deliver HIV prevention social and behavior change messages, products, services and referrals to the key populations most affected by HIV in the region. The program integrates messaging on STIs, gender-based violence and alcohol and drug abuse. In order to measure and demonstrate the effectiveness of the combination prevention approach, PASMO developed a system to track clients through a Unique Identifier Code (UIC). The UIC allows PASMO to maintain client confidentiality, while still ensuring clients are successfully linked to products and services. Read the full case study: Using Unique Identifier Codes to Monitor an Integrated SBCC Program.

MEASUREMENT AND DATA COLLECTION

As with any SBCC effort, continuous monitoring allows programs to gauge progress, identify challenges, report to donors and other stakeholders, and make necessary course corrections to maximize positive impact. Regular monitoring of integrated SBCC programs will help alert programs to the need for adjustments in messaging, channels, emphasis, and aspects of the communication strategy. Integrated programs should

monitor critical indicators against targets for all of the key topics of focus. Closely monitoring indicators for any problems or negative outcomes will help make the case to stakeholders that integration is worth pursuing, especially for technical areas that are less eager to advance integration. Keeping an eye out for adverse outcomes and being open to making adjustments to the approach is critical. Integrated programs can use adaptive management processes and realtime monitoring to identify and cope with unexpected outcomes. Through realtime monitoring, integrated programs collect data regularly in a format that is quickly available, efficiently process the data so it is digestible and usable, and set up systems for reviewing and using the data to make decisions. This regular data collection, processing, sharing, and use enables adaptive management – the process for coping with the uncertainty of implementing integrated programs by revisiting and revising monitoring models as the program progresses.

Planning for RM&E and operations research should start as early as the **Lay the Foundation** stage and be well-developed by the end of the **Design** phase.

TIP

Integrated SBCC programs are likely candidates for complexity-aware monitoring, an approach that is meant to track the unpredictable. It can be used alongside performance monitoring and is especially relevant when cause and effect relationships are not well understood. Promising practices for complexity-aware monitoring include sentinel indicators, stakeholder feedback, process monitoring of impacts, most significant change, and outcome harvesting. See USAID's Discussion Note on Complexity-Aware Monitoring for more information.

Measuring Integration Performance

In order to build the evidence base for integrated SBCC, programs must identify integration-specific performance indicators that will say something about how and how well integration is working.

In their Guidance for Evaluating Integrated Global Development Programs, FHI360 categorizes performance indicators as sector-specific indicators or value-added indicators.

> **Sector-specific** indicators are the standardized indicators either required or recommended for programs to collect for example, unmet need indicators for family planning and indicators related to exclusive breastfeeding for newborn health. Each sector or donor may have its own distinct variations of indicators, which can complicate data collection or comparison. For example, indicators that describe the same outcome may vary in terms of the timeframe they refer to (e.g. within the last 3 months, 6 months, 1 year), the age range of the respondents (e.g. defining adolescents as 15-19, 15-24, or 18-24 years), or other demographic characteristics of respondents (e.g. modern contraceptive prevalence rate (mCPR) using married women, unmarried women, or all women as the denominator).
>
> **Value-added** indicators measure effects beyond what would have occurred in a vertical program. They can be quantified both in terms of **amplified effects** (e.g. reaching more people, achieving greater ease or use of the program) and in terms of **synergy** (e.g. reaching new population groups).
>
> (Source: FHI360's Guidance for Evaluating Integrated Global Development Programs)

Develop indicators that are most appropriate for measuring the performance of complex, integrated SBCC programs.

Depending on the goal of your program, your indicators might measure:

Coordination, Collaboration, and Stakeholder Engagement

- The time and resources required for relationship building and coordination that typically go beyond the requirements of a vertical program.
- Other indicators might include frequency of and participation in coordination meetings, adoption and use of processes for information/data sharing across sectors, timeliness of inputs and reporting, level of staff participation in coordination meetings (e.g. decision-makers, note-takers), or new partners added, among others.

Extent of Integration

- Indicators might include degree of equity in supplying and utilizing program resources across sectors, degree of task shifting within and across sectors, and number or proportion of personnel responsible for tasks that cut across sectors.

Quality of Integration

- Indicators might include self-assessments of partner input and interaction, involvement of sectoral leadership, use of RM&E data for decision making across sectors, adoption of the program logic model across sectors, and use of formal knowledge management techniques to support a cross-sectoral community of practice.

Value Added by Integration

- Indicators might include pre-post integration increases within and across sectors in terms of service delivery, service utilization, proportion of relevant population reached, diversity of population reached, timeliness of services delivered, client and provider satisfaction with services, cost-effectiveness, and others.

Harmonization of Messages

- Indicators might include number or proportion of messages that include information about more than one sector, degree to which messaging is branded with a cross-sectoral identity, degree to which messaging describes the cross-sectoral benefits of within-sector service utilization and degree to which message development involves stakeholders from multiple sectors.

Data Collection Tools and Resources

As part of your RM&E plan, you will also need to determine how to collect relevant data for each indicator. As with vertical programs, some general principles for data collection include building data collection into larger health information systems, including electronic medical records, and building on what already exists. For integrated SBCC programs, consider the following when developing your data collection tools and processes.

Considerations for Data Collection

- **Reduce redundancies:** In general, the aim in integrated SBCC programs is to reduce redundancies. This is true for data collection too. When designing data collection forms, take into account the number of topics, partners, or target audiences involved and ensure that the forms are either combined, or if kept separate, that they are harmonized to avoid duplication. (Source: FHI360)
- **Balance needs:** Integrated SBCC programs need to be able to design and implement tools that shed light on the degree and effects of integration, while at the same time avoiding over burdening respondents and data collectors (e.g. community health workers). Not everything has to be measured and compromises are inevitable. But programs should make every effort to measure enough things to enable drawing lessons about integration, as well as about separate components.
- **Test relationships:** Design your RM&E system to allow testing of the relationships between indicators. For example, at the facility level, collect indicator data relevant to multiple sectors so that co-occurrence and

TIP

Measurements of inter-institutional collaboration and networking can be useful indicators for integrated programs with a goal of collaboration. These indicators should systematically measure the kinds of interactions organizations may have with each other, including the personnel that attended, as well as the types of activities they did together (e.g. planning, budgeting). A capacity assessment in Ethiopia found that things identified activities that strengthen competencies, including: joint training, information and experience exchange, standardization of processes and tools, utilization of research for decision making, mentorship, financial planning, and engagement by leadership. (Source: HC3 Ethiopia Capacity Assessment)

interactions among them can be analyzed. Also, consider how to collect both input and output data from the same sources (e.g., collect data from clients about services they received and what they did as a result, as well as data from providers about services delivered and client health outcomes), so that causal links can be explored. Where possible, link individuals across different data collection tools. For example, in a community-based MCH program, monitoring data collected from mothers about their own antenatal health might be linked to postnatal monitoring data collected from the same mothers about their child's growth and nutritional status.

- **Plan for long-term:** Programs might want to develop tools that allow for routine data collection done over a shorter period of time (for example, a hotline or call center) to monitor output and outcomes. As integrated SBCC might phase in or stagger topics over a long period of time, programs should have longer-term routine data collection in addition to periodic surveys, as well as formal plans for how to utilize those data for routine ongoing decision-making across sectors.
- **Build on what exists:** There may be an existing monitoring system that can be modified to include additional indicators and data sources. If not, you may need to create an entirely new system for capturing the information required for your integrated program, or link multiple systems together. All relevant sectors should be involved in the design and deployment of that monitoring system.

PROCESS EVALUATION

Program monitoring and process evaluations share some overlap. Monitoring, however, is typically a continuous process meant to document inputs, outputs and outcomes over time and confirm that implementation plans are proceeding as intended. Sometimes, these data are used to make mid-course corrections if benchmarks established by the program strategy are not being met. Process evaluation goes beyond monitoring to analyze *why* certain elements of the programs are meeting expectations and others are not. Like everything else, process evaluation poses unique challenges and requirements when applied to integrated programs.

Process evaluation can help answer questions such as:

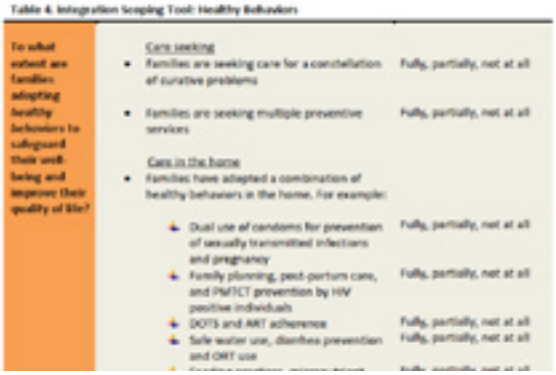
- What level of integration is occurring across sectors?
- What is the quality of the program components that contribute to integration?
- How can data on the implementation experience explain how any observed amplified or synergistic effects were achieved? If none was achieved, how can we use the data to explain why they were not?
- What strategies are facilitating (or inhibiting) the cross-sector coordination or collaboration required by the program?
- How did the implementation process change in the transition from a vertical to an integrated approach?
- Are the target beneficiary population(s) being reached, with which activities, and how does the integration strategy explain that?
- Are households or individuals accessing more than one part of the intervention (and if so, how many and why)?

(Source: FHI360's Guidance for Evaluating Integrated Global Development Programs)

Include the experiences of a wide range of individuals operating at various levels in your process evaluation to assess how the program is perceived, establish what is working as expected, and identify any problems or possible barriers. Solicit feedback from program beneficiaries, non-beneficiaries, service providers, local leaders, program staff, partner organizations, Ministries, donors, and other stakeholders in the process evaluation to gain a broad perspective. A mixed methods approach including document review, secondary data analysis, quantitative surveys, qualitative techniques, and/or systems approaches can help give a richer understanding of associations and context.

ADDITIONAL RESOURCES

The Global Health Initiative developed an Integration Scoping Tool that can be used to better understand the nature and extent of integration efforts. The tool examines five functional domains, each of which is broken down into several integration elements and assesses to what extent the integration has taken place: policy, programs, system support strategies, services, and health behaviors.



It helps answer the following questions:

1. To what extent is a supportive **policy** environment in place to foster integration?
2. To what extent are **programs** being consolidated to achieve better outcomes at lower cost?
3. To what extent are **health system support strategies** being managed to support integrated service delivery and health promoting behavior in the home?
4. To what extent **have facility-based**, **community-based**, **and other services** been integrated to expand access, improve quality, lower costs and respond to client needs?
5. To what extent are families adopting **healthy behaviors** to safeguard their well-being and improve their quality of life?

The tool for health behaviors is included above and can be viewed larger here.

IMPACT EVALUATION

Evaluation of integrated SBCC should focus on extracting lessons learned, identifying challenges, and explaining successes that would not occur in the absence of integration. In other words, integration can be considered effective if it offers advantages over a singular or vertical SBCC program approach. Impact evaluation is crucial for understanding whether or not these additional gains took place and the degree to which they can be attributed to the integration efforts. Evaluation questions may revolve around:

- Whether integration adds value over non-integrated SBCC programs, for example, cost-effectiveness, health outcomes, quality of services, intra or inter-organization collaboration or reduced redundancy of effort.
- If the planned amplified effects or operational benefits from integration were realized.
- The strength of the type of integration model deployed, compared to other integration approaches.
- The effect of communication separately and in combination with other intervention strategies, such as increased availability of products or services, and how this is different in integrated approaches.
- The impact of topic-specific messages separately and when combined across topics.
- The combined effect or dose effect of the particular mix of cross-sectoral topics/messages or branding.
- Social norm change and impact on social capital and how integration amplifies these.
- Capacity of government or stakeholders to design, implement, and monitor and evaluate integrated SBCC programs and/or how that capacity changes over the course of the intervention.
- Degree to which the processes and outcomes of integration are sustained or sustainable.
- Potential for scale-up, and/or the effectiveness of integrated programs that have moved from a pilot to a scale-up phase.

Evaluation of integrated SBCC programs should also seek to capture any unanticipated positive and negative consequences of integration. The more (and more varied) data that can be collected linking program inputs to outputs and outcomes, and the more systematically that these are tracked over time, the better the chances of detecting negative consequences that reveal unanticipated costs or burdens on the systems created by the new approach. For example, given the connectedness of topics in an integrated campaign, change in one sector may have unexpected consequences in another sector, such as shifting of priorities and resources. Or the addition of a new topic could distract the audiences from other important topics or behaviors. Conducting frequent site visits and holding consultations with stakeholders also will help you discover unintended consequences of your efforts.

EVALUATION DESIGN

Given the likely size and complexity of an evaluation to assess not only health outcomes but also the value added by integration, programs should begin planning their impact evaluation at the earliest stages of project design. The best impact evaluations for any kind of program use a combination of evidence from formative research, implementation monitoring, and process evaluation, as well as post intervention data collection, to understand not only the magnitude of change but the mechanisms of change, as well. This is even more important when evaluating integrated programs, due to the greater number and diversity of inputs, the degree of cross-sectoral collaboration and, often, the longer time frame involved in integrated programming.

TIP

It is unlikely that a single type of evaluation design will tell the whole story of complex, integrated SBCC programs. Evaluation of integrated SBCC programs almost always requires a mixed methods approach. A combination of both quantitative and qualitative methods often gives the most robust picture, bringing to light direct and indirect impact pathways at multiple levels. Quantitative methods provide the most rigorous methods for measuring the magnitude and modeling the process of change at the population level, while qualitative methods provide in-depth, localized insights into synergies, unanticipated consequences, and contextual factors that help explain outcomes. The research designs that follow, therefore, are not meant to be mutually exclusive.

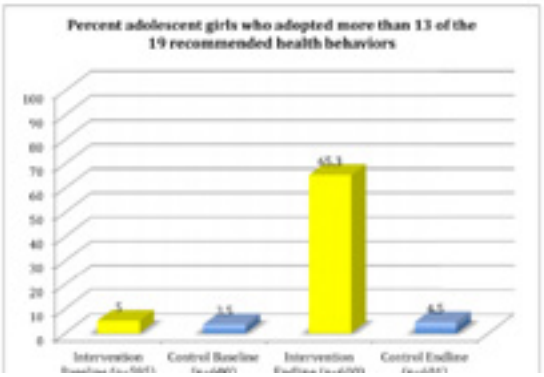
Research designs will vary depending on what is being integrated, the amount of time and funding available, the level of control the program has over implementation processes, the potential (or mandate) for dissemination of learnings from the program, and the practicality and acceptability of certain research designs (e.g., randomized trials vs. quasi-experimental vs. observational designs), among other factors. Below are several examples of research designs and examples of their appropriate use. Since true experimental designs involving random assignment to program interventions are rarely feasible with large scale full coverage programs, donors and key stakeholder groups must decide what evaluation designs are considered appropriate and sufficient to demonstrate the value of integration and the achievement of project objectives.

Randomized Control Trials

Randomized controlled trials (RCT), sometimes called experimental designs, randomly assign individuals or groups to receive or not receive a particular intervention, then compare outcomes among those exposed and unexposed. RCTs are generally considered to provide the strongest evidence of cause and effect, but have low external validity, meaning that they don't generate evidence of how the intervention would work in the real world where controlled conditions are not possible. The RCT approach also builds knowledge about successful interventions by replicating studies multiple times with minor variations; this is not feasible with population-based interventions at scale. Also, programs that employ mass media as part of their intervention strategy are difficult to randomize because it is hard to prevent spillover between treatment and control locations. Integrated programs are even harder than vertical programs to study using RCTs because they typically have too many components to be systematically randomized. Facility-based interventions can sometimes be randomized—if the populations served by different facilities do not overlap—by sampling service delivery points (or providers) and randomly assigning some to implement an integrated program while others

implement a vertical program, then comparing outcomes across the two groups of facilities.

PROGRAM EXPERIENCE: CLUSTER-RANDOMIZED CONTROL DESIGN



The *Saloni—Seeds of Prevention* project used a cluster randomized control design to evaluate an integrated RH, nutrition and hygiene program for adolescent girls aged 11-14 years in rural Uttar Pradesh, India. The Saloni strategy included a 10 session in-school intervention based on compassion, self efficacy, emotional well being, and peer and parental support, packaged in the form of short, easy-to-use instructional modules. A diary designed to engage adolescent girls in managing their own health was provided to each girl. A block of 15 schools was assigned to the intervention arm and another block of 15 schools was assigned to the control arm. A sample of 1200 girls was randomly selected from the two blocks for post-intervention interviews with them and their parents. The intervention had a significant impact on more than 13 preventive health behaviors: 65 percent of girls in the intervention group had adopted 13 or more health behaviors at end line compared to five percent at baseline and to 4.5 percent in the control group at end line. (Source: Kapadia-Kundu N, Storey JD, Safi B, Trivedi G, Tupe R & Narayana G. (2014). Seeds of prevention: The impact on health behaviors of young adolescent girls in Uttar Pradesh, India, a cluster randomized control trial. Social Science & Medicine 120, 169-179)

IN THEIR WORDS

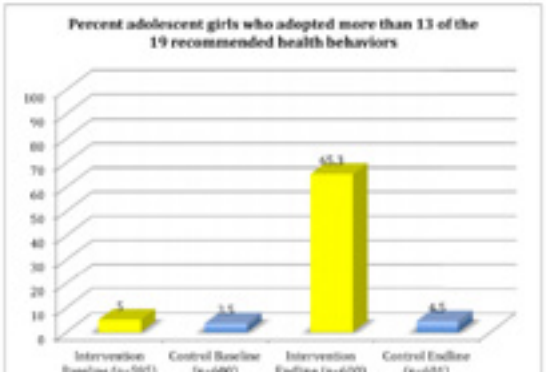
"Using a full factorial experimental design can help integrated programs determine whether an integrated design contributed to amplified or synergistic effects. In this method, participants are randomized to either: 1) a control group (no intervention), 2) a single intervention arm for each activity included in the study, or 3) a multi-intervention arm for each permutation of integration. The more components there are in the integrated strategy, the more arms of the study that must be created and randomly assigned to reflect all the possible combinations of components. FHI360 observes, "The simplest full factorial design for integrated evaluation will include four arms: one control, one for the first activity, one for the second activity, and one for the integrated activities. In such a design, if true amplification is achieved, the integrated arm(s) should show a degree of change that is greater than the sum of change among all of the arms that are not integrated." "

– (Source: FHI360)

Quasi-Experimental Designs

Quasi-experimental designs can be used when the footprint of an intervention makes it impossible to meet RCT requirements. For example, randomly assigning communities to treatment or control conditions may result in spillover or contamination if selected communities are too close to each other or if the number of randomization units (e.g., communities or service facilities) are few, randomization may not achieve the equal distribution of background characteristics that makes the approach useful. Quasi-experimental designs purposively assign units to treatment or control with an eye toward making the two sets of communities or facilities comparable and unlikely to contaminate each other.

PROGRAM EXPERIENCE: QUASI-EXPERIMENTAL DESIGN



The *Communication for Healthy Living* (CHL) program in Egypt (2003-2010) used a quasi-experimental impact evaluation design to evaluate the added value of community-based outreach and mobilization on top of a national mass media campaign around a diverse set of lifestage-specific family health issues. In the Minya Governorate, five villages were designated as treatment sites and two additional villages of comparable size and health status were designated as comparison sites. All villages throughout the country, including the Minya control villages, received the national package of media interventions, while only the treatment villages received a community-based outreach and mobilization program implemented by local civil society organizations. This allowed comparisons between "program villages" (media plus community-based) and "non-program villages" (media only) with statistical controls to account for exposure bias (Hutchinson & Meekers, 2012).

Development Media International (DMI) used a non-randomized, controlled before and after study design to test a mobile phone intervention in southwest Burkina Faso (2014-2015). Using an entertainment education approach, DMI produced eight short (3-minute) videos on mobile phones for primary care givers. The videos were shared by mobile phone distributors and promoted four key behaviors related to malaria, hygiene, pneumonia, and diarrhea. The study tested the reach and impact of the intervention by choosing nine intervention and ten control villages in the Gaoua region – an area where traditional media channels were not available. Study results showed that 32% of women and 46% of men in the target area had seen the films, and there was evidence that the videos were shared.

Observational Methods

Observational methods collect data from populations of interest before and after an intervention (or after only) and use statistical techniques to control for variables that might confound an observed change in the outcome associated with program exposure. The commonly used pre-post survey approach to impact evaluation is a type of observational method. When used with population-based programs, including those that use mass media and allow stakeholders to decide for themselves whether to be exposed to the intervention, these observational designs are sometimes accused of failing to account for the fact that some people are more motivated or predisposed to be exposed in the first place and subsequently to change their behavior. Post-hoc statistical methods such as propensity score matching can be used to calculate the likelihood (propensity score) that an individual respondent is exposed or not, based on a set of background characteristics. The propensity score is then used as a control variable to compare the behavior of people at the same levels of propensity who were exposed or not exposed. This creates comparable treatment and comparison groups without pre-intervention random assignment and produces measures of impact that are similar to the results one would expect from an RCT (Kincaid & Babalola, 2009).

Interrupted Time Series Designs

Interrupted time series designs involve the periodic collection of psychosocial and/or behavioral data at multiple points in time prior to, during and after an intervention is implemented then using trend analysis and statistical modeling to explain changes in the outcome trends at the time the intervention begins or when new intervention components are introduced or reconfigured. Analysis of health service data often relies on this type of design. One advantage of interrupted time series designs is that they allow the use of results for making adjustments to the program, with the effects of these adjustments then assessed through additional data waves. This may be particularly desirable with integrated programs whose complex nature may require adaptations to be made. Time series designs also allow for a historical control, which decreases the number of groups required. This is beneficial for integrated programs because, with multiple interventions, the number of arms required increases dramatically. However, such designs require the measurement of as many data points

before and after the intervention as possible, based on the desired resolution and anticipated time frame for observing intervention effects. This in turn may require extensive resources and also limits the applicability of this approach in the absence of sufficient pre-intervention data." (Source: FHI360)

Panels and Longitudinal Studies

Panels and longitudinal studies collect data from the same individuals at multiple time points to track changes in knowledge, attitude, and behaviors over the course of the intervention. Data can be collected pre-intervention, at intervals during the intervention, and at intervention completion to show changes along the way.

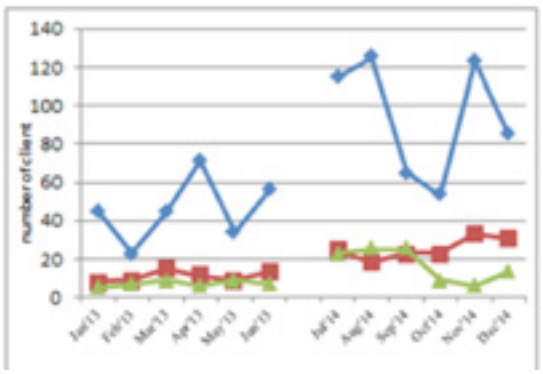
PROGRAM EXPERIENCE: PANEL SURVEY

The *Mabrouk! (Congratulations!) Initiative*, which was part of the integrated *Communication for Healthy Living* (CHL) project in Egypt (2003-2010), used a family lifestage approach to help families anticipate and respond positively to the interrelated antenatal, safe delivery, neonatal, postpartum, early childhood and lifestyle health issues they would soon face. The impact evaluation used a three-wave panel survey (2004, 2005, 2008) of women, their husbands and unmarried young adults in the same household, all interviewed at three points in time, to measure how household members responded to these issues over a four year period. The panel survey helped the program measure the cumulative impact of messaging on multiple topics as the phases of the intervention were introduced. It also permitted study of "health competence", that is, how an increase in knowledge, attitudes and resources related to healthy practices at an early stage of the project facilitated response to new health issues as they the arose. For example, when avian influenza broke out in 2006, families with higher health competence were better prepared to initiate protective actions. Panel designs have another advantage: because they compare the same people with themselves over time, respondent background characteristics remain constant, thus controlling for variations in the study population and strengthening causal inferences.

Dose Response

Dose response methods can help determine whether exposure through multiple communication channels and/or to different types of messages has a cumulative effect on outcomes. By collecting detailed information on where beneficiaries engaged with the content, the type of content, and/or the frequency of exposure, you can determine how different forms or number of engagements affected program performance. While data collection may be tedious, once this detailed information is captured, there are many ways to analyze the data to determine what types of integration were most effective.

PROGRAM EXPERIENCE: PANEL SURVEY



The *Gateway Behaviors Project* in Nigeria (2012-2015) was designed to test the hypothesis that antenatal care (ANC) utilization and spousal communication (the "gateway" behaviors) could have a multiplier effect, catalyzing a whole range of perinatal health behaviors. To promote those two gateway behaviors, the project implemented an integrated set of messages including community signage and public dialogue sessions, parades and performances, door-to-door mobilization & referrals to services, SMS blasts, and communication training for service providers. The endline survey found that the more sources of exposure to Gateway messages that a woman reported, the greater the probability that she had gone for ANC and had talked to her partner about perinatal health. She was also more likely to report each of six different perinatal behaviors: delivering her most recent child in a health facility, having a medically assisted delivery, adopting postpartum FP, initiating breastfeeding immediately after delivery, getting an HIV test, and fully vaccinating her youngest child. For example, only 20% of women who reported the lowest level of message exposure reported getting a perinatal HIV test compared to 60% of women who reported the highest level of message exposure. Furthermore, women who neither had 4 or more ANC visits nor talked to her partner about perinatal health reported practicing an average of 2.8 perinatal behaviors, while women who had 4 or more ANC visits *and* talked to her partner about perinatal health reported an average of 4.5 perinatal health behaviors (Source: Storey JD, Adefioye O, Bamidele M & Awantang G. (2015). NURHI Gateways Supplement Evaluation Report. Johns Hopkins Center for Communication Programs, Baltimore, MD).

Social Network Analysis

Social network analysis measures the patterns and/or strength of relationships and interactions among a group of individuals (e.g. friends, colleagues), institutions (e.g. Ministries, NGOs, health facilities), or other social entities. A sociogram (e.g., a diagram of "who talks to whom" in a community or a diagram of the patterns of referrals between health facilities) allows you to visualize these connections, including the density of the network and the nature and strength of connections between nodes. Network analysis can provide quantitative, systems-level measures that reveal who the key actors might be in a neighborhood or an organization, as well as how different actors or agencies within an integrated program interact with one another.

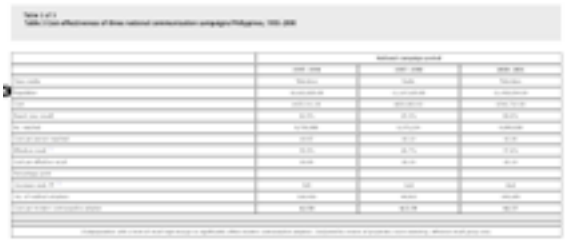
PROGRAM EXPERIENCE: SOCIAL NETWORK ANALYSIS

Impact evaluation of the Radio Communication Project in Nepal (1994-2002) used social network analysis to understand the indirect or "pass along" effects of a national family health radio drama. In randomly selected villages, all women of reproductive age were interviewed and asked to identify which other women in the community they talked to about family health, as well as about their exposure to the RCP radio drama. In the sociogram of each village's network, women were identified who had listened to the radio drama or not and whether or not they talked to someone who listened to the drama. Analysis revealed that non-listeners who had talked to listeners were just as likely to report key family health behaviors (e.g., contraceptive use, Vitamin A consumption) as women who had listened to the drama. Both were more likely to report those behaviors than non-listeners who did not report talking to listeners (Source: Storey JD, Boulay M, Karki Y, Heckert K & Karmacharya DM. (1999). "Impact of the Integrated Radio Communication Project in Nepal, 1994-1997." Journal of Health Communication, 4: 271-294).

Costing and Cost Effectiveness

Costing and cost effectiveness studies help establish if integrated SBCC costs more or less than other SBCC efforts in the short, medium, and long term, and if any increased costs result in equally increased positive outcomes. It helps quantify the extent and size of operational benefits and/or negative outcomes or missed opportunities.

PROGRAM EXPERIENCE: COST EFFECTIVENESS



A series of three national family planning campaigns in the Philippines between 1995-2001 that differed in terms of the channels of communication used, presented an opportunity to compare the cost effectiveness of different media channels (Kincaid & Do, 2006). Although these campaigns were not integrated in a cross-sectoral sense, the methodological approach could be applied just as well to comparisons of different integration strategies. The first campaign in 1995-1996 relied heavily on television to deliver its messages, but in 1997-1998, because of political and religious pressure, the government decided to use radio instead of television in order to keep a lower profile. The program returned to the use of television in 2000-2001. The impact of the campaigns was assessed using nationally representative population-based surveys that made it possible to extrapolate to the number of Filipinos who were exposed to the campaigns and who reported initiation of contraceptive use. The costs of developing, producing and disseminating the media materials (including the cost of airtime) was divided by the number of new adopters attributed to each wave of the campaign, producing a unit cost of reaching each person and achieving FP adoption. Because of the dramatically greater reach of television versus radio, it cost less to reach each person (about 5-6 cents for television versus 19 cents for radio) and to change FP behavior (less than USD 3 for television versus more than USD 13 for radio).

Outcome Harvesting

Outcome harvesting is particularly useful for complex, integrated programs where cause and effect are difficult to determine and outcomes cannot necessarily be predicted from the beginning. Using a consultative process involving stakeholders, outcome harvesting retrospectively identifies planned, unplanned, positive, and negative outcomes to understand the program's role in those outcomes, and how multiple outcomes lead to system change.

Case Studies

Case studies can help identify how and why integration added value and provide insight into the change process. Their rich, holistic view helps describe the importance of context and explain the non-linear pathways and complex causal links that often feature in integrated SBCC programs, including why those causal links did or did not occur. The most significant change (MSC) technique (a type of case study design) uses a

PROGRAM EXPERIENCE: CASE STUDIES

In Tanzania, listeners of the *Kamiligado* radio distance learning program submitted examples of how they felt their communities had benefitted from the program by SMS. Among those that submitted their MSC stories, 35 were selected to be profiled in written pieces, and of those, 15 were selected for in-depth interviews. The in-depth interviews revealed the dramatic impact of Kamiligado, and potential impact of other similar programs in Tanzania and elsewhere.

participatory methodology to systematically collect stories of impact from beneficiaries. Stakeholders then analyze the stories and select those deemed to be most significant. MSC measures changes that are difficult to quantify, such as those stemming from cultural shifts, or changes in expectations, power, or motivation. MSC is particularly useful for identifying unexpected changes and understanding program beneficiaries' definition of success in integrated SBCC programs.

RE-PLANNING

The most useful monitoring and evaluation results lead to programmatic improvements (and removal or discontinuation ineffective approaches). Use your monitoring and evaluation findings to make minor and major course corrections along the way, as well as to plan how to do the next program better and more efficiently. Consider:

- What should the program do more of?
- What should the program discontinue or do less of?
- What are the most appropriate way to package and organize or sequence topics?
- What new opportunities are suggested by the evaluation findings that might be worth trying?
- Is there any need for audience re-prioritization or different segmentation?
- How might the RM&E plan and its implementation be expanded, simplified, improved?
- Are there ways to strengthen partnerships (including adding and subtracting partners)?
- Are topics or approaches integrated to right degree? Could they be linked in a better way?
- Which topics worked well together and which did not?
- How did partners and stakeholder groups feel about the integration process?

ADDITIONAL RESOURCES

- Guidance for Evaluating Integrated Global Development Programs
- How to Develop a Monitoring and Evaluation Plan
- How to Develop Indicators
- Human-Centered Design Methods
- Monitoring and Evaluation for Serial Dramas
- DMI Resources
- Population Media Serial Drama Impact

Integrated SBCC Programs

Case Study: Lessons From the Integrated, Life-Cycle-Based Health Communication Campaign in Uganda

Introduction and Background

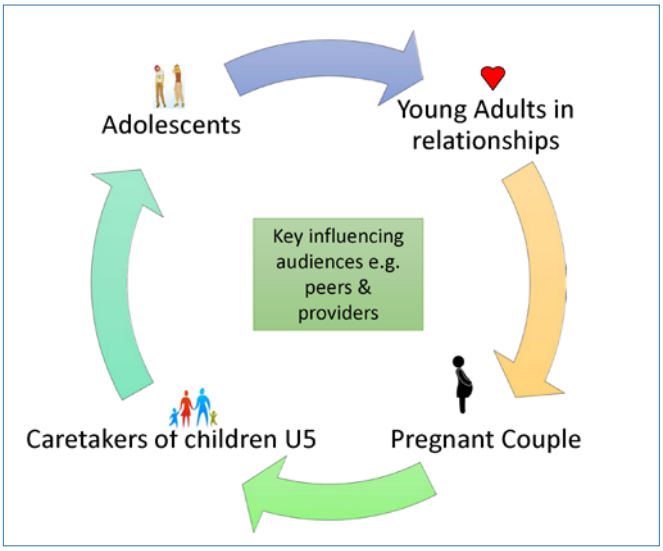
The Communication for Healthy Communities (CHC) project – funded by the United States Agency for International Development (USAID) – is designed to reduce HIV infection, total fertility, maternal and child mortality, malnutrition, malaria and tuberculosis (TB) by increasing the adoption of healthy behaviors, including the uptake of critical health services through the use of social and behavior change communication (SBCC). The program uses an integrated campaign platform to address health actions across six different health areas: HIV/AIDS, maternal and child health (MCH), nutrition, family planning, malaria and TB. The campaign platform, developed together with the Uganda Ministry of Health and implementing partners, serves as a base to stimulate dialogue and discussions around health actions, increase motivation and skills and to address gender and social norms that traditionally affect the uptake of health services and actions.

Challenge

An audit of health communication programs, approaches and interventions in Uganda took place at the beginning of the CHC project in 2014. The audit revealed the following key challenges: the availability of many health communication strategies and policies but with little implementation; fragmented implementation of interventions, with each implementing partner developing their materials and competing with the same audiences; as well as audience fatigue with instructive health messages that told audiences "what to do." Other issues included limited linkages between mass media and community-level interpersonal communication (IPC) interventions, which limited SBCC effectiveness, and the design of health communication interventions that focused on the disease instead of audience needs.

Response

Using results from the participatory health communication audit, desk reviews, formative research with audiences, a series of design workshops and stakeholder consultations, CHC segmented audiences, analyzed social determinants of health using the Social Ecological model (McKee et al., 2000) and developed an integrated health communication platform called **OBULAMU.** Obulamu, which means, "How's Life?" is a popular greeting in Uganda that elicits detailed responses about life and feelings. Instead of the traditional, prescriptive health messages that tell audiences what to do, OBULAMU engages people in a conversation, finds out what is important to them and positions relevant health actions in that context.



USAID Uganda/Communication for Healthy Communities (CHC) adaptation of the Life Cycle approach to a national integrated SBCC strategy and campaign.

OBULAMU is premised on the Life Cycle[1] approach, which identifies key life-cycle transitions as opportunities for change with the idea that health is not separate from people's day-to-day lives of working to earn a living, going to school, looking

1 *The CHC Life Cycle approach is an adaptation of the Family Life Cycle concept which provides a basis for segmenting audiences by recognizing predictable influences on behavior when transitioning from various life stages for example; youth at home, bachelorhood, newly married couples, parenthood, post-parenthood and surviving spouse.*

after children, falling in love or finding a spouse. The approach integrates several messages and issues relevant to the audience (see illustration below) and positons health as a facilitator to achieving people's aspirations in life.

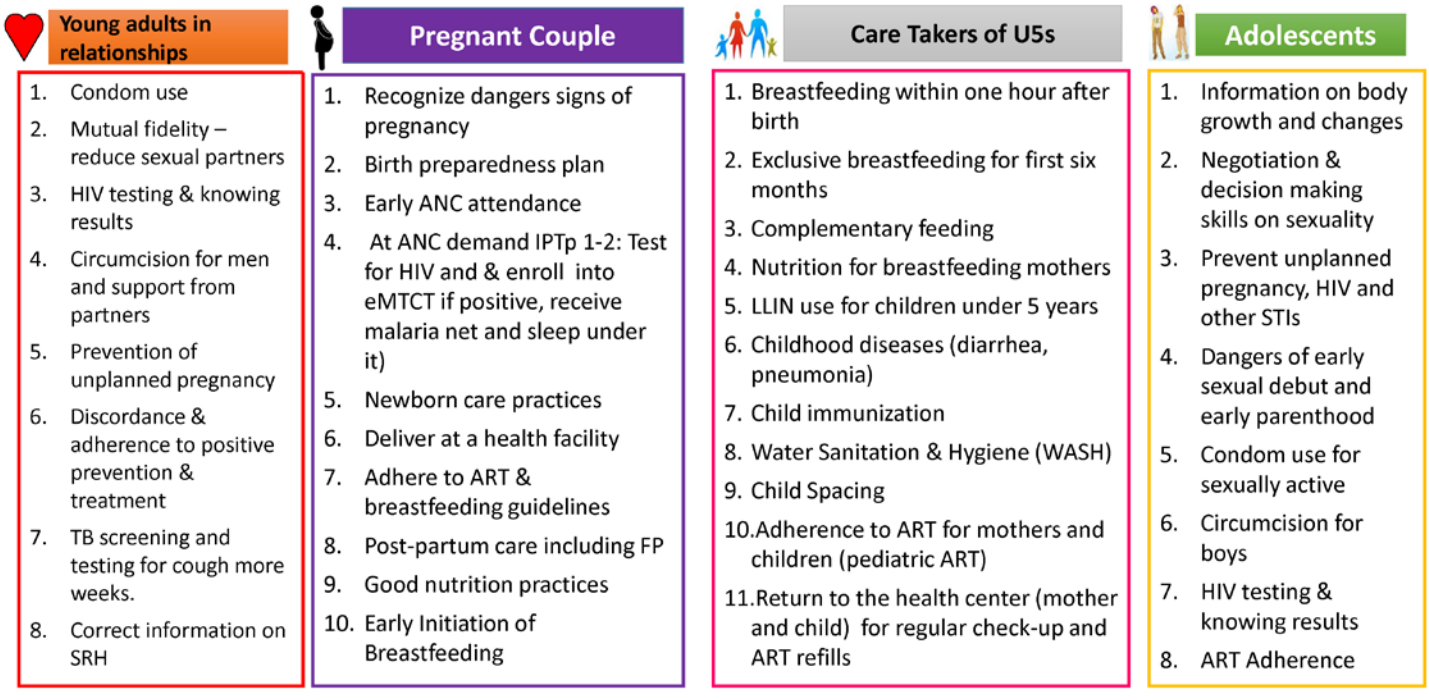
Instead of developing a new communication strategy (like most new projects), USAID/CHC reviewed existing communication strategies in the areas of HIV/AIDS, MCH, nutrition, family planning, malaria and TB – some of which were not being implemented – and developed an integrated communication platform which combines key actions for each life cycle from the six health areas. The platform focuses on four life-cycle transitions (adolescents, young adulthood, pregnancy and child rearing) under the following campaign phases per life cycle:

- **Life Cycle 1: "How's Your Love Life?** addresses the unique health needs of young adults in relationships
- **Life Cycle 2: "How's Your Pregnancy?"** caters to the health needs of pregnant women and their partners
- **Life Cycle 3: "How's Your Baby?"** targets children under five years old through their caretakers/parents
- **Life Cycle 4: "What's Up–What's My Choice?"** addresses the unique needs of adolescent girls and boys

Results

Due to stakeholder involvement in the design, the OBULAMU campaign has been widely adopted by the Government of Uganda and implementing partners across the country. As a result, there is a standardization of health communication messages and interventions where all partners use the same materials, tools and mobilization approaches. This has reduced fragmentation where each implementing partner or district used to design its own materials. To date, the project is taken as a one-stop center for all health communication needs and materials of partners.

The campaign approach of "OBULAMU?" or "How's Life?" has revitalized health communication by shifting focus from disease-based communication (e.g. HIV or TB) to audience-specific programming using the life cycle. This has enabled fine-grained audience segmentation and a focus on health issues relevant to audiences in each life cycle. For example, under Life cycle 4: "What's Up-What's My Choice?" while discussing issues on HIV prevention, teenage



This figure shows key actions for the four Life Stages in the OBULAMU campaign. Each of these actions is creatively developed into specific messages to support HIV prevention, antiretroviral therapy (ART)uptake and adherence, contraceptive choices and use, MCH, nutrition, TB and malaria prevention and case management.

pregnancy, body changes and life skills, the campaign extends the conversation to other issues including livelihoods, education, parenting, social and gender norms, among others.

Following participatory processes with audiences and stakeholders, the campaign has placed audiences under each life cycle at the center of the development, concept testing, field testing and placement stages. Part of this process involves a series of design workshops where target audiences develop and test their own SBCC interventions with guidance from SBCC facilitators. This has enabled the Ministry of Health and implementing partners to appreciate audience voices and context, compared to the previous times where SBCC materials appealed more to technocrats than target audiences.

Due to its personal touch of using a popular greeting, "How's Life?" the campaign triggers rapport, honest dialogue and self-reflection on health and life issues. This has provided a starting point for audience engagement and high exposure, a key starting point in tracking the hierarchy of communication effects including uptake of recommended practices and behaviors.

According to the Uganda All Media and Product Survey (2015), the campaign reaches an estimated 10 million people every day through IPC, mass media and social media (see **Table 1**). The December 2016 audience listening survey showed that over 80 percent of audiences had heard or seen OBULAMU campaign messages/interventions in the last six months, while more than 10 percent reported taking various health actions as a result of exposure.

The project is currently conducting the following studies to evaluate the impact:

1. *Qualitative Research with Target Audiences to Inform Process and Outcome Evaluation of an Integrated SBCC Campaign in Uganda (February-December 2017)*

2. *Evaluative Survey of an Integrated Health Communication Campaign in Uganda – Observation 2 report (August-December 2017).*

Application for Future Programming

Lessons Learned

- People want to be in charge of their health because "health is made at home." However, audiences often feel they are the helpless recipients of health services provided at the facility. Therefore, there is a need to strengthen individual and community ownership of health communication interventions and improve resilience to vulnerabilities. It is important to empower individuals and communities from the beginning, emphasizing that it is their adoption of recommended health practices and behaviors that will end HIV, malaria, TB or unplanned pregnancy rather than the actions from government or a development partner.

Table 1: OBULAMU campaign exposure in Uganda

Life Cycle Audience Segments (Life Stage)	Total Population according to 2014 National Census	Total that listen to radio (76%) according to UDHS 2011	Total that listen to OBULAMU (60%) according to the CHC Timeline One Survey 2015
Life Stage 1: Young Lovers (Ages 20 to 30)	4,537,000	3,448,120	2,068,872
Life Stage 2: Pregnant Couples	2,261,520	1,718,755	1,031,253
Life Stage 3: Care givers of children under age five	12,075,400	9,177,304	5,506,382
Life Stage 4: Adolescents (Ages 15 to 19)	3,141,000	2,387,160	1,432,296
Total	**22,014,920**	**16,731,339**	**10,038,804**

Note: The roll-out of the campaign was on radio, TV, social media, outdoor placements and IPC/community mobilization. However, the estimated reach by radio was used to avoid double counting.

- Listening surveys and facility observations have shown that the majority of people view health facilities as places to treat sick people. As a result, people who are not sick, especially men and adolescents, do not see the need to go to the health facility to consult a doctor. Health facilities need to be repositioned as a one-stop center for reliable health information and services instead of a center for treating disease.

In the ***Design*** stage:

- It can take a lot of time to build consensus and secure buy-in from implementing partners and government agencies on key actions for each life cycle. Implementing partners and government agencies often want to include every health issue/action that applies to every life cycle, yet focus demands sacrifice. It is important to plan for adequate consultation and involvement of stakeholders, which should include capacity strengthening on SBCC design to appreciate key elements in the design process.
- It can be challenging to determine how to handle crosscutting audiences, such as key populations and people living with HIV, who fit in more than one life cycle. Flexibility is needed. For example, one option is to include special campaigns that spin-off the life cycle platform and cater to crosscutting audiences and emerging issues. Such mini-campaigns however, should be well linked to the main platform through consistent branding.

In the ***Implementation*** stage:

- Implementing partners and government agencies focus on different health issues and are at different stages of implementing their programs. This can result in competing requests for focus and prioritization of health issues/actions no matter the campaign phase or life cycle. It can be useful to have shorter campaign phases that focus on each life cycle and ensure that each life cycle has been fully introduced and rolled out by the end of one or two years (at least through mass media). However, implementing partners and agencies need to spearhead longer and sustained IPC and community mobilization engagement linked to service delivery in order to meet their different rollout needs and expectations, and to help secure the right intensity and saturation with adequate linkage to services.

OBULAMU Campaign Resources

- Campaign Facebook page
- Campaign YouTube Channel

- Implementation Guide for Life Cycle One
- The Communication Initiative Network: Brief about the OBULAMU campaign
- Baylor Uganda partnership with OBULAMU campaign

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- Jane Alaii Consultant, USAID Uganda/ Communication for Healthy Communities (CHC)
- Paul Kagwa Assistant Commissioner, Health Promotion & Education, Ministry of Health, Uganda

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Integrated SBCC Programs

Case Study: Using an Umbrella Approach to Link SBCC Campaigns in Ghana

"What is Your Good Life?" This simple but provocative question got people in Ghana thinking and talking about what they want and value in life. This question then became a platform for a dialogue on the role that good health plays in helping them achieve what they want in life and, finally, how specific health behaviors can help them maintain their health.

For instance, in the opening of a television spot on childhood diarrhea, a mother and her son are desperate for help. A neighbor—followed by a health care provider—appears and tells the mother about the benefits and correct use of oral rehydration salts (ORS) and zinc (ORS + Zinc), a new treatment for childhood diarrhea available on the market. The woman expresses relief and voices that she feels empowered to take care of her family in the future. The spot closes with a simple message: "Good life goes with good health. Good life. Live it well."

This TV spot was part of the *GoodLife* initiative, which effectively tied good health to many of the things that matter most to Ghanaians—family, friends, faith, business and work. Similar to marketing campaigns, the overarching concept, "good life goes with good health," was used to communicate the value and personal benefits of healthy living and encouraged a relationship and opportunity for exchange between the brand and the intended audience.[1]

A brand is a persona that the target audience can identify with and aspire to.[2] *GoodLife* ultimately became a hallmark or umbrella brand under which multiple health campaigns were introduced and united with the aim of inspiring a nation towards a healthy lifestyle.

The opening of a GoodLife television spot on childhood diarrhea. © CCP

Background

Ghana is centrally located on the western coast of Africa. It is bordered by Togo, Cote d'Ivoire and Burkina Faso, and is comprised of 10 administrative regions and more than 45 ethnic groups, including the Akans (48 percent), Mole-Dagbon (17 percent) and the Ewe (14 percent).[3]

In 2008, several health indicators in Ghana had significantly improved while others had either stalled or worsened. According to the 2008 Ghana Demographic and Health Survey (DHS) and the 2007 Ghana Maternal Health Survey, exclusive breastfeeding and ownership of insecticide treated nets (ITNs) had improved. However, infant and child mortality had stagnated, and maternal mortality had worsened while the use of family planning (i.e., modern contraceptive) had declined from 19 percent (2003) to 17 percent (2008).

1 Evans, W., Blitsein, J., Hersey, J., Renaud, J. and Yaroch, A. (2008). Systematic review of public health branding. *Journal of Health Communication*, 13, 721-741. Retrieved from: http://www.tandfonline.com/doi/abs/10.1080/10810730802487364

2 Columbia University Mailman School of Public Health. (2014). *Branding Public Health*. Retrieved from: https://www.mailman.columbia.edu/public-health-now/news/branding-public-health

3 Ghana Statistical Service (GSS), Ghana Health Service (GHS), and ICF International. (2015). *Ghana Demographic and Health Survey 2014*. Rockville, Maryland, USA: GSS, GHS, and ICF International.

The *GoodLife* brand was introduced in Ghana under the United States Agency for International Development (USAID) funded Behavior Change Support (BCS) Project, which was implemented from 2009-2014 by the Johns Hopkins Center for Communication Programs (CCP) in partnership with the Ministry of Health (MoH) and the Ghana Health Service (GHS). BCS sought to increase demand and use of health promoting commodities and health services as well as positive behaviors related to six key health areas: family planning, malaria, maternal and child health, nutrition, water, sanitation and hygiene (WASH) and HIV/AIDS.

Challenge

CCP initially put forward their proposal for an umbrella campaign in response to a USAID solicitation seeking to employ social and behavior change communication (SBCC) to integrate multiple health issues. CCP was awarded the five-year project in 2009.

However, planning a large integrated health campaign was not without challenges. Among them were concerns from different stakeholders (i.e., malaria, capacity strengthening, WASH) regarding the effectiveness of integrated campaigns. They wanted to see evidence and they questioned whether an integrated campaign would help them make progress towards their objectives. Specifically, they asked, would an integrated SBCC campaign result in behavior change in the individual health topics?

Although the majority of project funds would be allocated for specific health campaigns, some stakeholders were reluctant to provide financial support to establish the *GoodLife* brand without clear evidence of its effectiveness. In the end, family planning and maternal and child health (MCH) stakeholders provided initial funding for the umbrella campaign; malaria, WASH and nutrition stakeholders bought into the brand after it proved successful.

Response

CCP organized a strategy workshop with a range of stakeholders and partners, and engaged them on the concept of the umbrella brand. A small content design team was formed to develop a number of different approaches and concepts, including *GoodLife*, *Golden Ring* and *Healthy Life*, among others. These concepts were pre-tested with both community members and stakeholders. Dialogues were held with about 150 people from government and non-governmental organizations (NGOs). Ultimately the group settled on *GoodLife*, and the GHS adopted the campaign. USAID provided a waiver at GHS's request, which allowed the campaign to launch without donor branding in order to increase ownership among GHS staff and the Ghanaian public.

GoodLife was the unifying element that bound all of the health areas together and purposefully linked personal happiness with the practice of healthy behaviors. The primary audience for the campaign was young Ghanaian families.

Before the launch of the campaign, the BCS team carefully reviewed existing data and health surveys. This data informed the design of the campaign strategy, which aimed to use the *GoodLife* concept as an approach to unite all project activities and media. The goal of the BCS strategy was to use *GoodLife* to facilitate the following:

1. Develop an overarching, unifying concept that made health messages personally relevant
2. Ensure coherence and continuity to avoid confusion around different messages that would be promoted over the life of the project
3. Prompt the desire to learn more about disease prevention and laid the foundation for individuals to adopt a variety of preventive and behavioral actions promoted by the project
4. Avoid audience message fatigue and confusion given that the campaign would promote separate messages on multiple health topics
5. Place the individual and their needs and wants at the center of health messaging

The BCS campaign strategy was implemented at the national, regional and community levels through mutually reinforcing approaches that were used for BCS activities, including:

1. **Integrated approaches** that addressed a wide spectrum of topics simultaneously over a prolonged period, including community-based activities, weekly *He Ha Ho* Radio Shows, and the *GoodLife* TV Gameshow;
2. **Health campaigns and approaches** that focused on one or two specific health issues at a time using multi-media at high intensity

for limited duration, including family planning, "Life Choices, Malaria," "Ah Ye De," Nutrition SuperHeroes, ORS plus Zinc Tablets and Handwashing with Soap; and

3. **Regional, district and community activation** events that reinforced the on-going media and community mobilization activities.

Mass-media activities were disseminated nationally while district- and community-level activities were implemented in three regions – Greater Accra, Western and Central Ghana – covering about one-third of the population. CCP hired several creative agencies to take on different aspects of the campaign, one of which was designated to work specifically on the umbrella *GoodLife* materials.

Roll Out of GoodLife Umbrella Brand

From November 2010 to April 2011, the *GoodLife* brand was established and maintained in two phases: **teaser** and **brand maintenance**. The teaser segment lasted about three weeks and was designed to generate curiosity and mystery. It simply asked of the audience: "What is your Good Life? What do you enjoy and value in life?" Health topics were not introduced at this stage so as not to risk losing the interest of the audience. The teaser campaign included TV and radio spots, newspaper ads, posters, community events and SMS messaging. The brand maintenance phase focused on increased engagement and maintenance.

Phase 1:

- A **teaser segment** ran from October-November 2010. The teaser only asked the question "What is Your GoodLife?" Six Ghanaians representing a cross-section of the country's population were selected to tell personal stories about what they value in life. Their stories were produced for television, radio and print. No reference was made to health. This created a large amount of "buzz" and curiosity as people speculated what the "Good Life" was all about.
- A **brand positioning segment** ran from December 2010 to May 2011. This segment revealed the brand's link to health issues and to the GHS. It was promoted through the use of TV, radio, billboards, posters, and T- shirts. This segment of the campaign was designed to increase visibility and understanding of the health campaign. This segment involved a music concert held in January 2011 as well as a *GoodLife* Quiz in newspapers, a theme song and music video, and television and radio spots featuring a prominent talk show host and comedian.

Phase 2:

- The **brand maintenance segment** included increasing visibility of the brand by outfitting 2,000 trained community volunteers with *GoodLife* vests, making sure all community materials had a *GoodLife* logo and slogan and weaving campaign themes into community dialogue guides.
- *GoodLife* **media platforms** included on-going programs that drew a regular audience and addressed a variety of health topics via the weekly *Healthier Happier Home* (HE HA HO) radio show and the *GoodLife* TV Game Show.
- **Mass-media campaigns** were used to link *GoodLife* to all GHS campaigns on family planning, malaria, nutrition and WASH by adding the *GoodLife* logo and phrase to each campaign slogan.

The initial roll out did not include any branding outside of *GoodLife*. The logo was developed based on the traditional Ghanaian adinkra symbol. It was modern and appealing, but played on the traditional "Nkyemekyeme" symbol, which implies initiative, creativity and determination can help one overcome obstacles in life. College students were hired as brand champions to canvass major towns in the Greater Accra, Western and Central regions as a way to help establish and reinforce *GoodLife* in the hearts and minds of those communities. This was important as an effective brand can give a product or service "a long-term value, enabling its target audience to associate with the campaign and its messages, and to adopt its use and sustain it."[4]

Subsequent campaigns on specific health topics were rolled out in phases. Once a campaign started, it continued through the life of the project, but the intensity of the coverage would go down as another campaign was rolled out. Each campaign had its own logo and slogan, but were linked to the *GoodLife* brand through a standard message or tagline.

4 Basu, A., & Wang, J. (2009). The role of branding in public health campaigns. *Journal of Communication Management*, 13(1), 77-91. Retrieved from: www.emeraldinsight.com/1363-25X.htm

Descriptions of the specific health campaigns are outlined in the table below.

GoodLife Campaigns			
Health Campaign/ Slogan	**Description**	**Communication Channel(s)**	**Resources**
Family Planning *Life Choices* **Slogan:** "It's your life. It's your choice."	*Life Choices* was designed to address key barriers to contraceptive use, including: (1) concerns about side effects; (2) lack of perceived social support for contraceptive use; (3) men's involvement; and (4) understanding the consequences of unintended pregnancies.	Mass media, community outreach and interpersonal communication	• TV Spot: "It's Your Life. It's Your Choice" • Extended TV Spot: "Sista, Sista"
Malaria *Aha Ye De* **Slogan:** "Let's come together to drive malaria away…for goodlife."	*Aha Ye De* ("It's good here") sought to increase the perception of malaria behaviors across the following program areas: Artemisinin-Based Combination Therapy (ACT) case management, ITN use and IPTp uptake.	Mass media and community outreach	• TV Spot: "Malaria and ACT: Bites" • TV Spot: "Kuma Sutra" • TV Spot: "Game Plan" • TV Spot: "Eni Boni" • Music Video: "Aha Ye De Ntomtom Be Wu" • Net Use and Care: "Ntomtom Po Suro Song" • Documentary: "Severe Malaria"
Maternal and Child Health **Slogan:** "ORS + Zinc tablets, stops diarrhea faster and protects…that's your good life. Good life goes with good health. Good Life. Live it well."	The ORS + Zinc campaign was launched to create demand for zinc tablets by promoting the benefits of using both zinc and ORS together to treat childhood diarrhea.	TV, radio and point-of-sale materials in pharmacy and chemical shops and health care facilities	• TV Spot: "ORS + Zinc"
Nutrition **Slogan:** "If you follow this plan, you children will Grow. Glow. Go. Goodlife goes with good health. Good Life. Live it Well."	Five local Ghanaian animated superhero characters were used to introduce the main food groups (energy, protective and body-building) and address issues related to exclusive breastfeeding from 0-6 months, and infant and young child feeding (IYCF) practices for children from six months to two years. The priority audience was mothers and caretakers of children under five.	Mass media and community mobilization	• TV Spot: "The GoodLife Food Heroes"
WASH **Slogan:** "For truly clean hands, always wash with soap."	The WASH-related campaign was meant to promote hand washing with soap and water at five critical times (before food preparation, before eating, before feeding a child, after going to the toilet and after cleaning a child's bottom).	Outreach in communities, schools and other venues; TV spots GoodLife Game Show; and HE HA HO radio show	• TV Spots: "Handwashing"

Still from "The GoodLife Food Heroes" TV spot. © CCP.

To learn more about *GoodLife* and to view campaign materials, see the *GoodLife* Spotlight.

Results

Multiple data sources were used to evaluate the *GoodLife* program. A baseline, midpoint omnibus and endline surveys were conducted under BCS. Health service statistics and sales of health commodities data were also analyzed. Approximately 70 percent of people were exposed to the *GoodLife* campaign, which had significant impact across health areas.

Child Health

- Sale of zinc tablets increased 280 percent after media campaign

Nutrition

- The proportion of women who immediately started breastfeeding within 30 minutes of birth increased significantly in the Western and Central regions, but not in Greater Accra (please see chart)

Malaria

- 80 percent of pregnant women in rural areas exposed to *GoodLife* slept under bed nets, compared to 36 percent of those not exposed
- Women exposed (64 percent) to the *GoodLife* malaria messages were significantly more likely to have taken at least two doses of intermittent preventive treatment in pregnancy (IPTp) while they were pregnant compared to those unexposed (49 percent)

Maternal Health

- Blood donations increased 47 percent in the Greater Accra Region after the start of *GoodLife* social mobilization and blood drives. About half of all maternal deaths in the region are due to postpartum hemorrhage and lack of available blood.
- The proportion of females who received a post-partum checkup from health personnel increased from 79 percent at baseline to 87 percent at endline ($p<.001$).

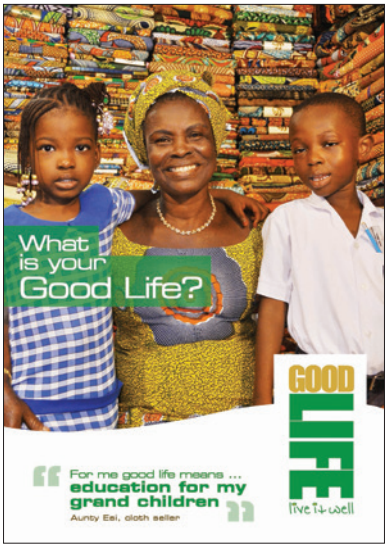
Family Planning

- Contraceptive prevalence increased from 17 to 23 percent between 2008 and 2011.
- In the endline survey, 18 percent of the none/low exposed used a modern family planning method, as compared to 20 and 23 percent of the medium and high exposed, respectively.

The BCS project ended in 2014; however, the GHS retained ownership of the *GoodLife* brand and continues to use it today.

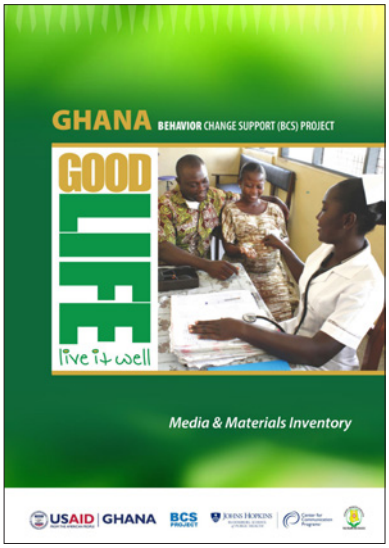
Application for Future Programming

- Be sure to involve stakeholders in the creative process so that they feel a sense of ownership over the brand.
  - » The GHS accepted the *GoodLife* concept and supported it wholeheartedly, leading to local ownership and sustainability of the brand, which is still in use today.
- Develop a brand that is compelling and broad enough so that it's relevant to multiple health areas and audiences.
  - » The concept that health can help one achieve their good life was applicable across all health areas.



Goodlife Live it Well Posters. © CCP.

- » Additionally, the *GoodLife* logo was inspired by a traditional Ghanaian Adinkra symbol (visual representation of concepts and aphorisms), yet had a modern edge. It appealed to the youth, traditional, urban and rural audiences.
- Consider identifying a theory or framework for the overarching or umbrella brand.
- Determine how best to link individual campaigns to ensure they are more cohesive in presentation.
  - » For example, use the umbrella brand to develop a strong intro and outro platform for each spot or audio/visual material.
  - » Mark all materials with the brand logo and tagline and ensure there is a set of quality standards regarding placement and consistency of messages.
- Develop a master media broadcast and buying plan to ensure each campaign receives adequate air time and is not in competition with the other.



Ghana BCS Project Media & Materials Inventory. © CCP.

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Integrated SBCC Programs

Case Study: Using Unique Identifier Codes to Monitor an Integrated Social and Behavior Change Communication Program

Introduction and Background

The Central America region is characterized by a concentrated HIV epidemic, with overall HIV prevalence ranging from 1.5 percent in Belize to 0.3 percent in Costa Rica and Nicaragua (UNAIDS, 2015). HIV prevalence is much higher among key populations, such as female sex workers (FSW), clients of sex workers and their partners, men who have sex with men (MSM), transgender persons (TG) and mobile populations. For example, HIV prevalence among MSM ranges from 6.6 percent in Nicaragua to 13.3 percent in Guatemala (UNAIDS, 2015), and among FSWs from 2.2 percent in Nicaragua to 9.7 percent in Honduras (Baral et al, 2012). HIV prevalence among transgender populations throughout the region is estimated to be 24 percent (Baral et al, 2013).

In October of 2010, the Pan American Social Marketing Organization (PASMO), a regional affiliate of Population Services International (PSI), began implementing the United States Agency for International Development (USAID) funded ***Combination Prevention Program for HIV in Central America***. The program uses a combination prevention approach to deliver HIV prevention social and behavior change (SBC) messages, products, services and referrals to key populations most affected by HIV in the region: FSWs, their clients and partners; MSM; TG women; certain ethnic populations (i.e., Garifuna, Mixquito and Kuna); highly mobile male populations; and people living with HIV/AIDS (PLHA).

While the Combination Prevention Program is primarily focused on reducing the incidence of HIV, the program meaningfully integrates complementary health products and services that provide for the holistic needs of the intended populations. These complementary services—including family planning, sexually transmitted infection (STI) testing and treatment, gender-based violence services and treatment for alcohol and drug abuse—are not only important for reducing the incidence of HIV, but also providing for the comprehensive sexual and reproductive health of individuals.

Under the program, PASMO has developed a minimum package of behavioral, biomedical and complementary services that is offered to key populations in the region. PASMO and other program partners work intensively to provide each individual from the intended key populations with at least three behavioral interventions, including SBC to promote safer sexual practices and access to condoms and lubricants, at least one effective biomedical service such as HIV testing and counseling or screening for STIs, and referral to complementary or structural services such as family planning for FSW, treatment for alcohol and drug abuse, gender-based violence prevention services, human rights counseling and legal services or support groups for PLHA, among others.

Challenge

When implementing an integrated SBC program, it can be challenging to track individuals who are exposed to different SBC messages and activities, as well as any resulting use of products, services and referrals.

Working with stigmatized and vulnerable populations can add another level of complexity to tracking individuals, as confidentiality plays an even more important role. In Central America, key populations are subjected to stigma, discrimination and inequality, and are often reluctant to access medical services due to fear of experiencing social and interpersonal abuse, if identified.

Response

In order to measure and demonstrate the effectiveness of the combination prevention approach, PASMO developed a system to track clients through a Unique Identifier Code (UIC). The UIC allows PASMO to maintain client confidentiality while still ensuring clients are successfully linked to products and services. PASMO adapted the UIC principles and guidelines developed by PSI's country teams in Central Asia to monitor the *Drug Demand Reduction Program* (DDRP).

Intervention Description

The UIC used by PASMO is a seven-characteristic code. The characteristics of the code are based on personal information that does not vary over time and that the client can easily recall through simple questions. While the code is confidential, it still provides important data (such as gender and age) necessary for the monitoring and evaluation of the program. In order for the UIC system to work properly, it must have a probability of less than two percent that two individuals will share the same code.

In addition to these characteristics, PASMO also considered important factors about the populations it serves, including levels of education, sensitivity to paternity (i.e., not knowing parents) and sensitivity to changing names, particularly in the TG population. With all these factors in mind, PASMO developed the following seven-digit code based on four components:

1. First two letters of first surname
2. Gender Identity (Male/Female/TG; TG is considered a third gender in order to identify all TG individuals reached)
3. Birth date (day, two digits)
4. Birth year (last two digits)

A family planning user and a health promoter discuss contraceptive methods in El Quiché, Guatemala. © 2014 Haydee Lemus/PASMO PSI Guatemala, Courtesy of Photoshare

The UIC was piloted in Belize and Guatemala with three key populations: FSW, MSM and TG individuals. After analyzing the results of the pilot, PASMO made adjustments to the management information system (MIS), reporting and monitoring forms and prepared for roll-out. A voucher system was also developed to help link clients to services, especially those services offered by partner organizations.

PASMO has developed several innovative outreach activities in order to increase access to target populations that can be difficult to identify and organize. The UIC is used in all activities to track clients and assess the success of these new services. For example, "cyber educators" enter chat rooms that MSM frequent and engage in conversations with clients about safe sex and HIV prevention. Without needing to know their true identity, the cyber educator collects the information necessary to create a UIC, refers him to a near-by clinic and sends him a link to a voucher that can be printed. When the client arrives at the clinic, he hands over the printed voucher and the clinic also collects his UIC. In this manner, PASMO is able to know the success of online interventions in linking clients to the minimum package.

PASMO has also adapted the UIC for mobile phone and short message system (SMS) activities. In 2013, the Combination Prevention Program launched a "soap opera" delivered to FSWs and TG individuals in the form of SMS messages to their mobile phones. Participants send their UIC data in order to obtain a subscription and for additional incentives such

as airtime, prizes and ringtones. By collecting the UIC data, PASMO is again able to track clients and establish a more accurate number of total participants.

Results

The UIC has allowed PASMO to successfully track individuals exposed to the various SBC messages and activities implemented under the program and the impact of these messages and activities on behavior and use of products and services.

Since implementation began in 2010, 148,187 individuals from the key populations have participated in the Combination Prevention Program. Among those individuals who have participated in the program, 14,866 have received the full minimum package of services.

The program has not only been successful at reaching the intended key populations in high numbers, but has also had an impact on changing behavior. Among the 148,187 individuals participating in the program, 42,645 individuals have accessed HIV testing and counseling services.

In Costa Rica and in Guatemala, MSM and FSWs who are exposed to the program's interpersonal communication activities are 1.93 times and 2.66 times more likely to use condoms consistently with their clients, respectively.

In Nicaragua and in Guatemala, MSM who are exposed to any of the program's activities—behavioral, biomedical or complementary/structural—are 2.21 and 4.08 times more likely to have tested for HIV in the last 12 months, respectively. Similarly, FSWs in Nicaragua and in Guatemala who are exposed to any of the program's activities are 2.61 and 5.62 times more likely to have tested for HIV in the last 12 months, respectively.

Application for Future Programming

Programs implementing an integrated SBC communication (SBCC) program can benefit from the use of a UIC in tracking exposure to program messages and activities, and any resulting behavior change or use of products or services.

Advantages of using a UIC include:

- knowing the total number of individuals reached by country and region;
- the possibility of knowing if a person has migrated;
- knowing if each individual has been exposed to more than one SBC message or activity;
- knowing at what time period and with what frequency a client participated in activities; and
- knowing if the referral to biomedical or complementary/structural services was effective.

Resources

For more information on PASMO and the Combination Prevention Program visit http://asociacionpasmo.org or contact Heather Chotvacs at hchotvacs@psi.org.

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Integrated SBCC Programs

Case Study: Setting Up a Strong Coordination System to Support an Integrated SBCC Program in Egypt

Introduction and Background

Coordination and collaboration among stakeholders – at the national, district and community levels – is critical to the success of any social and behavior change communication (SBCC) program. It creates awareness of the scope of SBCC programs in a country to avoid duplication of efforts. It facilitates a process where communication materials are developed and reviewed based on quality standards, ensures health services and supplies are available once SBCC is used to generate demand for them (Lawson, 2013) and brings new partners together around shared goals.

In fact, a strong coordination system can serve as a lifeline for increasing the effectiveness of SBCC programs, particularly those designed to address multiple health issues or involve stakeholders looking to influence various health outcomes.

This was the case when, in 2003, the government of Egypt (GOE) set out to coordinate one of the first integrated health communication programs funded by the United States Agency for International Development (USAID). **Communication for Healthy Living** (CHL) was a multi-dimensional program intended to address behaviors around family planning and reproductive health (FP/RH), maternal and child health (MCH), infectious/non-communicable diseases and healthy lifestyles. CHL promoted "Healthy Families, Healthy Communities" in Egypt by personalizing messages about multiple health areas at the household level.

CHL was implemented by the Johns Hopkins Center for Communication Programs (CCP), in partnership with the GOE, Save the Children and Tulane University. The project ran from 2003 to 2010 and centered on three main objectives: 1) provide improved strategic information and coordination for effective health communication programs; 2) increase adoption of healthy behaviors and demand for health services; and 3) develop institutional, technical and financial sustainability to implement health programs

Nagwa Amr of SIS and Nahed Matta of USAID/Egypt discuss health priorities, 2003 CHL Strategic Planning Workshop

in the public, non-governmental organization (NGO) and commercial sectors.

By 2010, there was significant evidence that CHL helped to influence positive health outcomes in Egypt around RH, infectious disease control and smoking. At the core of CHL's success was a robust management and coordination system that leveraged existing strengths, resources and partnerships across public, private and NGO sectors.

Challenge

By the early 2000s, SBCC/health communication programs in Egypt operated mainly in a vertical fashion, but had the potential for the expanded coordination needed to implement integrated health approaches. For instance, the Ministry of Health (MOH) had an existing inter-ministerial partnership with the Ministry of Information (MOI)/ State Information Services (SIS) in the area of FP communication, offering the potential for extending cooperation to other health sectors. Internally, the MOH organizational service structure offered potential for the integration of different health sectors (e.g., FP, MCH and infectious diseases). In 2003, SBCC was carried out primarily by the GOE, to a

very limited extent by NGOs and almost not at all by the private sector.

The challenges to be addressed varied within each organizational context. For example, to expand cooperation between two autonomous ministries for integrated health beyond FP required new lines of inter-ministerial cooperation by multiple MOH section chiefs. Within the MOH itself, integrated SBCC programs – covering FP, MCH and infectious disease – required expanding beyond conventional vertical approaches in which each sector focused narrowly on its sectoral results. In addition, since each of the section heads were of roughly equal position, a higher authority was required to initiate and sustain the inter-sectoral coordination.

Message and Materials Design Workshop, June 2004

Response

The broad approach to building cooperation was to create a shared vision around a common goal, then engage the leaders with appropriate levels of authority to act upon it. This began by building support for the integrated health agenda among key stakeholders through one-on-one meetings with MOH representatives and their respective section chiefs. These individuals were selected according to whether they had the authority to direct staff and program resources toward (or away from) integration efforts.

Once the key leaders were aligned in a common purpose, the next step was to employ a participatory approach to engage the broader stakeholder community for their support and input. Specifically, activities were planned to secure buy-in, create alliances and develop a roadmap for the integrated campaign. In addition to this, training in SBCC skills and concepts was completed with stakeholders across multiple sectors to bolster their existing skills and ultimately create a stronger national system for supporting integrated SBCC programs. Overall, these activities, highlighted below, helped to lay the foundation for a functioning national coordination system and eventually the success of the CHL Project.

Strategic Planning Workshop

A three-day strategic planning workshop was convened in October 2003 with public, private and NGO stakeholders. A respected local research firm was invited to set the stage for an integrated platform by sharing evidence on the topics that would be addressed under CHL. By the end of the workshop, the group had collectively developed a shared vision, determined the disease burden, identified health objectives and outlined the technical strategy for the program. The group also adopted an integrated family health model, which was carried out through the Life Stage approach. This workshop was also key to forming the basis for the program's technical coordination. As a follow up to the planning workshop, CHL met separately with the MOH and SIS to determine the specific content of the health messages.

Formation of the Executive Steering Committee

In December 2003, CHL obtained GOE agreement to form an Executive Steering Committee (ESC) under the MOH to oversee management of the integrated SBCC strategy. The ESC was convened under the authority of the MOH First Undersecretary, to whom all section chiefs (FP, MCH and infectious disease) were responsible and who, in addition, had the authority to invite representatives from a partner ministry, in this case the MOI. The ESC was responsible for identifying health priorities, developing annual work plans and budgets, approval of campaign messages and major research for the project as well as coordinating activities across sectors. CHL developed terms of reference for the role of the ESC chairperson and sector coordinators and provided support to quarterly meetings. CHL also provided technical assistance to smaller subgroups and coordination committees to focus on integrating messages and activities into all health sectors.

Training of Trainers for Family Health Communication
Based on recommendations from the 2003 strategic planning workshop, CHL organized a training of trainers for family health communication in 2004 to strengthen capacity among a core group of master trainers from the MOI/SIS, Ministry of Health and Population (MOHP) and its partner, Save the Children, on advanced training skills and the integrated family approach. These master trainers conducted step-down trainings to stakeholders at the local level.

Message and Materials Development Workshop
CHL also facilitated a 2004 message and materials development workshop with 31 stakeholders from the public, private and NGO sectors as well as USAID to develop specific family health messages and materials for the campaign. The messages and materials were based on the strategic objectives outlined in the 2003 strategic planning workshop.

Results

One of the goals of CHL was to ensure the GOE was strengthened in its SBCC leadership role. This entailed improved inter-ministerial coordination and integration within the MOH to enhance the effectiveness of its SBCC, leading to improved health outcomes among beneficiaries.

Another goal was to create a resilient national system for SBCC by establishing cross-sector partnerships and technical working groups that could continue beyond temporary institutional or leadership changes.
In the end, CHL successfully achieved these goals through the following activities:

- **Successfully established and maintained the ESC, which was the national coordinating body for the project**
  - » Used evidence-based MOH priorities to build a shared, unified goal and guide strategic communication
  - » Developed and coordinated a technical strategy for health communication addressing specific national priorities in FP/RH/, MCH, infectious diseases and healthy lifestyles
  - » Developed coordinated annual health communication work plans across two ministries and multiple sections of the MOH
  - » Coordinated joint work plans, budgets and implementation with other ministries and among multiple health sections of the MOH
  - » Managed production of communication materials (media and print) for national use by the GOE
  - » Pre-tested information, education and communication (IEC) materials
  - » Monitored outreach activities systematically
  - » Met on a quarterly basis to report on progress and obtain feedback from section directors
- **Successfully implemented a national coordination system, which laid the groundwork for a highly effective response to the Avian Influenza (AI) outbreak in 2006.**
  - » National partners were brought together under the MOH to form a national AI Communication Strategy. Following the precedent of the inter-ministerial MOH-MOI collaboration, the MOH established coordination with the Ministry of Agriculture to tackle AI prevention through SBCC. The mechanisms for planning, production and dissemination of materials that CHL had in place were put to immediate use to respond to the emerging AI threat on a national scale.
- **With important lessons learned from AI response, the MOH led a coordinated and strategic campaign in response to the H1N1 global pandemic alert in 2009.**
  - » The MOH took full advantage of the partnership with CHL to cooperate on a series of materials, and then took the initiative to extend many of those materials to achieve a widespread reach (see private sector partnerships below)
- **CHL staff provided technical assistance to increase MOH coordination with private and NGO sectors, initiating unprecedented partnerships on the strength of shared goals. These public-private partnerships supported communication efforts for the following:**
  - » MCH (e.g., a partnership with Proctor & Gamble that disseminated an important integrated health booklet to 10 percent of hospital delivery mothers in Egypt over a two-year period);
  - » RH (e.g., Femcare promotion for adolescent women);
  - » Viral hepatitis C prevention;
  - » Non-communicable diseases, including anti-smoking and breast cancer awareness/case detection;
  - » Avian Influenza; and
  - » Pandemic Influenza, for which firms like Roche and Reckitt Benckiser/Dettol directly

supported the MOH in the massive production and prevention of influenza prevention print materials that were disseminated throughout the country.

Application for Future Programming

- Create a shared vision and common purpose; identify and align the key decision-makers with the authority to coordinate across organizational boundaries and to lead in pursuit of the shared goal.
- Identify a local and respected independent research firm to present the health evidence at the initial stakeholder-planning workshop. This provides an objective lens through which stakeholders can coalesce around a set of common challenges.
- Create a forum/mechanism in which key stakeholders can participate in and guide the planning and implementation process.
- Once the coordination system is in place, conduct regular (i.e., quarterly) meetings to provide opportunities for continued dialogue among stakeholders and partners.
- Identify or create a secretariat or organizational grouping to lead the coordination system and determine whether that entity has adequate resources and the capacity to do so.

Message and Materials Design Workshop, June 2004

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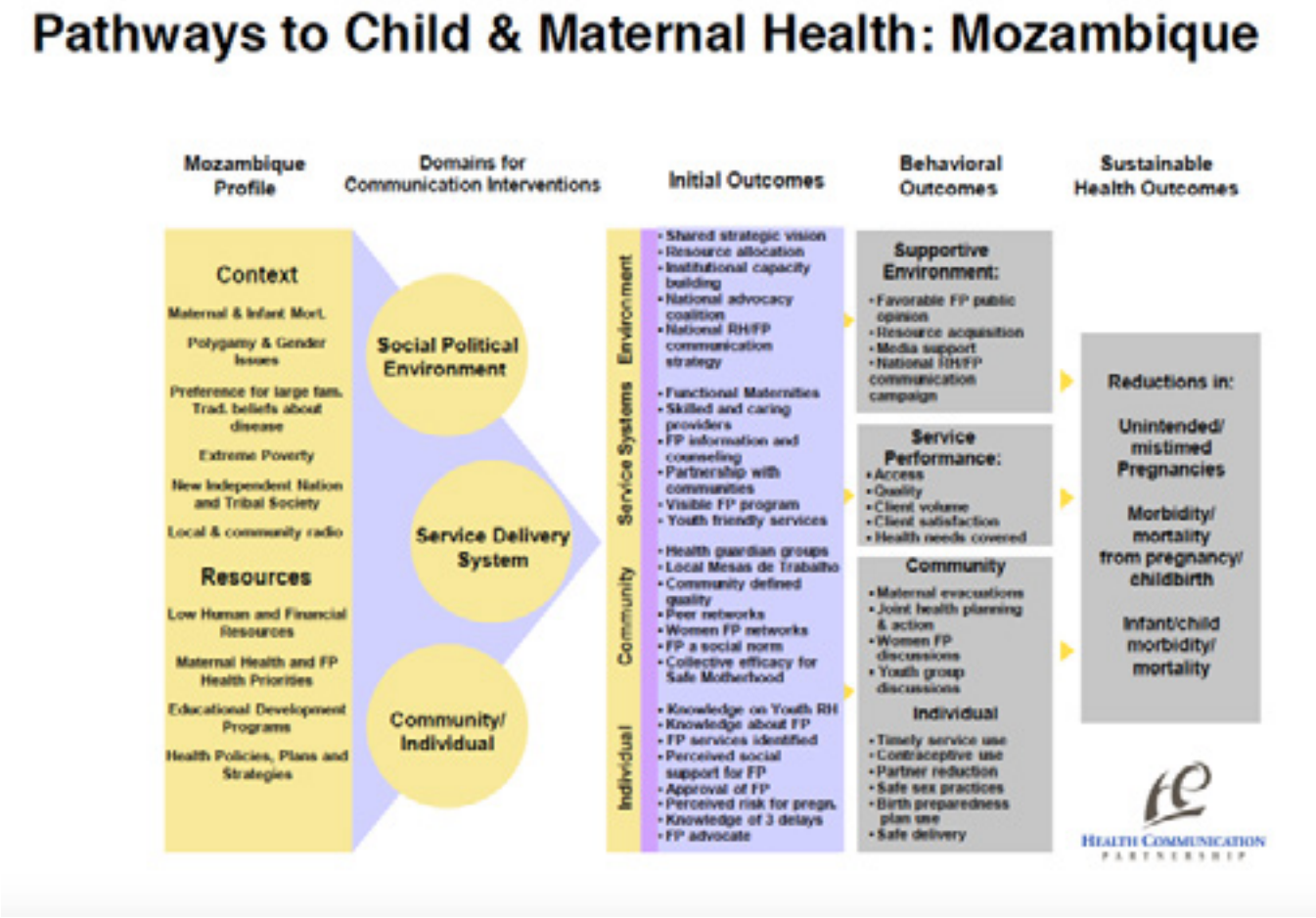
ANNEX A: SOCIO-ECOLOGICAL MODEL

The Socio-Ecological Model is a process which guides communication strategy by accounting for all levels of society that influence individuals. This model moves away from communication as a one-time, one-way "act" towards a view of it as an iterative social process that unfolds over time. For example, each level shown in the model encompasses theories of change for that particular level. In other words, it considers the complex

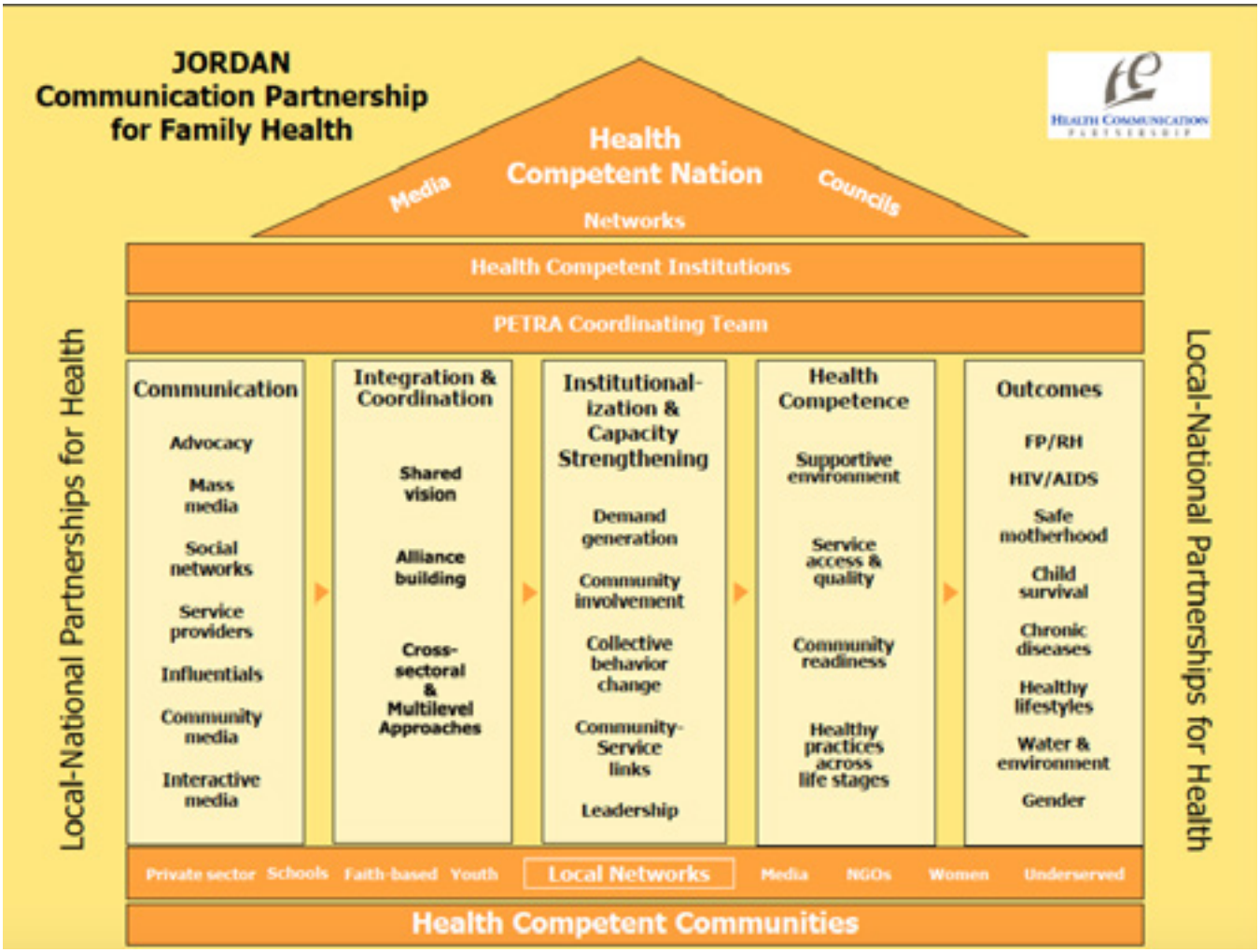
ANNEX B: PATHWAYS MODEL™

The Pathways Model™ recognizes that effective communication is grounded in a particular socio-ecological context, including enabling environments, service delivery systems, communities, husbands and wives, family members and individuals. It helps in identifying and understanding "pathways" to change within these complex systems and developing strategies that address these behavioral pathways, and then creating and mobilizing a comprehensive array of communication approaches to catalyze change. These communication approaches can include digital media, broadcast media, community mobilization, interpersonal communication, advocacy and capacity building to catalyze change.



ANNEX C: HEALTH COMPETENCE

Health Competence focuses on the individual's ability to demand or use health services appropriately or adopt health practices, and can be used across a number of different topics or behaviors. Once health competence is built in one life stage, and an individual achieves specific, visible health results and the resultant improved self-efficacy then carries over to future life stages.



ANNEX D: BOUNDED NORMATIVE INFLUENCE

Bounded Normative Influence (BNI) is a group-level theory that explains how a minority can influence the majority. BNI "is the tendency of social norms to influence behavior within relatively bounded, local subgroups of a social system rather than the system as a whole." A minority position can become the social norm when certain criteria are met – namely, when the minority maintains a majority status within its own, locally bounded portion of the network, allowing it to persist, to recruit adapters in the vicinity and to ultimately establish its behavior or position as the norm for the entire network. (Click here or below for more details.)

The Principle of Bounded Normative Influence

Bounded normative influence is the tendency of social norms to influence behavior within relatively bounded, local subgroups of a social system rather than the system as a whole.

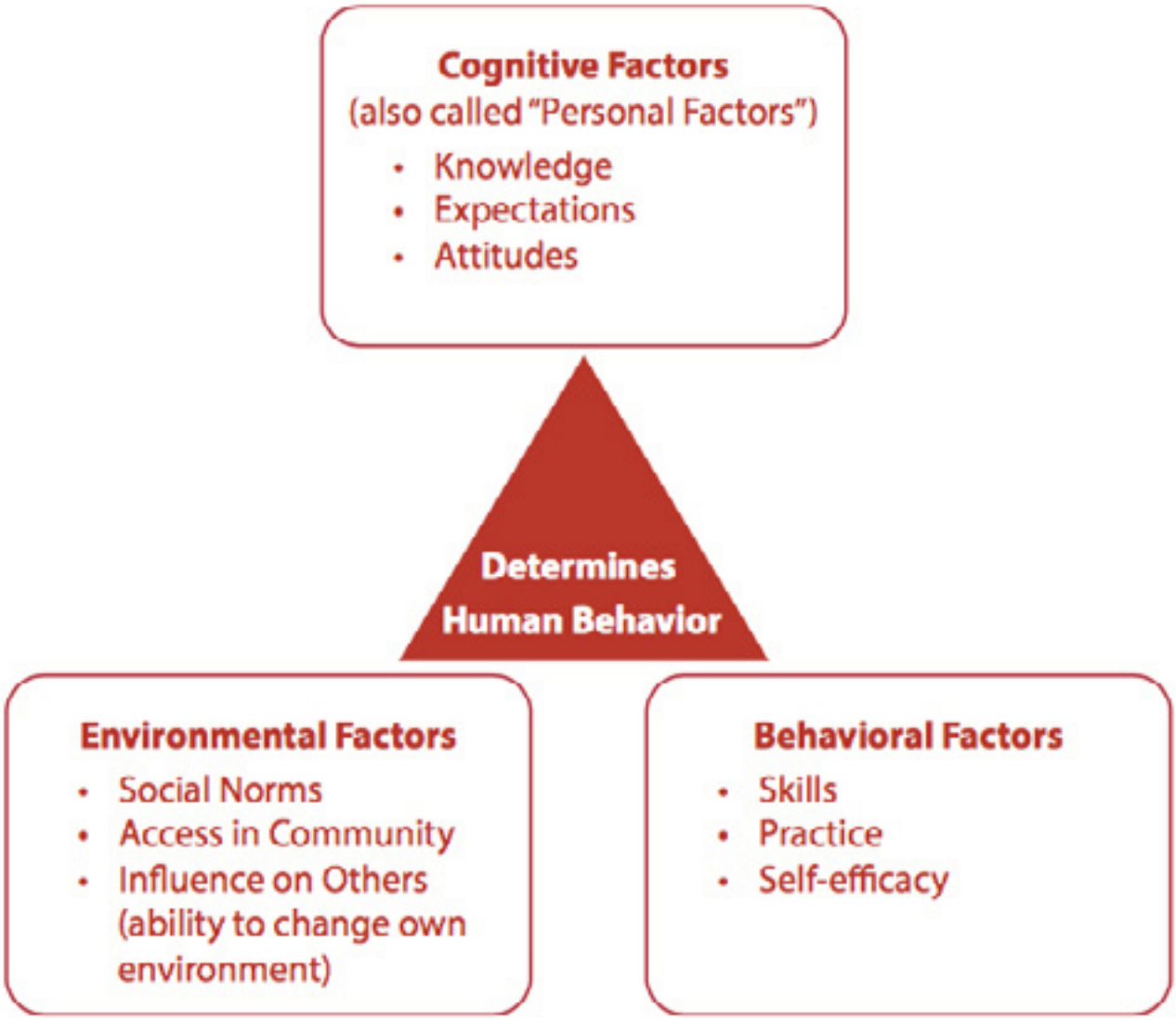
Source: Kincaid, 2004

- As long as a minority maintains its **majority status** within its own, locally bounded portion of the network, then it can survive, recruit converts in the near surround, and establish its behavior as the norm for the network as whole.

- The process is accelerated when the minority subgroup is **centrally located** in the network and communicates more **frequently** and **persuasively** than the majority.

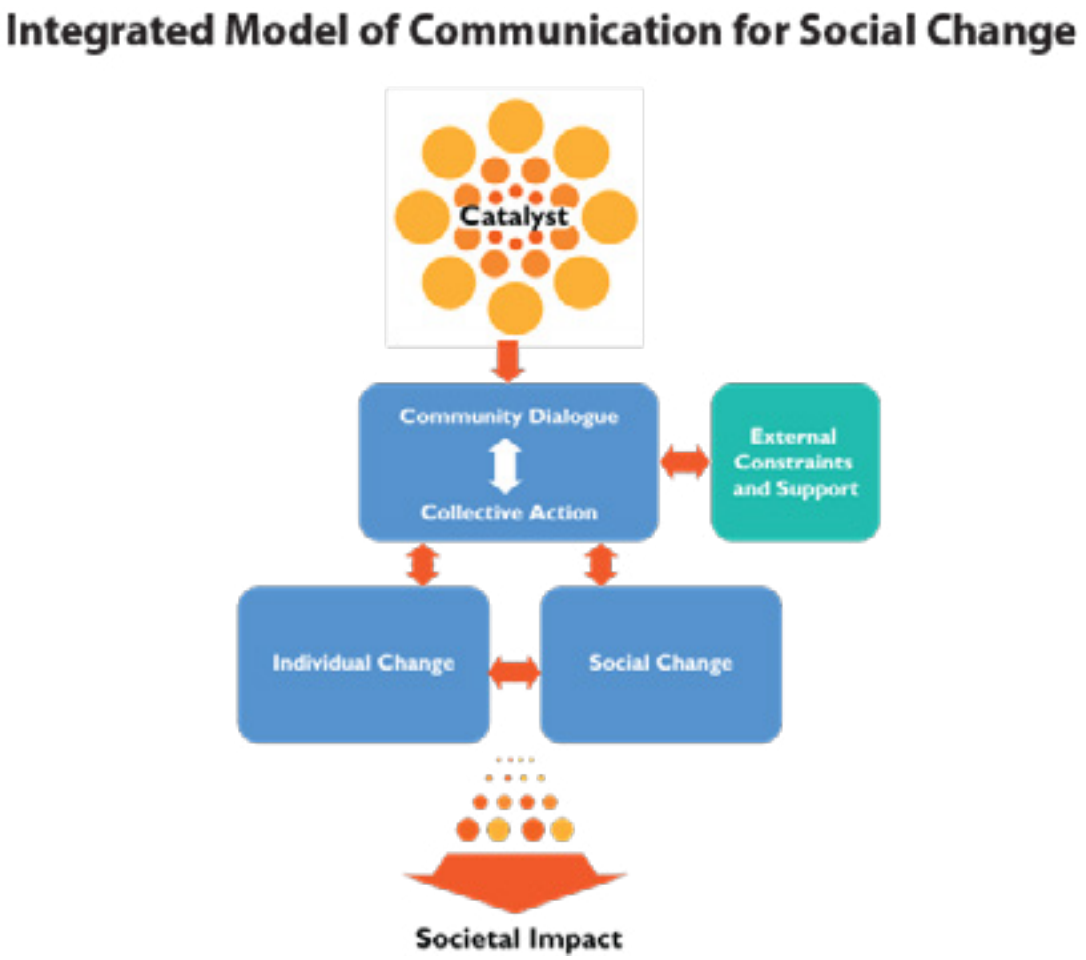
ANNEX E: SOCIAL LEARNING THEORY

Social Learning Theory offers a narrative lens and behavioral modeling, which lends itself well to multiple topics. With the premise that people learn through observing the behaviors, attitudes and behavioral outcomes of those that are similar to themselves. The fundamental concepts of social learning theory are modeling, efficacy, and parasocial interaction. Modeling shows someone performing the desired behavior, efficacy describes a feeling of personal empowerment or confidence in one's ability to perform that behavior, and parasocial interaction takes place when people begin to identify with and think of fictional characters as if they were real people.



ANNEX F: COMMUNICATION FOR SOCIAL CHANGE

Communication for Social Change (C4SC) is an iterative process where "community dialogue" and "collective action" work together to produce social change in a community to improve the health and welfare of all its members. In other words, this model is a dynamic, iterative process that starts with a "catalyst/stimulus" that can be external or internal to the community. This catalyst leads to dialogue within the community that when effective, leads to collective action and the resolution of a common problem. The model also postulates that every time a community goes through the dialogue and collective-action processes to achieve a set of shared objectives, its potential to cooperate effectively in the future also increases. Likewise, after each problem-solving process is completed, all of the outcomes of social change specified by the CFSC model will be strengthened.



ANNEX G: THEORY OF PLANNED BEHAVIOR

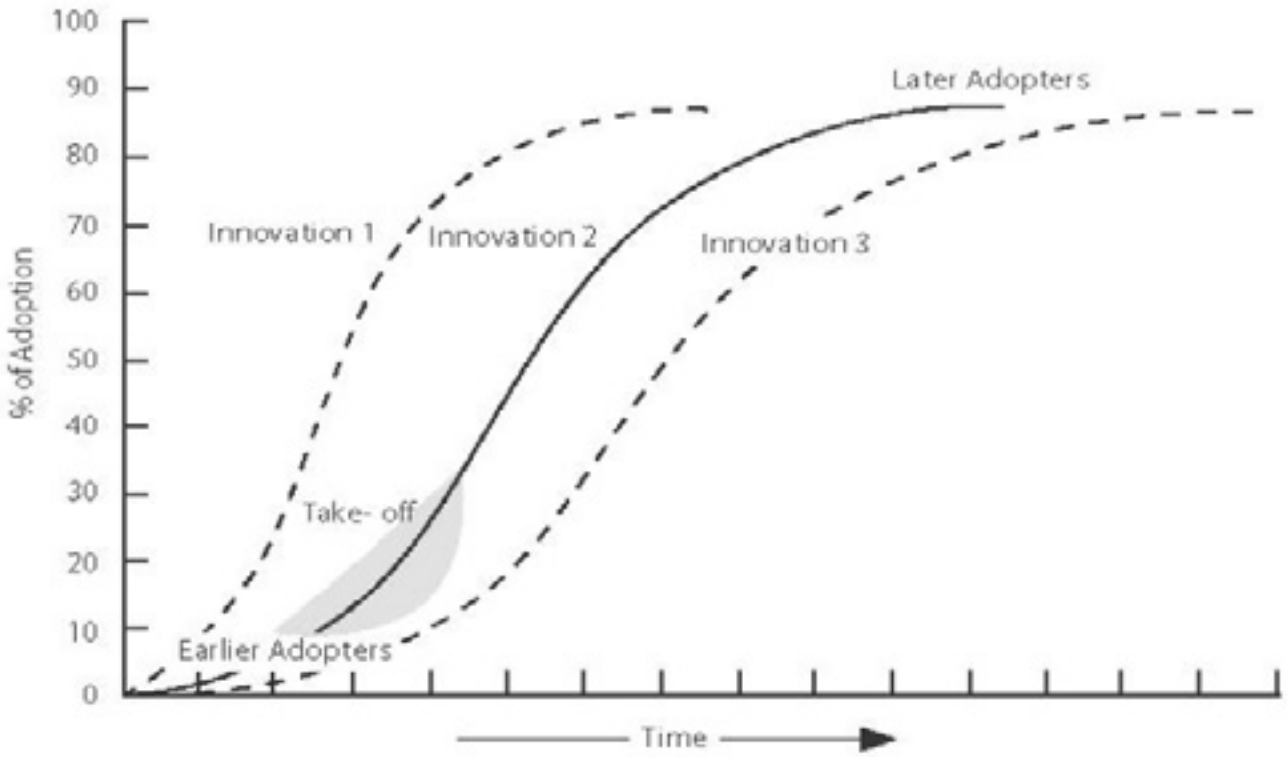
The Theory of Planned Behavior considers three types of beliefs that tend to guide human behavior:

1. Behavioral beliefs, which consider the positive and negative outcomes of the decision
2. Normative beliefs, which result in perceived social pressure or subjective norms
3. Control beliefs, which help determine self-efficacy, or confidence in one's ability to perform the behavior

When combined, the three types of beliefs result in the formation of an intention to engage in the behavior (or not). This theory may work well when your goal is to create logical linkages between different topics and behaviors (Source: HC3, 2014).

ANNEX H: DIFFUSION OF INNOVATIONS

Diffusion of Innovations (DOI) helps explain and predict factors that influence the adoption of innovations such as products, services or ideas over time. Successful innovations typically spread from a few innovators and early adopters to the rest of the population – early majority, late majority and laggards. Understanding the characteristics of each of these types of adopters can help you apply different strategies to each segment. DOI might be useful for rapid behavior change, especially when used with Social Network Analysis (SNA) or the Positive Deviance Approach (PDA). SNA provides a visual and mathematical analysis of human relationships, showing where there are clusters or groupings in a network, who is in the core of the network, who is on the periphery and who takes on various roles (e.g., connectors, mavens, leaders, bridges and isolates). PDA, on the other hand, identifies people or groups whose "special or uncommon behaviors or strategies enable him/her/them to overcome a problem without special resources and facing similar barriers and challenges as their peers."

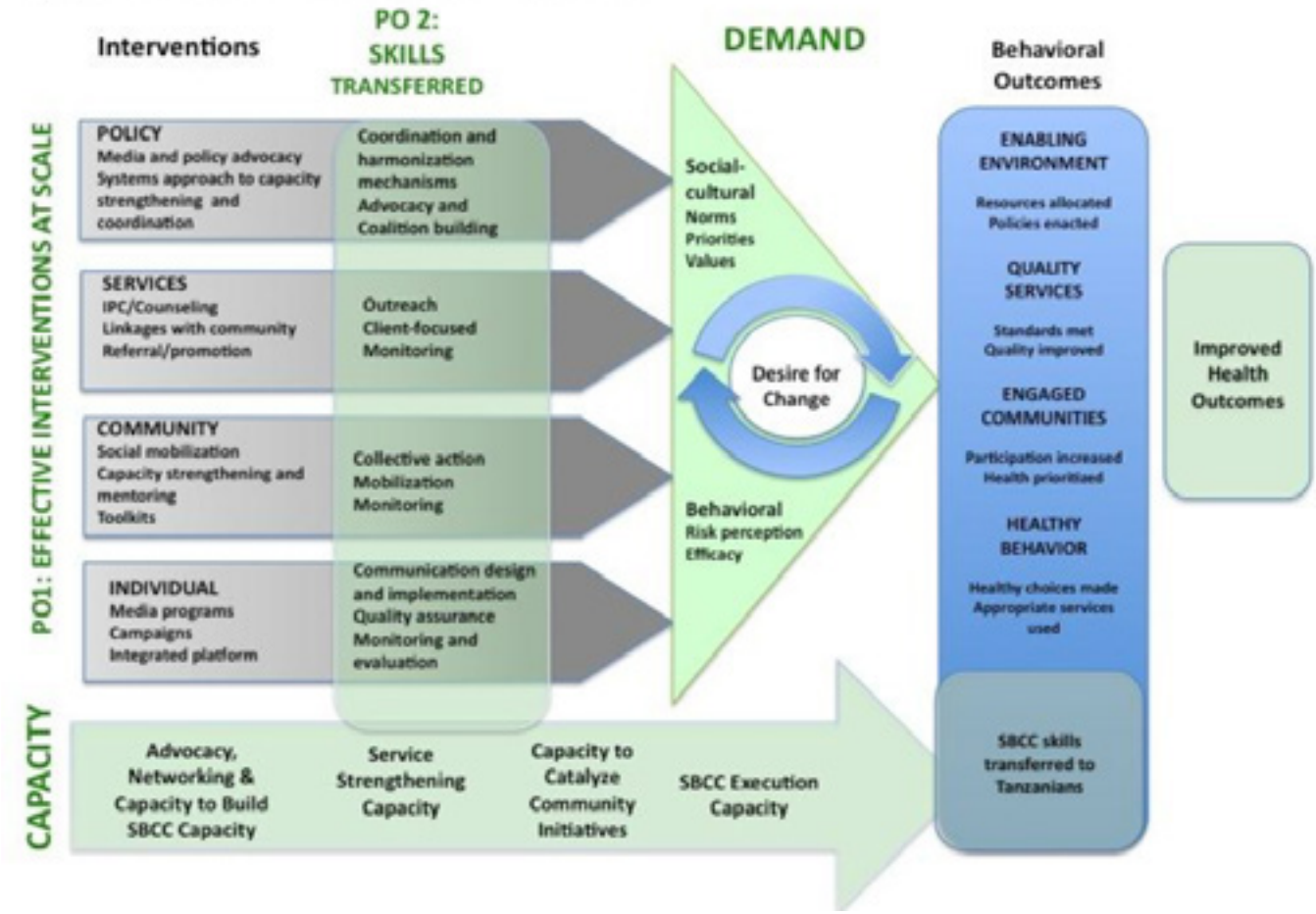


ANNEX I: CUSTOMIZED

Other programs have combined theories or developed their own, based, for example, on how bringing the different topics/behaviors together should lead to greater overall change.

Example: One example of this is the TCCP Integrated Change Model. Central to the model was the belief that creating desire for change across all levels of society is at the heart of real progress. Multi-level communication strategies and interventions operated at the policy, community, family and individual levels. The model posited that, together, the interventions would catalyze demand by shifting perceptions of risk and efficacy at the individual behavioral level and norms and priorities at the socio-political and cultural levels.

Figure 1: TCCP INTEGRATED CHANGE MODEL



ANNEX J

WORKSHEET 1: Stakeholder Identification for Integrated SBCC Programs

Partner Category	Name	Contact Information
Ministries, divisions within each Ministry, and other government bodies		
Donors and funding agencies		
Multi-sectoral bodies		
Non-governmental organizations, civil society organizations, and faith-based organizations		
Health service delivery partners		
SBCC, demand creation, and social marketing partners		
Systems strengthening partners		

ANNEX J

Partner Category	Name	Contact Information
Universities		
Media, technology, telecommunication or other communication organizations		
Other		

ANNEX K

WORKSHEET 2: Integrated SBCC Program Stakeholder Interview Guide

Institution/Organization: _____

Interviewee Name: _____ Phone number: _____

Email address: _____

This interview guide is meant to be all encompassing, and can be adapted for use with government, donors, and implementing partners by selecting the relevant questions for each.

Basic Information

1. What are the goals and objectives of your institution/project?
2. What are your intervention topics?
3. What are your geographic areas of operation? Do you have any zonal, regional, or other sub-national offices or staff?
4. Who are your target audiences?
5. What local organizations are you working with on the ground, if any?
6. When is your fiscal year? If a time-bound initiative, when did your project start? When does it end?
7. How is your institution staffed? Do you have individuals responsible for individual topical areas (e.g. HIV, malaria, family planning)? SBCC skill areas (e.g. mass media, community engagement)? Both?

SBCC

8. What is your organization's understanding of and experience with social and behavior change communication?
9. How important do you feel SBCC is to your program?
10. What is the level of support for SBCC in your institution?
11. What SBCC strategies and approaches have you used in your institution, if any?
12. What SBCC channels and activities have you used, if any?
13. What do you feel are your institution's SBCC strengths?
14. Where might you need SBCC capacity strengthening?

Integration

15. What is your understanding of integrated SBCC, and what it is meant to do in the context of this initiative?
16. To what extent do the various divisions within your institution support an integrated SBCC approach? Where do you see the biggest resistance? Why?
17. Please describe your previous experience with integrated programs, if any.
18. How do you feel your institution might benefit from SBCC integration?
19. What can your institution contribute to the SBCC integration effort?
20. What concerns do you have about SBCC integration?
21. What topics do you feel should be prioritized in the integration? Why? How flexible are you in this prioritization?
22. How do you envision the integration process taking place?
23. What are the working relationships like between the funding agency and the government? Between each of those and the implementing partners?

ANNEX K

RM&E

24. What indicators are reported on for each of your topics?
25. How is this data collected (e.g. paper-based, SMS, database)?
26. What is your timeframe for reporting?
27. What monitoring and evaluation systems are already in place?
28. How amenable are your reporting systems to change?

Resources

29. What are the funding levels available for integrated SBCC?
30. What are the sources of funding, and what are the requirements and expectations of the donor for its use?
31. What non-financial resources can your institution contribute to this initiative?
32. How well are your existing financial tracking systems able to handle integration?

ANNEX L

WORKSHEET 3A: Stakeholder Capacity Matrix

List your stakeholders in the left-hand column. Rank them as low, medium, or high on each of the following criteria to better understand potential areas in need of advocacy or capacity strengthening.

Stakeholder Name	Understanding of and Support for SBCC	SBCC Programmatic and/or Research Capacity	Understanding of and Support for Integration	Level of Experience with Integrated Programs	Health Area Expertise	Resources Available for SBCC Integration

Based on this information:

1. Which organizations will you need to do more advocacy with? In which areas?
2. Which organizations will need capacity strengthening? In which areas?
3. Are there certain stakeholders that could mentor or be paired with other stakeholders?

ANNEX M

WORKSHEET 3B: Implementing Stakeholder Matrix

List your stakeholders that are currently implementing projects in the left-hand column. Fill in the following information for each stakeholder in order to obtain a comprehensive overview of potential synergies, overlaps, and gaps among existing projects.

Stakeholder Name	Project Start Date	Project End Date	Fiscal Year	Topic Areas	Target Audiences	Geographic Areas of Operation	Local Partners	Key Indicators

ANNEX N

WORKSHEET 3C: Stakeholder Analysis: Overlap, Synergies, and Gaps

What is the **process** by which the various stakeholders expect the integration to take place?	
Which **topic areas** are addressed by multiple stakeholders? Are there any important areas not currently addressed?	
Where are there areas of overlap in **target audiences** between stakeholders? Are there any important audiences that are not currently addressed?	
Which **geographic areas** are saturated? Are there any geographic areas important for the integrated SBCC that are not currently addressed?	
What are other areas of **overlap** between stakeholders? How might they be reduced?	
What existing **synergies** can be taken advantage of?	
What are the similarities and differences in **indicators and reporting mechanisms**?	
What **competing demands or agendas** of stakeholders might complicate the integration process?	
What **resources** are available for the integration?	
What **gaps** exist and need to be addressed?	
Based on this information, what are the **highest priorities** for a successful integrated SBCC program?	

ANNEX O

WORKSHEET 4: Environmental Analysis

Fill in what you know about the current situation for each environmental factor in the first column, using the questions in the I-Kit to guide you. Consider the implications of these findings for your integrated program in the second column.

	Current Situation	Program Implications
National Level Documents for SBCC Integration		
Extent of Current Integration		
National Level SBCC Coordinating Bodies		
Decentralized Human Resources Available for SBCC		
Extent of Service Availability and Integration		

ANNEX O

	Current Situation	Program Implications
Health Provider Capacity to Integrate		
Presence and Roles of CHWs		
Existing Referral Mechanisms		
Existing Adaptable Media		

GLOSSARY

Appreciative inquiry: "[A] group process that inquires into, identifies and further develops the best of 'what is' in organizations in order to create a better future. Often used in the organization development field as an approach to large-scale change, it is a means for addressing issues, challenges, changes and concerns of an organization in ways that build on the successful, effective and energizing experiences of its members." (Preskill & Catsambas, 2006)

Behavior: What is meant by behavior in this I-Kit? A behavior is an action on the part of the audience that the project will attempt to influence, such as newly married couples adopting a method of family planning.

Clustered behaviors: Health-related behaviors that influence each other in a collective fashion, instead of acting independently on one's health (e.g. diet, physical activity and sedentary behavior, or alcohol consumption, cigarette smoking and unhealthy nutritional habits).

Collaboration: Joint planning, with some implementation of activities carried out together.

Co-location: Multiple sectors offer programming to the same geographic area. Programs may or may not be coordinated and work with the same target audience or participants.

Concurrent programming: Programs on different topics that are implemented at the same time, but with no intentional unification between topics.

Coordination: Joint planning between different programs to harmonize interventions. Implementation of the programs remains separate.

Coordination mechanisms: Refers to the collection of bodies or processes used to coordinate the project. The bodies may include the various groups such as the coordinating body, task forces or working groups. The processes refer to regularly established meetings, alignment of systems and forms of communication that support coordination.

Cross-training: Program staff receive basic training in the additional topics or sectors, enabling them to include and offer complementary information.

Gateway behavior: A positive health behavior or facilitating factor that may trigger or facilitate other positive health behaviors, both simultaneously and across the family life cycle (e.g., getting women to attend ANC can then lead to malaria intermittent preventive treatment in pregnancy (IPTp) uptake, HIV testing, birth planning and other healthy behaviors).

Integrated service delivery: The World Health Organization (WHO) defines integrated service delivery as "the management and delivery of health services so that clients receive a continuum of preventive and curative services, according to their needs over time and across different levels of the health system" (WHO, 2008).

Message harmonization: The process of reviewing existing or proposed messages to ensure consistency in meaning and content. Message harmonization helps ensure that all messages given by all partners recommend the same action, do not provide conflicting technical information and use similar terms and language.

Ripple-effect mapping: "Uses elements of appreciative inquiry, mind mapping and qualitative data analysis to engage individuals to map the intended and unintended changes a program targets." (Hansen Kollock et al, 2012)

Stakeholders: Stakeholders are people with an interest or concern in your integrated SBCC initiative. Stakeholders can affect or be affected by the program (BusinessDictionary, 2017).

Topic: What is meant by topic in this I-Kit? Topic relates to the overall health or development problem the project seeks to remedy, such as high birth rates among young unmarried women or malaria incidence in children under age five.

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