# DESIGNING SBCC FOR HEALTH SERVICES



Whether service communication is implemented by a service delivery partner directly or through coordination with an SBCC partner, understanding better communication practices is important for ensuring better behavioral and health outcomes. For service delivery partners collaborating with SBCC partners, understanding these principles will foster better consistency between communication and service delivery, more realistic expectations for planning and timelines, and improved coordination overall. For service delivery partners directly implementing SBCC, understanding and applying these key principles is essential for producing high-quality communication outputs and improving program quality.

The types of communication activities you design will depend on the needs that exist along the continuum of care. For example:

- For needs in the *before* stage, you might design demand generation and outreach, normative change, or provider trust activities.
- For needs in the *during* stage, you might design counseling, provider behavior change, clinic environment, or client empowerment activities.

- For needs in the *after* stage, you might design peer support, outreach, or follow-up activities.

All of these activities will be part of your larger service delivery efforts and linked to the same overarching behavioral and health outcomes.

Each organization will have its own design process. The SBCC field has a number of strategic approaches, frameworks, and guidelines for designing effective campaigns and activities. Some examples can be found in **Appendix N: Resources**. Since most service delivery partners are not designing full SBCC programs, this section of the I-Kit provides specific tools and techniques to address some of the most common challenges organizations face in integrating SBCC across the continuum of care.

The table below summarizes some of the key challenges service delivery projects face, potential service communication solutions, and the skills necessary to delivery those solutions.

In Burkina Faso, the RESPOND project addressed barriers to contraceptive choice across three districts through a holistic design approach. To improve the supply of services, the project trained providers and supervisors, held special service days and helped the MOH adopt the REDI counseling curriculum and the facilitative supervision approach. To create an enabling environment, RESPOND assisted the MOH to update its FP registers and orient providers on how to complete them. In addition, the MOH used Reality Check to estimate contraceptive needs, costs, and the resulting health impact for the National Plan for Repositioning FP. To improve demand for FP, the project held community-based FP talks and theater; radio shows, spots and advertisements (linked to special FP service days); and nationally disseminated client testimonial videos. As a result, the number of public facilities that could offer implant and the IUD increased from eight to 25 and from two to 26, respectively. IUD insertions in public facilities increased nearly 14-fold, and implant insertions rose 27%.

**Read more**: http://www.respond-project.org/archive/files/5/5.2/5.2.1/Brief27-2014-Holistic-Approach.pdf

| CHALLENGE | POTENTIAL SERVICE COMMUNICATION SOLUTIONS | REQUIRED SERVICE COMMUNICATION SKILLS |
|---|---|---|
| Getting clients to services | <ul><li>Strategically segment audiences</li><li>Seek to understand clients and what matters to them</li><li>Design activities based on an understanding of what motivates client behavior</li><li>Address provider bias and how providers treat clients</li><li>Tailor messages to different audiences</li><li>Address underlying norms and attitudes</li></ul> | <ul><li>Audience analysis, including effective segmentation, prioritization, and profiling</li><li>Identifying and selecting the most relevant determinants of behavior change</li><li>Addressing providers as an audience for behavior change</li><li>Designing and tailoring messages for different audiences</li><li>Community outreach and mobilization</li></ul> |
| Helping clients adopt desired behaviors and use products | <ul><li>Strategically segment audiences</li><li>Seek to understand clients and what matters to them</li><li>Offer clear benefits for adopting behaviors and using products, based on what the clients care about</li><li>Address provider bias and how providers treat clients</li><li>Design activities that address the true determinants of behavior</li><li>Foster support systems</li><li>Design activities that address the true determinants of behavior</li><li>Seek to understand clients and what matters to them</li></ul> | <ul><li>Audience analysis</li><li>Determining key benefits</li><li>Addressing providers as an audience for behavior change</li><li>Identifying and selecting the most relevant determinants of behavior change</li></ul> |

| | | |
|---|---|---|
| Helping clients maintain desired behaviors and adhere to treatment regimens | • Foster support systems<br>• Design activities that address the true determinants of behavior<br>• Seek to understand clients and what matters to them | • Community mobilization<br>• Identifying and selecting the most relevant determinants of behavior change<br>• Audience analysis |
| Reaching the desired audience with messages | • Tailor messages to different audiences, based on a clear understanding of the audience<br>• Use appropriate communication channels | • Designing and tailoring messages for different audiences<br>• Selecting an appropriate channel mix based on communication landscape and audience preferences |
| Getting the audience to respond to communication efforts | • Seek to understand clients and what matters to them<br>• Tailor messages to different audiences, based on a clear understanding of the audience<br>• Offer clear benefits for adopting behaviors and using products, based on what the clients care about<br>• Use appropriate communication channels | • Audience analysis<br>• Designing and tailoring messages for different audiences<br>• Determining key benefits<br>• Selecting an appropriate channel mix based on communication landscape and audience preferences |
| Achieving positive client-provider interactions | • Address provider bias and how providers treat clients<br>• Create counseling and job aids<br>• Improve the work environment<br>• Empower clients | • Address providers as an audience for behavior change<br>• Materials development |

Based on these challenges and solutions, this I-Kit will provide step-by-step guidance on four areas:

1. Audience Analysis
2. Understanding the Determinants of Behavior Change
3. Tailoring Messages and Aligning with Communication Channels
4. Addressing Providers as a Behavior Change Audience

# Audience Analysis

## Segmenting, Prioritizing and Profiling Key Audiences



For service communication activities to be successful, you must segment your audiences into similar groups and gain a deep understanding of those audiences. This is the first step you will take before designing or implementing any activities. You will select the **primary** and **secondary audiences** you need to work with to achieve your goals.

The **primary audience** is the individual or individuals who are directly affected and whom the program wants to practice the desired behavior (for example, women of reproductive age, urban youth, male heads of household). Primary audiences may also be the people who can make decisions on behalf of those who would benefit from the behavior (for example, caregivers of children under 5). The **secondary audience** – individuals who exert influence – are people who can guide behaviors of the primary audience (for example, spouses, parents, peers and coworkers). Secondary audiences can also include people who shape norms, influence policies or affect how people think about the behavior (for example, the media, traditional leaders and local opinion leaders).

The intended audience for services could include a number of different types of individuals, and may differ throughout the three stages of service delivery. For example:

- **Before:** When seeking to increase demand for HIV testing, the audience may include female sex workers in urban areas.

- **During:** Providers may be the intended audience for behavior change to motivate them to provide high-quality counseling on informed choice.

- **After:** The client and the client's peers may comprise the intended audience, with the objective of helping the client maintain consistent use of family planning methods and encourage social support.

This section walks through **audience analysis –** the step-by-step process for understanding the intended audience.

## Why Is Audience Analysis Important to Service Communication?

An audience analysis helps establish a detailed and realistic picture of the audience. A good audience analysis ensures that messages and activities realistically reflect and address the audience's values, desires and barriers to change. Messages informed by this analysis are more likely to resonate with the audience, leading to the desired behavior change and better outcomes. Audience analysis should be conducted at the beginning of the program, before any communication activities are developed.

To some extent, **audience analysis** is similar to something that is done regularly in service delivery programs. For example, in developing a training program to build clinical skills, many programs assess providers' existing capacity to determine training needs. This assessment often identifies categories of providers, based on their current skills and knowledge. The results of the assessment help ensure that training and capacity building resources are allocated based on need. A similar principle applies for audience analyses for service communication.
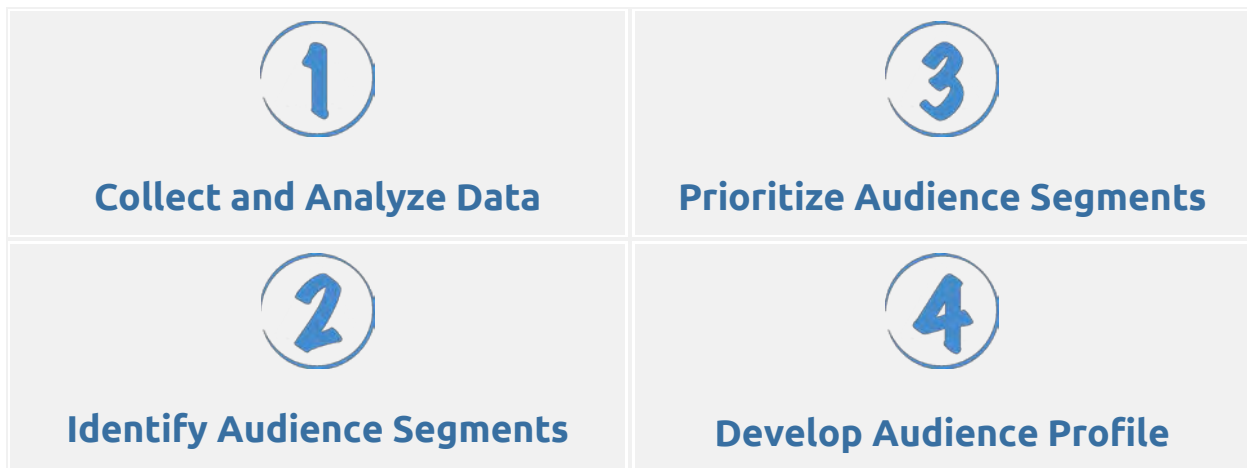
## What Is the Audience Analysis Process?

An audience analysis is a multi-step process that begins with data and results in a description of the intended audience summarized in an "audience profile." The audience analysis process typically identifies a primary audience (the individuals whose behavior the program seeks to motivate) and the secondary or influencing audience (the individuals who have influence over the primary audience in whether

they are able to adopt and maintain new behaviors). For example, a program seeking to increase uptake of adolescent reproductive health services may determine that there are a limited number of high-quality clinical services dedicated to adolescents. The program identifies young people ages 10-18 as the primary audience. It also identifies different influencing audiences for each stage.

As a result, communication during the *before services* stage will concentrate on advocacy to *influence* policymakers or leaders in the Reproductive Health Division of the Ministry of Health who can allocate more resources for adolescent health services. In the *during* stage, the program will train service providers to improving counseling techniques for adolescent clients and providers, and in the *after* stage, the program may focus community mobilization on the peers or parents who enable adolescents to maintain positive reproductive health behaviors.

The audience analysis process has four main steps:

| | |
|---|---|
| **(1)** **Collect and Analyze Data** | **(3)** **Prioritize Audience Segments** |
| **(2)** **Identify Audience Segments** | **(4)** **Develop Audience Profile** |

## 1. Collect and Analyze Data and Insights About Potential Audiences

The first step in an audience analysis is data gathering. This can be done by reviewing past experiences, conducting research or analyzing secondary data. Information that is typically gathered to inform the audience analysis includes the following:

- **Demographic characteristics** – Sex, age, language, religion, income levels; where the audience lives, where they work, proximity to services

- **Psychographic characteristics** – Emotional needs (for example, to be respected, to feel valued); hopes, concerns and aspirations; thoughts; beliefs; knowledge; and actions related to the health issue or service

- **Preferred media** – Where does the audience prefer to get health or health service information? What sources do they trust and consider reliable?

- **Other opportunities to reach the audience** – Are there events, groups the audience belongs to or other occasions that the audience considers a credible and preferred source of information?

- **Current behaviors related to the targeted behavior** – Do they currently access the targeted service or not? Do they talk to their spouse/partner about the service?

- **Barriers to improved behavior** – What limits their ability to adopt the service or maintain the behavior (for example, lack of transportation, low ability to pay, lack of awareness, lack of knowledge, negative attitudes, low risk perception, lack of time)?

- **Facilitators of improved behavior** – What things encourage or help facilitate the audience to adopt the desired behavior change (for example, skills, motivations, awareness, positive norms)?

- **Gender's impact on individual behavior and on a person's ability to change** (for example, women are not allowed to spend much time out of the home, which limits their ability to get to health clinic)

Capture this information in the Audience Characteristics and Behavioral Factors Template in Appendix A.

In addition to gathering information directly about the audiences, it can also be useful to gather insight about their experience with services – particularly if the service communication strategy is to create demand or sustained use of an existing service. This information will provide important additional insights into the audience's needs.

Every health service has "touch points," or occasions when the consumer comes in contact with the clinical service. These contacts happen throughout the three

stages of service delivery. Clients begin interacting with the service *before* they even enter the facility. Radio spots, call-center interactions, promotional billboards or interactions with outreach workers may all be touch points for the service. Once a client enters the facility, the waiting room, the admission staff, and the clinical counseling room all become touch points *during* service delivery. And *after* a client leaves the clinic, they may interact with peer educators, call-center support staff, community referral points, and more media. All of these touch points combine to create an image and an experience for the client, which may be positive or negative.

To gather this information, it may be helpful to conduct a **touch point analysis**. The inputs for this analysis may include observations of the clinic and routine services, client feedback, mystery client visits, quality assurance and/or quality improvement visits.

This information can be combined in a **Client Journey worksheet** (Appendix B) as part of the **audience analysis**. The worksheet can be completed in the following manner:

1. **Touch points:** List the different moments at which the client may come in contact with the existing service or information about the service, including promotional billboards, a website, referral points, a call center.

2. **Expectation:** List the standards for quality and/or what the client should expect to see and experience at each touch point. For example, billboards should be attractive and present clear information about the service and where it is available; waiting rooms should be clean and orderly; the provider must meet quality standards for counseling procedures and provides correct information; and counseling materials should be well maintained and informative.

3. **Observation:** Indicate what was actually observed and any feedback received, if this information was gathered from clients (for example, outdoor media is faded and illegible; key messages are unclear; counselors did or did not answer client questions).

| TOUCH POINT | EXPECTATION | OBSERVATION |
|---|---|---|
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

For complete step-by-step guidance on how to gather and analyze audience data, see **How to Do an Audience Analysis** (http://www.thehealthcompass.org/how-to-guides/how-do-audience-analysis).

Condoms for the every girl | The pill for Ms Perfection | The injection for Girl on the Go | The implant for Ms Ambition | The IUD for the Supergirl

## Divine Divas

In Zambia, MSI and IDEO did in-depth client research before developing their concept and materials. The project's primary audience was teenage girls, with the aim of encouraging them to use family planning. The project team spent lots of time with adolescents, seeking to understand their cares, barriers to seeking services, what they like to do, and what inspires them. Some of their findings included:

- Adolescent boys want to date "divas"

- Contraception is usually talked about in clinical terms that adolescents find confusing

- Teenage girls feel more comfortable talking about sex and contraception in fun, social settings

- Teenage girls have ambitions for the future and are concerned about unplanned pregnancy

The result was the creation of the Divine Divas concept – five cartoon characters that represent different contraceptive methods. The Divas bring the methods to life in terms teenage girls can understand and connect with the teens' self-visions and aspirations for the future. These Divas are at the center of all the communication materials. The project also created Diva Centres where the teenage girls can come paint their nails and discuss sex and contraception in a relaxed setting and access services. **Read more about the Divas** (https://designtoimprovelife.dk/divine-divas-beauty-and-brains-pop-up-salon-educates-african-teens-about-reproductive-health/).

## 2. Identify Audience Segments

After information has been gathered about the different audience types, summarize the audiences into broad categories. To identify each audience category, consider one key criterion that distinguishes these groups. The example below describes potential audience categories for a family planning intervention. Each category is described using one distinguishing characteristic that makes it relevant using a 'because they' statement.

| **Women** | **Men** |
|---|---|
| Because they do not access family planning due to a fear of side effects. | Because they control financial decisions in the household and don't understand benefits of family planning. |
| **Policymakers** | **Health Care Providers** |
| Because there is no budget at the national level for family planning commodities. | Because they believe young unmarried women should not access family planning. |

The next step is to identify audience "segments" within each broad category. Segments are smaller groups of individuals with similar characteristics. Because people respond differently to SBCC messages and interventions, segmentation focuses service communication efforts, allowing implementers to hone messages and use the most appropriate channels.

Review the information from your completed Audience Characteristics and Behavioral Factors Template (Appendix A), looking for smaller groups with similar behaviors to identify smaller groups with similar behaviors, needs, values and/or characteristics from the larger audience. For example, the exercise will reveal similarities among female health providers who work in rural areas or urban males aged 15–19.

Audience segmentation should first identify the criteria for dividing the larger audience. This requires studying the audience and identifying the traits that different sub-groups share. A significant difference is one that requires a different

message or approach and could be defined by socio-demographic, geographic, behavioral and/or psychographic characteristics. For example, men who are the intended audience for a family planning intervention are a larger audience category but within that group are a number of segments which might be defined by: age (i.e., 25-44); marital status; location (i.e., men living in urban or rural settings); education (i.e., men with a secondary education); stage of readiness (i.e., men who may be more ready to adopt FP because they have heard of family planning or are not limited by cultural norms). Analyzing the data will help to understand which of these criteria distinguishes one group from the others.

Based on what you found during your review of the **Audience Characteristics and Behavioral Factors Template** (Appendix A), identify potential segments using the **Segmentation Table** (Appendix C). The table below provides some examples of characteristics that could help identify smaller audience segments.

## Examples of Audience Segments:

| AUDIENCE | POTENTIAL SEGMENTS |
|---|---|
| Women of reproductive age | ▪ Married, rural women ages 30-40 who are worried about side effects<br>▪ Female, urban, single university students aged 18–30 |
| Adolescents | ▪ Unmarried girls aged 15–19 living in rural areas, in school<br>▪ Unmarried girls in urban areas, aged 20–24, out of school |
| Male youth | ▪ Urban males, ages 15-19, who want to be seen as fearless and care about status<br>▪ Rural males, ages 15-19, in school, currently not using condoms in casual sexual encounters |
| Health providers in rural areas | ▪ Clinical officers in rural areas with less than 5 years of experience<br>▪ Female, community health workers, more than 5 years' experience |

Use the **Checklist to Assess Proposed Segments** (Appendix D) to determine whether a group represents a distinct audience segment.

*Source: Health Communication Capacity Collaborative – How to Do Audience Segmentation (http://www.thehealthcompass.org/how-to-guides/how-do-audience-segmentation)*

EXAMPLE: TRADITIONAL AUTONOMISTS

GUIDING PRINCIPLES

**Behavior Change Objectives:**
Consistent and effective use of traditional methods
Increased trial of modern methods, over time

**Considerations:**
- This woman dislikes feeling like ideas are being pushed on her
- She prefers traditional methods, esp. breastfeeding, and needs support in this
- Her husband's opinion is very important to her. He should be included in decision-making around FP, if possible

PROGRAMMING & FUNDING CONSIDERATIONS

**Most relevant existing programs:**
Mobile clinics ✓ CBD and Education
Youth Outreach Other
✓ Husband Outreach

MESSAGING CONCEPT

"FP is a decision that you and your husband make together, and that's the way it should be. Healthcare workers can help you understand your current approach better or discuss new methods, but the choice is up to you."

In Niger, the Camber Collective conducted audience research that led to innovative audience segmentation for family planning programming. Given the need for behavior change, they used attitudinal and behavioral variables rather than traditional demographic and psychographic variables to segment the audience. Specifically, they looked at use behaviors, proactivity, social norms, contraceptive specific behaviors, and attitudes and beliefs. Using these key variables led to the creation of five distinct segments: Modern Elites, Healthy Proactives, Traditional Autonomists, Conservative Passives, and Sheltered Skeptics.

These segments were used to design distinct behavioral objectives, messages, benefit statements, and materials for each group.

*Source: Camber Collective's ICFP Presentation January 2016 (http://static1.squarespace.com/static/55723b6be4b05ed81f077108/t/56a8e5aa25981d0625a512f2/1453909419778/CamberCollective_ICFP-Presentation_20160126.pdf)*

**Read more** about the research and the segmentation process. (https://static1.squarespace.com/static/55723b6be4b05ed81f077108/t/566712fe05f8e2d4918a0acf/1449595646623/Niger+FP_Project+Recapitulation.pdf)

## 3. Prioritize Audience Segments

Available resources and program goals often drive decisions about a communication intervention's reach. By prioritizing audience segments, communication can focus on the segments that can have the most impact on service delivery objectives or can estimate the resources needed to reach a particular segment.

The following are some questions to help prioritize audience segments:

- How much impact does this segment have on the overall program objectives? (How big is the segment? To what extent do they contribute to the health problem at hand?)
- How easy are they to reach?
- Are sub-populations marginalized socially due to ethnicity, language, or other forms of exclusion? (Reducing service inequity may be an important goal.)
- How ready are they for behavior change? To achieve "quick wins," consider prioritizing those that are more ready to adopt new behaviors.

A similar process can be used for the secondary (influencing) audience.

See Appendix E for the [Influencing Audience Template](#) to summarize this information.

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**NOTE: IDENTIFYING INFLUENCING AUDIENCES**

Individuals who influence the primary audience's behavior are the secondary, "influencing" audience. They can be identified by posing questions such as:

Are there groups or individuals who have considerable influence over the behavior of the primary audience?

How do they exert that influence?

What are the benefits to the audience for participating in this program?

Can the program address the barriers to involving them?

What do we know about their current knowledge, attitude, and behavior regarding the health or service issue? What insights are we missing?

Also make sure to consider each of the stages of service delivery. Are there different influencers *before*, *during*, and *after* service delivery? If so, you will need to prioritize which influencers to focus on first.

*Source Health Communication Capacity Collaborative – How To Conduct an Audience Analysis (http://www.thehealthcompass.org/how-to-guides/how-do-audience-analysis)*

For more complete step-by step guidance on how to segment and prioritize an audience, go here: **How to Do Audience Segmentation** (http://www.thehealthcompass.org/how-to-guides/how-do-audience-segmentation)

**KEY AUDIENCES**

In service communication, health providers can be the primary audience. Provider audiences can include doctors, clinical officers, nurses, community health workers, pharmacists and sometimes facility support staff. When providers are the primary audience, we seek to influence their behavior (for example, to improve clinical counseling, change stigmatizing behavior, adopt more friendly attitudes).

See the **Provider Behavior Change** section (http://sbccimplementationkits.org/service-communication/lessons/addressing-providers-as-a-behavior-change-audience/) for more information on providers as an audience for behavior change.

## 4. Develop an Audience Profile

An audience profile helps describe a member of the audience as a "typical person" representing the audience segment. An audience profile can be developed for all prioritized audiences – primary and influencing. To develop the profile, review the data collected about the prioritized segment and summarize what is known about them. This summary profile should include the following information:

- Demographic information, such as geographic location, gender, age, number of children, marital status
- Current values and beliefs
- Current behavior as it relates to the targeted behavior and health area
- Known barriers and facilitators that help or prevent adoption and/or maintenance of the desired behavior
- Psychographics and any other key insights about the audience gathered during the analysis phase, such as aspirations, desires for the future, fears or concerns

- Sources of information and preferred media channels, such as radio, television, social media, peers, and coworkers

Below are two sample audience profiles, one of a woman of reproductive age who is the primary audience for family planning services, and the second of her spouse, the influencing audience.

## Audience Profile – Family Planning Client



*Photo credit: © 2005 Jane Brown, Courtesy of Photoshare*

**Ambitious Zione (Primary Audience)**

**Demographics:** Zione is 27 years old, a married mother of two children. She runs a small business selling tomatoes in a market near her home. She completed primary school. She speaks Chichewa and can understand basic English.

**Knowledge/Values/Beliefs:** Zione is familiar with most modern contraceptive methods and understands the benefits of having a smaller family. With only a primary school certificate, Zione wants to go back to school. She aspires to be a modern, successful mother and businesswoman. To do this, she wants to delay having any more children right now. She knows she can get contraceptives either from a private clinic or from the public clinic, but she would prefer a method that doesn't require repeat visits to the clinic.

**Current Behavior:** Zione is hesitant to discuss contraceptive methods with her husband, but they have talked about how they can plan well for their family. Zione is a lapsed contraceptive (pill) user, and they are not using any method right now.

**Barriers/Facilitators to Desired Behavior:** Zione doesn't like the side effects of hormonal methods. If she could find a method with fewer side effects that doesn't require repeat clinic visits, she would definitely try it.

| | **Preferred Sources of Information:** Local/community radio, women's investment group, friends and peers, fellow market women, and social media, especially her WhatsApp group. |
| --- | --- |

## Audience Profile – Spouse of Family Planning Client (Influencer)



*Photo credit: © 2001 Harvey Nelson, Courtesy of Photoshare*

**Worried Ben (Influencing Audience)**

**Demographics:** Ben lives in an urban center and works at a local restaurant. He has a secondary education and is married with two children.

**Knowledge/Values/Beliefs:** Ben values large families and would like to have two or three more children, but he is worried that if he and his wife have more children now, they won't be able to take care of them. His family is already struggling to get ahead. He's heard rumors that some hormonal methods make it difficult to have a baby later. As a result, he feels that he and his wife don't have many options. Non-hormonal methods such as condoms or female condoms are a barrier to intimacy and will only mean they don't trust each other, since where he lives, condoms are for preventing HIV.

**Current Behavior:** He and his wife are not using any contraceptive method and they don't really talk about it much.

**Barriers/Facilitators to Desired Behavior:** He doesn't really know much about modern contraceptive methods or how to talk about them, since that's really a woman's responsibility.

**Preferred source of information:** Local/community radio, friends and peers, local newspaper.

More information and examples of audience profiles: **Developing an Audience Profile** (http://sbccimplementationkits.org/fbo-breastfeeding/lessons/step-3-choose-intended-audiences-2/)

## Applying the Audience Analysis and Profiles in Service Communication

The audience analysis and profile help direct the overall communication objectives (what you want the audience to know, believe, or do as a result of being exposed to the message), the message content, and the types of communication channels used to reach the intended audience.

Based on Zione and Ben's profiles, the following decisions might be made for service communication that aims to increase informed demand for family planning services among women and their partners.

|  | COMMUNICATION OBJECTIVE | MESSAGE | COMMUNICATION CHANNELS |
|---|---|---|---|
| **Zione** | Increase the proportion of women of reproductive age who have heard about a safe, high-quality contraceptive method with fewer side effects | Talk to your health provider about safe family planning options that have fewer side effects | • Community radio<br>• Women's group meetings<br>• *WhatsApp* groups |
| **Ben** | Increase the proportion of spouses of women of reproductive age who talk openly about contraceptive methods with their spouses | Encourage your spouse to get more information, seek family planning services from your family planning provider | • Community radio<br>• Newspaper<br>• Outdoor billboards, street poles, wall paintings |

For more information on how audience analysis is being used successfully to inform service communication, see the case study on **Challenges Getting Clients to Services** (Appendix I).

# Understanding the Determinants of Behavior Change

The primary objective of service communication is to compel the intended audience to **act**– to publicly support an available service, to talk to their partners and friends about the benefits of a service or health intervention, to adopt or maintain a behavior, to provide high-quality counseling, or to visit a clinic. In most cases, just sharing information is not enough to get people to go for services. This is why it is so important to understand why people act the way they do. Identifying those determinants needs to happen before designing your strategy and your communication activities or materials.

## Why Is Understanding Behavioral Determinants Important to Service Communication?

There are many theories about the underlying reasons why people do or do not adopt behaviors. One of the most fundamental principles of SBCC is to reduce these barriers, as a means of facilitating change. Effective service communication first seeks to understand the full range of reasons why an audience is unwilling to adopt or maintain a behavior, and/or their motivators, before developing communication strategies and messages. Failing to do so before program design can lead to inappropriate communication objectives, poor allocation of resources, ineffective programs, and limited impact on behavioral outcomes.

More information on the key behavioral theory used in SBCC: **Popular Behavioral Theory** (https://www.utwente.nl/cw/theorieenoverzicht/Theory Clusters/Health Communication/)

## What Are Determinants of Behavior Change?

An individual's ability and willingness to adopt and maintain positive behaviors is often affected by a number of factors that make it easy or difficult to change. Knowledge and awareness of a health problem or service are rarely the only reasons why individuals act or adopt positive behaviors. For example, simply knowing that family planning services or HIV tests are available and where to find services is typically not enough to motivate the intended audience to visit or to make long-term changes in their behavior. Individuals have a number of reasons for adopting or resisting behavior change. These barriers or facilitators are called behavioral "determinants."

In addition to individual determinants, relationships and communities can influence someone's willingness and capacity to get health services. Barriers can result from deliberate blocking of access to services or from a general perception that services are inappropriate or wrong. Lastly, physical or logistical barriers and gender and cultural norms can prevent service uptake.

In Guinea, HC3 sought to rebuild confidence in health services after the Ebola epidemic. To do so, they needed to understand why people were not accessing services. They started a community dialogue intervention (assise communuautaire) where health providers and community representatives meet to discuss reasons why people do not use health services. Community members cited unfriendly providers, high medication costs, incompetent staff, dirty health centers, and lack of motivation. At the end of the dialogues, both groups commit to specific actions they will take to improve relationships. Based on their understanding of key behavioral determinants, the project developed IPC and training materials, radio to inform clients of their rights, songs, community outreach, and health education sessions.

Determinants can be categorized into three main groups related to the environment, skills and knowledge, and ideation.

### Environmental:

- Availability of services
- Location of services – is the location that is preferred by clients
- A supportive legal and policy environment for the services

**Skills and Knowledge:**

- Level of awareness of the service and/or the resulting health benefit
- Level of awareness of the skills or steps required to access the service or maintain the behaviors
- Beliefs about the required skills or behavior: Are they considered too difficult? Does the intended audience believe they have the time to perform the necessary behaviors?
- Does the intended audience feel that they can't do the behavior on their own? Do they need help to accomplish the behavior?
- Is the behavior something the audience can consistently remember to do, or do they often forget (for example, keeping a treatment journal, keeping appointments, taking a daily pill)?
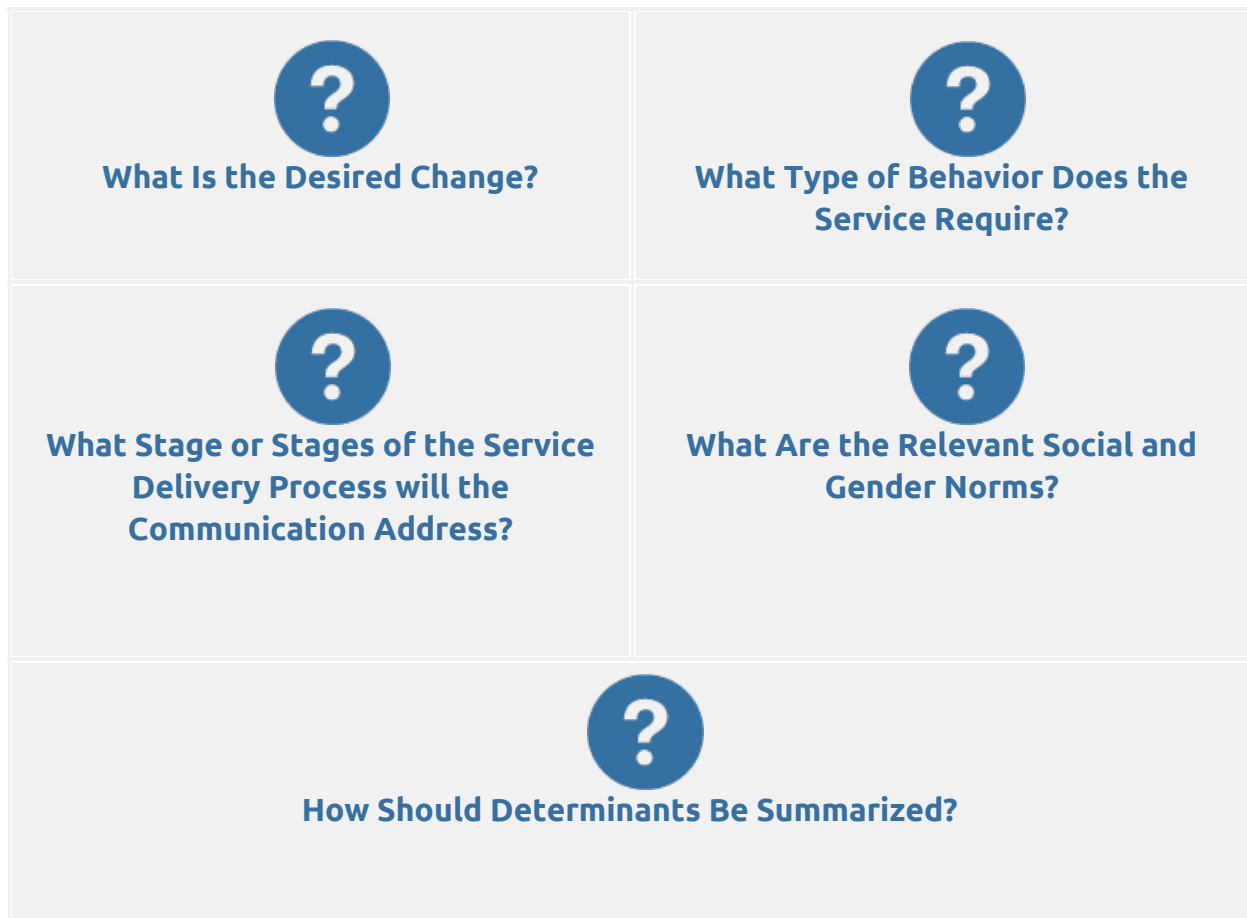
**Ideational:**

- What are the prevailing beliefs about the behavior or intended audience? Are they positive or negative (for example, "men who have sex with men are immoral" or "adolescents should not use family planning")?
- How much social support does the audience have to pursue services or maintain required behaviors?
- What are the prevailing social and gender norms about the service or health area? Are they supportive or unsupportive?

For more information on ideation, see HC3's **Ideation Primer** (http://healthcommcapacity.org/hc3resources/ideation-hc3-research-primer/)

## NOTE: EXTERNAL BARRIERS AND THE ROLE OF SBCC

Very often, the ability to effectively address a health problem and motivate change is linked to other types of barriers that communication cannot address on its own (for instance, policy barriers that render services unavailable, under-resourced, or criminalized). Although advocacy can help mobilize resources for new technologies and motivate support for more supportive policies, communication alone cannot change other problems that limit access, such as poor health systems, inadequate commodity supplies, and limited financing. Service delivery programs must carefully understand all external barriers to behavior change and then determine what role communication can play.

Identifying and selecting the most relevant determinants for any service delivery program requires programs to consider several questions:

| ? **What Is the Desired Change?** | ? **What Type of Behavior Does the Service Require?** |
|---|---|
| ? **What Stage or Stages of the Service Delivery Process will the Communication Address?** | ? **What Are the Relevant Social and Gender Norms?** |

? **How Should Determinants Be Summarized?**

## What Is the Desired Change?

It is important to define the desired change before identifying the determinants. The desired change is a statement of what the audience would **do** as a result of being exposed to the communication intervention. This is typically expressed as a behavior change objective that answers the following three questions:

1. What is the desired change in behavior? *(Example: Pregnant mothers seek the full course of IPTp during pregnancy; clinical providers provide accurate information on malaria and pregnancy to all pregnant mothers during each antenatal visit)*

2. How much change can be expected of the audience? *(Example: The proportion of pregnant mothers who receive the full course of IPTp increases from 50–75%)*

3. What is the time frame for the change; by when do we want to see these changes? *(Example: in three years)*

More information on **How to Develop Good Objectives for SBCC** (http://sbccimplementationkits.org/lessons/step-3-communication-objectives/)

## What Type of Behavior Does the Service Require?

The related behaviors may vary with the type of service. For instance, services that are rarely needed or tied to a unique event may be difficult for clients to adopt because they are not part of their day or because they may forget. Typically, behaviors related to health services fall into the following three main categories - each with its own set of barriers:

- **One-time:** Services that require one-time behaviors (for example, one service visit or clinical procedure, facility-based delivery) with long-term or permanent results (for example, inserting an IUD, tubal ligation, male circumcision).

- **Repeated but finite:** Services that require more than one visit or action but have a definite end point (for example, childhood immunizations, cancer treatments, TB DOT, IPT for pregnant mothers).
- **Permanent lifestyle changes:** Services that require a behavior to be sustained in the long term, or forever, to be effective (for example, HIV treatment, oral contraceptives, sleeping under nets).

Behaviors can also be affected if they require prior planning, as in a facility-based delivery. It is important to consider which type of behavior the service requires and then to look at the categories of determinants (environmental, knowledge/skills, and ideational) and determine which are most important to address through service communication.

## What Stage or Stages of the Service Delivery Process Will the Communication Address?

Another factor to consider in identifying determinants is the stage of service delivery.

Although internal and external factors may impact the specific determinants throughout the three stages, the determinants that have an impact on initial health-seeking behavior are often different from those that limit effective counseling during the clinical encounter and those that may affect ongoing follow-up and long-term behavioral maintenance.

This I-Kit includes illustrative case studies describing how determinants linked to internal and external barriers have been addressed in each of these three stages:

- **Addressing key barriers in the Before stage to get clients to voluntary medical male circumcision services in Zimbabwe** (Appendix I)
- **Addressing client/provider challenges During HIV counseling services in Kenya** (Appendix J)

- **Addressing challenges in the After stage with maintenance and follow up for maternal and child health services in Bangladesh** (Appendix K)



*After Services* highlight: In Cambodia, the MOTIF Project, implemented by LSHTM and MSI, used mobile phone messages to increase FP use after abortion. Clients received an automated, interactive voice message with counselor phone support every two weeks, for a total of six messages. Clients could also call in to the call center to enable interactive discussions as desired. The intervention increased contraceptive use at 4 months and also overall LARC use.

## What Are the Relevant Social and Gender Norms?

Prevailing social and gender norms are recognized as important determinants of individual health-seeking behavior throughout the three stages of service delivery. Norms have an impact on whether clients feel comfortable seeking services, seeking the necessary support to maintain required behaviors, or even discussing the service or health concern with anyone, including peers or the health provider. However, the relative importance of norms on individual behavior often depends on whether the individual thinks others are conforming to the norm and/or whether they believe others in society (friends, peers, family members, other influencers) expect them to adhere to the norm.

**Norms** are a specific set of beliefs, attitudes, and behaviors that are typical, acceptable, or even expected in a particular social context. **Social norms** are collectively agreed-upon standards and rules that most members of a group or society adhere to and accept. **Gender norms** are commonly accepted social or cultural rules that specify male and female characteristics, roles, acceptable behaviors, and capacities.

Social and gender norms can include a number of other rules or norms:

- **Participation norms** – Rules about who in a community or organization has power and can participate in decisions for the group. For some communities, participation norms allow only married adult men or elder women to make decisions about what community and/or health services are available; younger women and adolescents are not allowed to participate. These norms may also dictate whether a female client or youth is comfortable asking questions during a counseling session.
- **Leadership norms**– Community beliefs about what characteristics and responsibilities a leader should have and how leaders are chosen. These norms may determine whether an individual is considered credible and, therefore, a reliable source of information who can motivate others to adopt new behaviors.
- **Norms about a specific issue or behavior** – A community's beliefs and rules about what is acceptable to discuss—who can participate on a specific issue, or whether a particular service is even appropriate. For example, when men who have sex with men and sex workers are seen as having "unacceptable" behaviors, they are often stigmatized and their health issues and required services are often taboo.

It's important to understand which norm-related determinants present barriers or opportunities to inform service communication. For example, a social norm that restricts men's involvement in reproductive health services may present a barrier for married women's accessing family planning services. On the other hand, a cultural practice of male initiation ceremonies may create an opportunity for counseling and referrals to voluntary medical male circumcision services and clinical follow-up among young men at risk for HIV infection.

During the audience analysis, you identified information about each intended audience segment's barriers to behavior. Before developing communication materials and strategies, it's important to review the audience analysis to identify the existing barriers and determine whether they are related to environmental, skills/knowledge-based, or ideational determinants.

In doing so, consider the following questions:

- Does the audience face barriers to seeking health services related to prevailing social and gender norms? For example, is it acceptable for the primary audience (especially women or youth) to seek health services outside of the home or to pursue services without spousal or parental consent or financial support?

- Is it acceptable for the primary audience to speak openly with someone who is considered as having greater authority, better education, or a higher social class?

- Can services target a specific group or those whose behavior is deemed culturally unacceptable and therefore heavily stigmatized, such as sexually active youth, unmarried women, pregnant adolescents, sex workers, men who have sex with men, injecting drug users? Can these services be openly discussed and/or promoted? What confidentiality and security measures could avoid prevailing norms about stigmatized groups?

- Is the health area considered culturally taboo and not openly discussed?

- Are there existing hierarchies and rules of authority that dictate lower-quality treatment for the poor, uneducated, or those belonging to a certain ethnic group or social class?

- Is there a prevailing cultural belief that some modern medicine and/or clinical practices are unacceptable, imported from outside, or against tradition or religious beliefs?

The table below describes how various social and/or gender norms may be addressed using service communication.

| ISSUE | BEFORE | DURING | AFTER |
|---|---|---|---|
| **Required parental/spousal consent is prohibitive** | ▪ Conduct Community mobilization/ meetings with parents/partners<br><br>▪ Direct outreach to spouse/parent to encourage involvement | ▪ Couples counseling services | ▪ Community mobilization to identify and engage popular opinion leaders/early adopters to motivate others |
| **Cultural norm prevents primary audience from speaking openly or freely with providers** | ▪ Introduce branded strategy to promote "friendly, welcoming" services and providers<br><br>▪ Train providers in effective consultative techniques | ▪ Provide job aids and counseling tools that encourage interaction<br><br>▪ Create branded materials to communicate friendly clinic atmosphere<br><br>▪ Provide ongoing support and supervision to ensure providers are more interactive and friendly and maintain positive behaviors<br><br>▪ Reward and celebrate providers who adopt and maintain new behaviors in media, community meetings | ▪ Provide tools to allow clients to communicate with providers after the visit (mHealth, SMS)<br><br>▪ Conduct outreach through home visits and community mobilization, referral and follow-up |

| | | | |
|---|---|---|---|
| **Primary audience or behavior is stigmatized** | ▪ Conduct community sensitization activities about behavior and target group<br>▪ Provider sensitivity training<br>▪ Engage "positive deviants"/opinion leaders who challenge social stigma in community and mass media activities | ▪ Provide confidential clinical counseling through designated, discretely branded services<br>▪ Provide peer-based counseling<br>▪ Provide counseling through trained/sensitive providers | ▪ Encourage clients to return for follow-up and maintain contact using mHealth and interpersonal communication |
| **Health area and/or service is considered taboo** | ▪ Conduct community sensitization about the health area/service<br>▪ Provide information to address misinformation<br>▪ Conduct provider sensitivity training | ▪ Provide information to address misinformation<br>▪ Conduct provider sensitivity training | ▪ Use mass media and community mobilization to address misinformation |
| **Cultural beliefs reject some modern medical practices** | ▪ Increase knowledge and awareness of medical practice<br>▪ Conduct community and mass media activities to address misinformation | ▪ Increase knowledge and awareness of medical practice and counter misinformation through community sensitization and clinic-based information sessions | ▪ Increase knowledge and awareness of medical practice and address misinformation<br>▪ Identify and work through popular opinion leaders and early adopters (community mobilizers) |

A number of tools are available for specifically identifying and prioritizing relevant gender norms. For more guidance on the steps to best identify and integrate gender into service communication, see the **Integrating Gender into Social and Behavior Change Communication I-Kit.** (http://sbccimplementationkits.org/gender/)

## How to Summarize Determinants

To guide the selection of messages and communication channels, summarize the identified behavioral determinants for each intended audience. Consider using the **Matrix for Change Worksheet** (Appendix F) as you review the following elements.

- **Audience segment** – Drawing from the results of your audience segmentation and audience profiles, list each primary and influencing audience that the program will engage.

- **Desired change** – For each intended audience, indicate the desired change as a result of the communication intervention and the stage of service delivery (before, during, or after) when the desired change should take place. If there are behaviors for multiple stages, indicate each as a separate behavior (for example, "take children under 5 for routine immunization" or "get tested for HIV with spouse").

- **Service delivery type** – Indicate whether each desired behavior is a one-time, repeated but finite, or permanent change.

- **Key barriers** – Indicate which barriers you think are most important to address in order to achieve the desired change. Indicate which internal and/or external barriers the program will address.

For more information on behavioral theories and barrier analysis, see **The Role of Behavioral Theory in SBCC** (http://www.annualreviews.org/doi/abs/10.1146/annurev.publhealth.012809.10360 4)

## Tailoring Messages and Aligning with Communication Channels

In service communication, messages may be used with clients, providers, or an influencing audience and disseminated through a variety of channels, such as community mobilization and events, mass media, interpersonal communication, social media and community media. Developing effective messages and delivering them through the right communication channels does need not be complicated, but doing both of these things well requires strategic thinking.

This section discusses two key principles of message development and dissemination for service communication:

The Qualities of Effective Service-Related Messages

Aligning Messages with Appropriate Communication Channels

## The Qualities of Effective Service-Related Messages

### Why Are Effective Messages Important in Service Communication?

If the intended audience doesn't understand or is turned off by the message in any way, the entire effort has been wasted. Many service delivery programs provide information about services and products—"Services are available here;" "it's important to treat malaria;" or "family planning costs X"—and expect these informational messages to be enough to change audience behavior. As discussed in the section on determinants, however, this isn't enough. Communication must be

tied to the communication objective and must address the most critical barriers to behavior change, which are rarely just knowledge and awareness.

## What is an SBCC Message?

The **message is a brief, value-based statement that captures a concept and summarizes the idea or belief that the audience should retain.** These words, directed at the intended audience, are designed to achieve the communication objectives. These objectives are defined by what the audience must overcome (the identified barriers) in order to change their behavior.

## Components of a Good Message

Every audience is exposed to many messages each day. Messages about health services compete for attention with professionally developed commercial marketing messages that have been developed by well-resourced companies like Coca-Cola, Vodafone and Apple. Messages developed for service communication have to compete with these commercial messages for the audience's time and attention. To do this, they must draw on an understanding of the audiences' needs and motivations and creatively present solutions to the barriers to behavior change, while offering something in return. This is where it is very important to tailor messages to specific audiences. Everybody should not be receiving the same message because each audience segment has different information needs and unique motivators.

The following are key principles for developing good SBCC messages:

1. **Messages should be clear to the intended audience** – Good messages are free of jargon and technical language. Messages about clinical procedures and health services use language the audience will understand, while maintaining accuracy. This might not be the same language that technical experts use.

2. **Messages should be concise** – The main point of any service communication message should be conveyed quickly. Some argue that the key points of any message should be delivered within 15 seconds (the "elevator speech," defined as the short period we have before the audience is confused or loses interest).

3. **Messages should be repeated** – The most effective messages do not stand alone; they are incorporated into all related materials and communication channels, and they are repeated so they sink in with the audience. Although there isn't consensus about how many times it takes for an audience to change their behavior, there is agreement that multiple exposures to the same message through multiple channels can help maximize the effect of an SBCC program. For more information, see **Communication for Better Health** (http://pdf.usaid.gov/pdf_docs/Pnadl383.pdf).

4. **Messages should state the benefits** – Effective SBCC messages should clearly state how the audience will benefit from adopting a behavior. Each intended audience faces specific barriers to changing their behavior, such as lack of skill, lack of social support, or lack of time. Effective messages clearly present a benefit—something positive that the audience will receive in exchange for changing their behavior. This benefit must be relevant to the audience. Benefits are typically described as functional or emotional.

**Functional benefits** describe the physical attributes that the product or service can deliver and how it works (prevents malaria, leads to a healthier pregnancy, has no side effects, is affordable, is easy to use, etc.). Functional benefits must be supported with proof. For example, claims of a service's quality may refer to accuracy of testing or how clinical guidelines reflect international standards of care. Clinical trial data and project performance records can also demonstrate the effectiveness of the product or service.

**Emotional benefits** describe the social or psychological benefit the service delivers in terms of the emotional impact on the audience, such as reassurance, peace of mind, confidence, or social status.

Although most service communication tends to focus on the functional benefits, emotional benefits are important to emphasize, because it is these benefits that often drive human behavior. Without understanding the emotional benefits, the audience may not see the value in overcoming the barriers to adopting and maintaining a new behavior.

Examples of functional and emotional benefits:

| Audience Insight | She wants an FP method that is discreet and low maintenance, but is afraid that the IUD will make her infertile. |
| --- | --- |
| Benefit (Functional) | Highly effective, reversible contraceptive that can prevent pregnancy for up to 10 years without using hormones. |
| Benefit (Emotional) | Quiet confidence in my busy lifestyle, this product offers discreet protection with no user maintenance that can be removed easily when I want to become pregnant |

## Additional Message Considerations for the Stages of Service Delivery

Service communication messages may differ based on the intended audience and the stage of service delivery. Consider the following questions:

- How familiar is the audience with the topic or service and what is their attitude toward it? Is this a new area that they need more basic information about or are people fairly familiar with this topic or service, although they may have biases or misinformation?
- What type of **appeal** do you think will be most appropriate? Appeals are the way messages are framed. Depending on the context and audience, some effective messages can instill fear ("AIDS kills, use a condom"), whereas others may use a more positive emotional appeals ("Be the mother you always wanted to be: Treat your children's water"). Your decision on appeal should be based on what you know about the context, your intended audience, and the health area and stage of service delivery. For more information on choosing message appeals, see the National Cancer Institute's Pink Book. (http://www.cancer.gov/publications/health-communication/pink-book.pdf)
- How sensitive is the health area or service? How do you balance message clarity with cultural norms that determine the rules about what can be discussed openly?
- How literate is the audience? Messages and materials should use "plain language" and be structured to match the audience, and how you do this will differ based on the audience and stage of service delivery. For resources on

how to develop effective messages and materials for low-literacy audience, see this **guidance on using plain language** from the National Institutes of Health (https://www.nih.gov/institutes-nih/nih-office-director/office-communications-public-liaison/clear-communication/plain-language/plain-language-getting-started-or-brushing).

## How to Develop a Good Message

When constructing a message for service communication, first make sure the message has two components—a functional and/or emotional benefit and a clear "call to action":

- ***A promised benefit that the audience will realize*** by overcoming the barriers (determinants) and performing the targeted behavior. Benefits should come from an understanding of what the audience values, such as respect from peers, a better love life, a healthy family, or greater success. *Example:* "It pays to plan, talk to your provider about family planning."
- ***A clear call to action*** – A statement indicating what the program wants the audience to do (the behavioral objective) as it relates to the services. *Example:* "Take your partner for HIV testing today."

Then, use the Seven Cs of Effective Communication as a checklist to confirm that the message reflects the key principles of good SBCC.

| THE SEVEN CS OF COMMUNICATION | QUESTIONS TO ASK AND THINGS TO REMEMBER |
|---|---|
| 1. Command attention | ▪ Does the message stand out? Does your audience think it does?<br><br>▪ Remember to give thought to the following details: colors and fonts; images and graphics; sound effects; music; slogans; choosing innovative channels. |
| 2. Clarify the message | ▪ Is the message simple and direct?<br><br>▪ Remember, less is more! Stay focused only on what the audience needs to know. |

| | |
|---|---|
| 3. Communicate a benefit | ▪ What will the audience get in return for taking action?<br><br>▪ A key benefit may not necessarily be a health benefit. Choosing an immediate benefit (instead of a long-term benefit) is typically more effective in bringing about immediate change. |
| 4. Consistency counts | ▪ Activities and materials convey the same message and become mutually supportive in creating recall and change.<br><br>▪ "One sight, one sound" is a good motto. Pay attention to your use of logos, colors, words, sounds, themes, images and models. |
| 5. Cater to the heart and to the head | ▪ Is it better to appeal to the audience's emotions, intellect, or both? Emotional appeals are often more convincing than facts. |
| 6. Create trust | ▪ Does your information come from a credible source? Who does the target audience consider to be credible? Ask them. Is it still the male medical doctor, or has that changed? Is the source considered to be credible the same for men and women and for different age groups? Is there a celebrity who would impress your audience? |
| 7. Call to Action | ▪ What do you want the audience to do after seeing the communication? What action is realistic as a result of the communication?<br><br>▪ The call to action should focus on a concrete and realistic action and help achieve your objectives. |

Message content, approach and channels must be pre-tested with the intended audiences before they are finalized and produced. Because service communication messages are often developed with technical specialists who are not members of the intended audience, pre-testing ensures that an audience will understand the message as it is intended. Pre-testing should include:

- Stakeholder review – Allow relevant partners, donors, and representatives from other programs who may use the materials to review them before they are produced
- Audience pre-test – Allow representatives of the intended audience to review and comment on the materials. These audiences should include clients, providers, policymakers, and community members. Their review should check for understanding, motivation, appeal, confusion, offensiveness and controversy.

For more information on materials pre-testing, **Conducting Effective Pretests** (https://www.k4health.org/sites/default/files/AIDSCAP%20-%20Conducting%20Effective%20Pretest_0.pdf).

## ADDITIONAL RESOURCES

For additional considerations, steps, and guidelines for developing effective messages:

- C-Modules – Module 3: **How to Create Good SBCC Messages** (https://www.c-changeprogram.org/sites/default/files/sbcc_module3.pdf)
- Resource for developing better communication materials: **Why Bad Ads Happen to Good Causes** (http://www.rwjf.org/content/dam/files/rwjf-web-files/GranteeResources/BadAds.pdf)

## Sample Message: Demand Creation for HIV Testing in Swaziland

To encourage men and women to seek HIV testing with their spouses, PSI developed motivational messages that focused not on the functional benefits of HIV (know your status, linkages to care) but on the emotional benefits (showing your love and respect for your significant other).

PSI identified the key determinant for HIV testing as the amount of social support the audience received. As a result, the key message for the HIV testing campaign focused on testing as a demonstration of love for your partner—something that is very important to men and women in Swaziland.

The determinant being addressed was Social Support, which is the assistance that an individual receives to perform a behavior.

**Key Insight:** If you trust your partner, then you have nothing to hide.

**Benefit:** Getting HIV tested as a couple proves your love and commitment to each other

**Call to Action:** Take your partner to get tested today.

When combined, the benefit and call to action comprise the key message. Note in the poster below how the text is not the same as the key message but it conveys the same idea. Remember, key messages are strategic internal statements. There could be several executions of the same key message.

This poster from the Swaziland couples HIV testing campaign promoted HIV testing, in general, and not PSI's clinics specifically. For this reason, the poster did not need to also communicate the brand positioning for PSI's clinics with the key message. Many times, however, you will promote a PSI brand and, therefore, will need to communicate the brand positioning and the key message at the same time.

## Aligning Communication Channels with Messages

The process of aligning channels and messages means selecting the right communication tool or approach for the message and the intended audience (for example, mass media, interpersonal communication, information and communication technology, or social media). Doing this well is a strategic process that is informed by program needs, the local context, and your audience analysis.

### Why Is Selecting the Right Approach Important for Service Communication?

Aligning channels with messages helps ensure effectiveness by getting the best messages to the intended audience without wasting resources. Not all channels reach all audiences. Ensuring the right mix of channels increases repetition and improves the likelihood that the audience will understand the message, accept it, and act on it.

### Key Steps for Aligning Channels with Messages

The result of aligning messages with communication channels is often called the Channel Mix Plan. The following are the key steps for developing the plan. Fill out the Channel Mix Table (Appendix G) to develop your own plan.

1. Assess the available channels – Determine what communication channels are locally available. To the right is a list of the typical channels and how they are often used in service communication.
2. Determine the intended audience's habits and channel preferences – Does the proposed channel reach the intended audience? For example, first determine whether the audience listens to the radio, watches television, or uses the social media before deciding to use one of those approaches. This information is gathered in the Audience Analysis (http://sbccimplementationkits.org/service-communication/lessons/step-1-audience-analysis/) section
3. Consider the strengths and weaknesses of each channel – Channels may differ depending on the communication objectives and audience. Using a combination of several appropriate channels is likely to increase the effect of SBCC. To learn more about strengths and limitations of each channel, see Developing a Channel Mix Plan

(http://www.thehealthcompass.org/how-to-guides/how-develop-channel-mix-plan).

4. Leverage the strengths of each tool – Not all channels are appropriate for all messages. Some messages and new behaviors require a lot of interaction, information, or time, particularly when introducing a new skill or addressing deeply held beliefs or misinformation. The message requirements will determine the appropriate format: interpersonal, small group, mass media, or social media. For example, teaching a new mother how to overcome challenges with breast attachment (latching) may be best addressed with interpersonal contact or through demonstration videos using mobile technology to show examples and to answer questions.

5. Consider audience characteristics in creative decisions – Consider the intended audience's literacy and education levels, time available, technical savvy, and other characteristics. Then, choose the most appropriate tools that also allow the necessary amount of creativity and innovation for the message.

6. Determine what channels fit the program's objectives, considering the stage of service delivery and make a list of those challenges – Is the program's objective to inform and educate about a new service or product or to increase the intention to seek services? Is it to impart skills during a clinical encounter? Is it to reinforce new behaviors after the client leaves the facility? The objective should help you decide which channel is most appropriate.

7. Determine whether the preference is for **reach** (number of individuals or households exposed to the messages) or **intensity** (average number of times individuals are exposed to the messages). The level of intensity may be determined by amount of *depth (the necessary amount of information and detail)* the message requires to be understood. Services that are intended for a narrower audience (uncircumcised youth or pregnant youth) intensity may be more appropriate.  For new services or those targeting a large audience (for instance, family planning or malaria treatment in a malaria endemic area), the program may want to maximize reach over intensity.

8. Is the tool appropriate for the setting where it will be used? Channel selection should consider where and when it will be used and the topic it

addresses. For instance, clinical counseling may require materials suitable for a small and/or crowded clinical setting. Also be sure to consider infrastructure. Is electricity required for light or internet access?

9. Consider the fit between messages and channels and the audience – Whether a message is somewhat complicated or requires visuals will determine whether print, video, radio or interpersonal communication is best. Consider local norms related to the health topic, including whether it's difficult to discuss or is stigmatized, before making decisions about which communication channels to use.

10. Determine frequency – how often will the channel be used? In doing so, consider aligning the channels with holidays, payment cycles, elections, or other special events. This will help you take advantage of opportunities and make sure that the messages are not obscured by other media stories.

11. Summarize the results of this analysis into a **Channel Mix Table** (Appendix G). When making final channel selections, consider the budget – Is the channel affordable? Are there ways to collaborate with other partners or activities to minimize costs? Do production costs for this channel or approach fall within the budget? What is the cost per person reached, and is that reasonable? For instance, a radio spot may be more expensive to produce than community talks, but radio may reach many more people than the interpersonal communication sessions, reducing the cost per person reached.

For step-by-step guidelines on aligning channels with messages and completing a Channel Mix Plan, see **How to Guide - Developing A Channel Mix Plan**. (http://www.thehealthcompass.org/how-to-guides/how-develop-channel-mix-plan)

For an example of how family planning messages were developed and disseminated through various channels to improve service delivery uptake, see the **NURHI case study** (Appendix M).

## Message Channels

| Channel Types | Definition | Examples in Service Communication |
|---|---|---|
| **Interpersonal:** Peer-to-peer, client/provider, supervisor to community health worker, counseling | The process by which two individuals (or a small group) exchange information and ideas through face-to-face interaction. | ▪ One-on-one meetings between peers or between client and health provider<br>▪ Community group meetings, mother-to-mother groups, peer groups<br>▪ Supportive supervision visits, team meetings to improve clinical counseling and services |
| **Community Based:** Community dialogue, community drama, community radio | A process that engages and motivates a wide range of partners and allies at national and local levels to raise awareness of and demand for a health topic or service | ▪ Community dialogues to discuss the importance of the health area or introduce the new service |
| **Mass Media:** Radio and television, serial dramas, game shows, websites, newspaper, magazines, posters | Diversified media technologies that are intended to reach large audiences via mass communication, including radio, film, and television. | ▪ TV soap opera incorporating service uptake into a popular storyline<br>▪ Radio talk shows with health providers as on-air guests to address myths and misconceptions<br>▪ Newspaper articles providing information on where services are available, costs, and other basic information |
| **Social Media:** Facebook, WhatsApp, SMS, blogs, podcasts | Internet-based services in which users generate online content, such as blogs, social network sites, and wikis. | ▪ Facebook page to build interest for the service and provide follow-up information<br>▪ Demonstration videos on new skills to be shared among clients or newly trained providers<br>▪ Social media user groups of health providers to enable sharing of better practices, learning, and new techniques related to their work |

| Channel Types | Definition | Examples in Service Communication |
|---|---|---|
| | | ▪ SMS messages to remind users of follow-up services or to take treatment |

## Example

By aligning channels and messages with the right audiences, International HIV/AIDS Alliance was able to improve the sexual and reproductive health and rights (SRHR) of 940,000 10-24 year olds most affected by HIV across 5 countries. They recognized that changing attitudes and norms that influence young people's access to services requires discussion, community interaction, provider behavior change, and advocacy. They used peer educators and youth leaders, along with hotlines and social media, to allow for in-depth discussion, open sharing, and youth advocacy. They used print materials to inform and refer youth to services. They took advantage of in-service training to sensitize and build provider capacity. Finally, they used interpersonal and community channels to advocate for integrated services and the creation of youth-friendly spaces.



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### Read more about Link Up:

http://www.aidsalliance.org/assets/000/002/660/LInkUpOverviewJULY16_original.pdf?1468604285

# Addressing Providers as a Behavior Change Audience

Providers are at the center of any service delivery program or project. The behavior of clinicians, community health workers, counselors, and other health providers can determine whether clients are interested, willing, and motivated to adopt healthier behaviors. While clients often come to a health service with specific barriers and expectations that may affect the clinical encounter, competent and pleasant providers contribute to a positive atmosphere in clinics and outreach sites and, ultimately, to better client health outcomes.

## Why Is Provider Behavior Change Important?

To ensure that healthy behaviors are adopted and maintained during and after a client/provider interaction, behavior change among health providers is often necessary.

The determinants of provider behavior can be organized into four main categories. (For more, please see the **Provider Behavior Change I-Kit:** http://sbccimplementationkits.org/provider-behavior-change/)

- **Opportunity** – The availability of necessary resources, supplies, and infrastructure to support positive provider behaviors (including office supplies and materials, sufficient work space, facility infrastructure and available commodities)

- **Expectation** – The provider's level of understanding of performance expectations and the definition of quality

- **Ability** – The level of necessary skills and knowledge the provider has to do the job and the level of competence the provider feels

- **Motivation** – The presence of sufficient rewards to do the job (compensation, incentives, recognition) and lack of negative consequences for doing the job (social stigma, personal expense, time away from family and personal life).

Providers face a number of opportunity barriers that limit their performance that cannot be overcome by SBCC alone (for example, limited supplies, high patient loads and poor facilities). They also face a number of barriers tied to expectation, ability, and internal motivation that limit performance (for example, peer pressure, habits, attitudes and beliefs, feeling a need to meet patient expectations, skills and information levels). To ensure that health services are high in quality and valued by the client, providers must be motivated, confident in their work, able to provide non-discriminatory services and proud of what they do.

Clients who have a positive interaction with their provider are more likely to refer others and to advocate for the services. Services offered by unskilled or rude providers create barriers for individuals to seek services and/or maintain behaviors after seeing a provider. SBCC can play a crucial role in addressing key behavioral barriers tied to norms, attitudes, skills, knowledge and other ideational factors.

## What Is Provider Behavior Change Communication?

Provider behavior change communication is a strategic process of identifying individual provider needs and barriers to adopting desired behaviors and tailoring communication-based solutions.

Provider behavior change communication goes beyond traditional interpersonal counseling and communication skills building. It may include addressing provider knowledge and skills gaps, but it also addresses underlying motivations, norms, values, attitudes, and beliefs that impact provider behavior.

Ensuring that providers meet standards for high-quality service delivery and engage in positive interactions with clients helps increase service volumes, demand for services and perceptions of quality. Provider behavior change communication can influence a range of behaviors, including:

- Improved client screening and pre-service counseling (counseling on family planning method mix, TB DOTS)
- Improved adherence counseling (HIV treatment and care, routine immunizations)

- Improved infection prevention
- Improved recordkeeping

In Niger, E2A aimed to enable providers to offer quality youth-friendly sexual and


but I don't have access to anything but condoms…

reproductive health services. To address provider barriers to offering those services, E2A created the film "Whose Norms,"

(https://www.youtube.com/watch?v=2gtwszAXDw4) designed to spark reflection, dialogue, and action among service providers. The demand side was addressed in the first film in the series, "Binta's Dilemma," (https://www.youtube.com/watch?v=IgUWB9EYvLQ) which has been used to encourage conversations among young Nigeriens about culturally sensitive topics, including contraception, unintended pregnancy, and the societal pressures on young women to bear children once they are married.

While counseling alone is not usually the focus of provider behavior change communication efforts, it plays a critical role in improving the *during* stage of services – the client-provider interaction. As FANTA worked to integrate nutrition assessment, counseling and support (NACS) into health services, they found weaknesses in counseling and



communication. They developed a 2-3 day training curriculum focused on interpersonal communication skills, prioritizing key skills that are most neglected but have great potential to change interactions if put into practice. For example, 1) asking open ended questions to learn before you 'tell' patients what to do; 2) verify the patient's understanding of technical information you present, by having them put in their own words what they got; 3) negotiating an action plan that the patient is confident s/he can

do–some "small, doable action" towards the behavior objective and ultimate health goal. The training focuses on practice, using checklists. See Appendix N: Resources for more job aids and counseling tools.

## How to Address Provider Behavior through SBCC

There are a number of frameworks that define the components of provider behavior change. This section discusses the following:

1. The importance of understanding the provider, including gaps between current and desired behavior, attitudes, values and motivation, and barriers to change
2. The importance of emphasizing "value" as a motivator for change
3. Using supportive supervision to maintain provider behaviors

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| **Understanding Provider Needs** | **The Importance of Reinforcing Value** | **Supportive Supervision to Maintain Provider Behavior Change** |

For more information on this approach and other provider behavior change techniques using SBCC, see **Strategies for Changing Private Provider Behavior**: http://www.shopsproject.org/resource-center/strategies-for-changing-the-behavior-of-private-providers.

For an example of how provider behavior change techniques were applied in Kenya, see **Client/Provider Challenges case study** (Appendix J).

### Understanding Provider Needs

Developing a clear understanding of providers through an audience analysis is an important initial step to determine the objectives, overall approach, and channels and tools to be used in a provider behavior change communication strategy.

The process is nearly identical to any other audience analysis (see **How to Conduct an Audience Analysis:** http://www.thehealthcompass.org/how-to-guides/how-do-audience-analysis). In addition to demographic information (age, gender, location, years of service), a provider audience analysis should include insights to understand the gaps between the desired and current behavior and the underlying reasons for those gaps.

The following are types of information one might gather in a provider audience analysis:

- What is the provider's current behavior regarding the targeted service/health area? Does the provider perform the desired behavior all the time, only sometimes, or not at all?
- What are the reasons the provider does not consistently practice the desired behavior (the barriers)? Is it because they lack adequate resources, time or pay, or are the barriers tied to lack of knowledge, skill or other ideational factors?
- What is the provider's current attitude about the job, the service, or the clients with whom they work? Are they happy with their job? Do they have any biases toward the services they are being asked to provide or toward the clients they see?
- What does the provider perceive to be the benefits of adopting the targeted behavior?
- What is the provider most motivated by—peer support, social status, financial incentives?

Record these insights in a **Provider Profile** (Appendix H), which will help summarize the intended providers and offer insights on how to position the desired behavior change (improved counseling of adolescents, increased counseling on critical issues for contraceptives, etc.) in a way that offers a benefit to the provider (increases status in the community, reduces workload) while overcoming an important barrier (lack of confidence, lack of knowledge).

**Sample Provider Profile**

**Name:** Dr. Hema

**Age:** 50 years old

**Gender:** Female

Dr. Hema is a well-established, business-minded doctor. She is an Ob-Gyn with a big clinic. She has 50 OPD clients a day and does 20 deliveries per month. She aspires to hold important positions in social groups, be recognized in the community and attract more and higher income clients. She only inserts IUDs on request and does about 10 insertions per month. She believes her role is to instruct clients and not counsel.

## The Importance of Reinforcing Value

Providers are people, just like their clients, who are motivated by myriad factors – money, recognition, social status or a desire to improve their community. Like anyone else, providers may be more likely to make change in their behavior if they understand how the change will benefit them. Effective provider behavior change interventions identify what motivates providers most before developing messages. A simple statement that frames how a provider will benefit from a specific change is called a "value proposition."

PSI uses value propositions as the basis for provider behavior change communication in its social franchising programs. For example, family planning providers may be reluctant to counsel on IUDs if they assume that a client who doesn't directly ask for them is not interested. Meanwhile, these same providers are motivated by increased sales volumes. In order to get providers to introduce IUDs to clients seeking family planning services, value proposition messages are developed to present the ways the providers may benefit from introducing IUDs.

For example:

> **"***Your patient will be impressed with the services and options you offer even though she hasn't thought about it. This will result in increased patient satisfaction, repeat visits and referrals.***"**

Before developing a value proposition message, use the set of questions from the audience analysis to identify what the providers may value.

For more information on how to communicate value to influence provider behavior change, see the **Key Promise section of the PBCC I-Kit** (http://sbccimplementationkits.org/provider-behavior-change/lessons/step-5-determine-the-key-promise-and-support-points-2/).  See the **Community Health Worker Behavior Change I-Kit** (http://sbccimplementationkits.org/provider-behavior-change/courses/for-community-health-workers/) for other examples of how organizations have incorporated value-based motivation techniques in provider behavior change efforts.

## Supportive Supervision

There is no single SBCC technique or communication channel that is known to improve provider behaviors. Depending on the identified performance gap, supportive supervision can be used to help providers adopt and maintain new behaviors and stay motivated to do their jobs well.

Many service delivery programs already regularly provide supportive supervision through training follow-up and routine monitoring. Very often, however, routine supervision focuses on improving the provider's clinical data collection, reporting, or appearance and organization. A provider behavior change approach to supportive supervision focuses not only on training and improving skills, but also on the specific barriers a provider faces in adopting a new behavior. A provider behavior change approach to supportive supervision uses insights gathered during the audience analysis to develop strategies for maintaining long-term behavior change, framed around what the provider needs and values.

In addition to training, a supportive supervision plan may include:

- Monitoring and management through a supervisor
- New job aids and tools, which may use multiple media platforms (such as SMS, mobile phones, and short videos) to support better counseling and include support to use them properly
- Coaching and routine support provided by a supervisor and framed around a specific performance improvement plan
- Technical support through hotlines or videos
- Mentoring support provided by a high-performing peer or manager

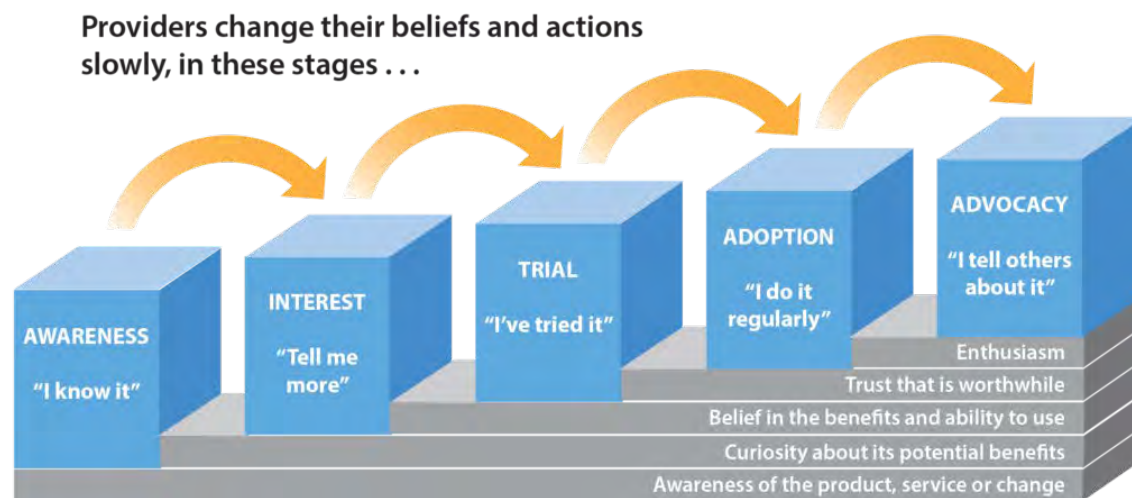## An Example: Applying a Provider-Based Framework

PSI developed and implements a system for provider behavior change in its social franchise clinics based on the : **Stages of Change (Transtheoretical Model):** http://www.orau.gov/hsc/theorypicker/ttm.html.  PSI uses the process to address gaps in a wide range of provider behaviors and health areas. The process recognizes that providers are at varying stages of behavior adoption:

- Awareness – The provider knows about the targeted behavior.
- Interest – The provider has expressed interest in adopting new behavior.
- Trial – The provider has taken an initial step to try the new behavior.
- Adoption – The provider has adopted the new behavior and regularly uses it
- Advocacy – The provider is encouraging others to adopt the new behavior because it has helped the provider achieve specific needs, such as more clients, more revenue, or more efficient work.

Another way of supporting providers in their new behaviors is the medical detailer approach. Medical detailers – who have fewer qualifications than supervisors – can pay visits to providers to help improve service availability and quality. The medical detailers discuss services with providers and uncover barriers that may prevent them from offering or improving services. If the medical detailer finds that the provider has training but lacks confidence in a certain skill, for example, the program can plan on-the-job training and supervision during special service days. If the medical detailer finds that the provider wants to serve youth but faces opposition by parents and community leaders, the program can plan SBCC activities to constructively engage those gatekeepers and influencers.

Interventions to change a provider's behavior must first identify where a provider is in the Stages of Change and identify the main barriers that prevent the provider from moving to the next stage.



**Adoption Ladder**
**Provider Behavior Change**

Providers change their beliefs and actions slowly, in these stages . . .

AWARENESS
"I know it"

INTEREST
"Tell me more"

TRIAL
"I've tried it"

ADOPTION
"I do it regularly"

ADVOCACY
"I tell others about it"

Enthusiasm
Trust that is worthwhile
Belief in the benefits and ability to use
Curiosity about its potential benefits
Awareness of the product, service or change

The process of identifying and developing tailored interventions to address the gaps in provider behavior follows four primary steps:

1. **Planning** – Similar to the audience analysis, identify targeted providers and prioritize provider segments. Examples of segments include providers working in urban areas, providers delivering services at high- or low-volume facilities, and providers offering integrated services.
2. **Audience analysis to uncover provider needs** – Using data gathered through methods like provider observation, client feedback, review of routine recordkeeping practices, client exit interviews, and mystery client's visits, develop provider profiles that describe the prioritized providers' current performance, barriers to adopting new behaviors (knowledge, skills, motivation, etc.), key values, and expectations.
3. **Development of a tailored behavior solution to address the performance gaps and behavioral barriers**. Develop communication tools tailored to address the identified gaps. The tools could include a range of materials to

address skills barriers (training or better job aids, motivation barriers) or support coaching and mentoring tools and strategies.

4. **Reinforce the value of the solution** – The fourth component is an ongoing process to remind providers how the behavior has benefited them and their clients. Reinforcement occurs through routine support supervision visits, regular acknowledgment and rewards, and/or recognition through community events, clinic "provider of the month" communications, and other methods to help sustain motivation and prevent providers from going back to their old habits.

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**Example: WhatsApp**

To strengthen supervisory support for Community Health Workers (CHWs) in 2 areas in Kenya, a mobile learning intervention launched a WhatsApp group for CHWs and their supervisors. The WhatsApp group enabled the group to engage in multiple forms of supervision: peer-to-peer, group, and one-on-one. The vast majority (88%) of the communication happening in the group related to predefined supervision objectives. The WhatsApp interactions helped supervisors understand the situation on the ground and ensure quality. It also helped users share relevant information with one another and create a supportive environment. **Read more here:** http://www.ghspjournal.org/content/4/2/311.full.pdf+html