



Service Communication Implementation Kit

Integrating SBCC into Service Delivery Programs



Learn how to design and integrate social and behavior change communication (SBCC) into all stages of the service delivery process.

Enhance service delivery and ultimately improve health outcomes by using SBCC before, during and after the clinical encounter.



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OVERVIEW

What Is Service Communication?

Service communication is the use of Social and Behavior Change Communication (SBCC) processes and techniques to motivate health service-related behaviors among intended audiences across the continuum of care – Before, During and After services. By integrating SBCC into your service delivery projects, you can get more clients to health facilities, improve client-provider interactions, and increase the adoption and maintenance of healthy behaviors.

Purpose of This I-Kit

This I-Kit aims to help service delivery project managers effectively use service communication to enhance the impact of their project. This I-Kit can be used to help increase demand for and uptake of services, and improve consistent long-term maintenance of healthy behaviors. It is designed to help users understand key service communication concepts, apply SBCC techniques to create successful communication activities, and learn how to better coordinate efforts with SBCC projects.

Who Is the Audience for This I-Kit?

The intended users of this I-Kit are project designers and project managers tasked with improving service delivery by better integrating SBCC into services, either through direct implementation or through coordination with an SBCC partner. Staff of organizations or entities that provide clinical health services will also benefit from an understanding of the content of this I-Kit. Ideally, users will have some understanding of SBCC theory and processes and a desire to better apply these concepts to their service delivery efforts.

What Does This I-Kit Contain?



Background Information

Key service communication concepts, programmatic approaches, and evidence



Step-by-Step Design Guidance

Step-by-step guidance on designing SBCC activities and materials for health services



Coordination Guidance

Key principles and models for effective coordination between SBCC and service delivery partners



Worksheets and Resources

Worksheets and templates to help apply service communication principles, and resources for future reference



Case Studies

Examples of projects that have successfully used service communication to address challenges

How to Use This I-Kit

You can use this I-Kit to help you integrate social and behavior change communication (SBCC) into all stages of the service delivery process – either through more effective coordination with SBCC projects or by designing your own communication activities.

- Start by **learning about Service Communication** (<http://sbccimplementationkits.org/service-communication/introduction-to-service-communication/>). Discover what service communication is and how it can be used through the three stages of service delivery. Explore the evidence for service communication.
- Next, learn how to design your own communication activities using the **Step-by-Step Guidance on Designing SBCC for Health Services** (<http://sbccimplementationkits.org/service-communication/courses/key-principles-of-designing-sbcc-for-health-services/>).
- Then, learn how to more effectively coordinate efforts with SBCC partners to jointly achieve positive health outcomes in the **Operational Considerations** section (<http://sbccimplementationkits.org/service-communication/service-communication-implementation-kit/operational-considerations/>).
- Last, learn from others' experience by studying the five **Case Studies** (<http://sbccimplementationkits.org/service-communication/case-studies/>) that illustrate how projects have successfully applied service communication principles.

This I-Kit is organized into four sections:



Learn

An overview of the I-Kit's content, purpose and rationale and a summary of the evidence for SBCC in services.



Designing SBCC for Health Services

Key principles and step-by-step guidance on successfully designing communication activities for health services.



Operational Considerations

Tips and guidelines on how service delivery and SBCC partners can effectively work together in a variety of implementation scenarios.



Case Studies

Five illustrative case studies describing how key SBCC principles have been successfully applied to service delivery programs.

LEARN

This section provides an introduction to service communication. Take time to review the key principles and rationale for service communication, as this information will be referred to throughout this I-Kit:

What is SBCC? **Understand key SBCC concepts and terminology**

(<http://sbccimplementationkits.org/service-communication/introduction-to-service-communication/#sbcc>).

What is Service Communication? **Learn what Service Communication is, why it should be used and how it is best applied across the continuum of care**

(<http://sbccimplementationkits.org/service-communication/introduction-to-service-communication/#servicecom>).

What evidence is there for Service Communication? **Study the evidence for Service Communication and access additional research**

(<http://sbccimplementationkits.org/service-communication/introduction-to-service-communication/#evidence>).

What is SBCC and Why Is It Important to Service Delivery?

Social and Behavior Change Communication (SBCC) is the use of communication to change behaviors – including service utilization – and promote social change by positively influencing knowledge, attitudes and social norms.

SBCC goes beyond the delivery of a simple message or slogan to encompass the full range of ways in which people individually and collectively convey meaning. Among the powerful tools employed by SBCC programs are mass media, community-level activities, interpersonal communication, information and communication technologies and new media.

Effective SBCC is critical to improving behavior and health outcomes across the continuum of care. SBCC can be used to increase demand for and uptake of services, and improve consistent long-term maintenance of behaviors. SBCC plays a key role in each stage of healthcare service delivery – before, during and after. In the **before** stage, SBCC can **help get clients to services** by building individual and

community support for health issues and related services, influencing norms and creating demand among intended clients. **During** service delivery, SBCC techniques can be used to **enhance the client experience and ensure new behaviors are adopted** by improving provider counseling and client support. **After** services, SBCC can **support follow-up and behavioral maintenance** by building and maintaining linkages between communities and service providers.

SBCC can also help ensure sustained demand and access to services through engaging community leaders and influencers in community mobilization and advocacy to shift underlying norms around service-seeking behavior.

Key Principles of SBCC

- SBCC is a process: SBCC is an entire ***process rather than a product***. Communication products and materials such as posters, TV or radio spots, flipcharts or leaflets are just a small part of the SBCC process. Effective SBCC starts with research and analysis to understand the context and the intended audience. Then, strategies are developed to coordinate key messages across multiple channels (print, community-level, social media, interpersonal communication, radio, TV) to reach the intended audience.
- SBCC works at multiple levels: Achieving sustainable social and behavior change requires SBCC programs to work at multiple levels of the system – individual, family, community, service delivery, and enabling environment. SBCC recognizes that individual and social change does not happen in a vacuum, but is dependent on larger structural systems and norms.
- SBCC uses multiple channels: SBCC coordinates messages across a variety of communication channels to reach multiple levels of society. Behavior and social change is more likely through repeated and varied exposure to messages.
- SBCC is strategic: SBCC programs are grounded in theory and designed using evidence that helps programmers understand the situation, the audience, and existing programs.

What is Service Communication?

Service communication is the use of SBCC processes and techniques to motivate health service-related behaviors among intended audiences across the continuum of care – Before, During and After services. Service communication can be used with community and facility-based services across health areas



to improve a range of behavioral outcomes; for example, creating demand among couples for HIV tests *before* they seek services, motivating women of reproductive age to initiate long-term family planning *during* clinical counseling, or encouraging caregivers to ensure their children continue a full dose of artemisinin-based combination therapies (ACTs) *after* a positive malaria test result.

Service communication can also be used to improve provider performance (provider behavior change communication) with clients *during* and *after* clinical service.

Service communication can use multiple channels, including community mobilization and outreach, interpersonal communication, local TV and radio, print materials, and social media. The most common channels are interpersonal, community, and print.

Service delivery implementers may design and implement their own communication activities, partner with an SBCC implementer, or both. However, it is implemented, service communication is vital to achieving behavioral outcomes - increased demand, improved uptake, and consistent long-term maintenance—across the three stages of service delivery. See the **Design** section (<http://sbccimplementationkits.org/service-communication/courses/key-principles-of-designing-sbcc-for-health-services/>) for guidance on designing your own communication activities. See the **Operational Considerations** section (<http://sbccimplementationkits.org/service-communication/service-communication->

[implementation-kit/operational-considerations/](#)) for guidance on effectively coordinating efforts with SBCC projects.

Service Communication Addresses Key Determinants

Programs must first identify and understand the most important determinants that make adopting services difficult or impossible before developing communication strategies and messages. These determinants may include knowledge, attitudes, social norms or a range of other “ideational factors.” [More on Ideation:](#) <http://www.healthcommcapacity.org/wp-content/uploads/2015/02/Ideation.pdf>.

The table below describes how service communication activities may address identified behavioral determinants and ultimately lead to improved service uptake and behavioral maintenance.

SBCC ACTIVITIES AND CHANNELS	BEHAVIORAL DETERMINANTS	BEHAVIORAL OUTCOME
<ul style="list-style-type: none">▪ Community dialogue and outreach on the importance of HIV testing▪ Provider training and supportive supervision among providers working with sexually active youth▪ SMS reminders for caregivers of young children▪ Branded mass media campaign for family planning services targeting women of reproductive age	<ul style="list-style-type: none">▪ Awareness of available HIV services; perceived social support for testing; attitudes toward testing▪ Provider attitudes, knowledge, skills and self-efficacy;▪ client attitudes toward providers▪ Caregiver knowledge, motivation;▪ services accessibility▪ Norms around health-seeking; attitudes about services and health providers; social dialogue about health topics	Improved service uptake and behavioral maintenance

Importance of Service Communication Throughout the Three Stages of Service Delivery

Each service delivery stage presents unique and important opportunities for communication to increase demand and uptake and help the intended audiences maintain new behaviors. It is important to remember that SBCC not only engages the individual client and provider, but also works to influence other levels of society: the national/policy level, the community/health facility, and peers and family. Clients and providers are influenced by many factors at multiple levels: Individual, Interpersonal, Community and Facility, and National. Those levels of influence are summarized in the Socio-Ecological Framework:

Socio-Ecological Model:

Enabling Environments

- Leadership
- Resources and Services
- Policies and Regulations
- Guidance and Protocols
- Religious and Cultural Values
- Gender Norms
- Media and Technology
- Income Equality

Service Delivery

- Access
- Quality
- Client volume
- Client satisfaction

Community

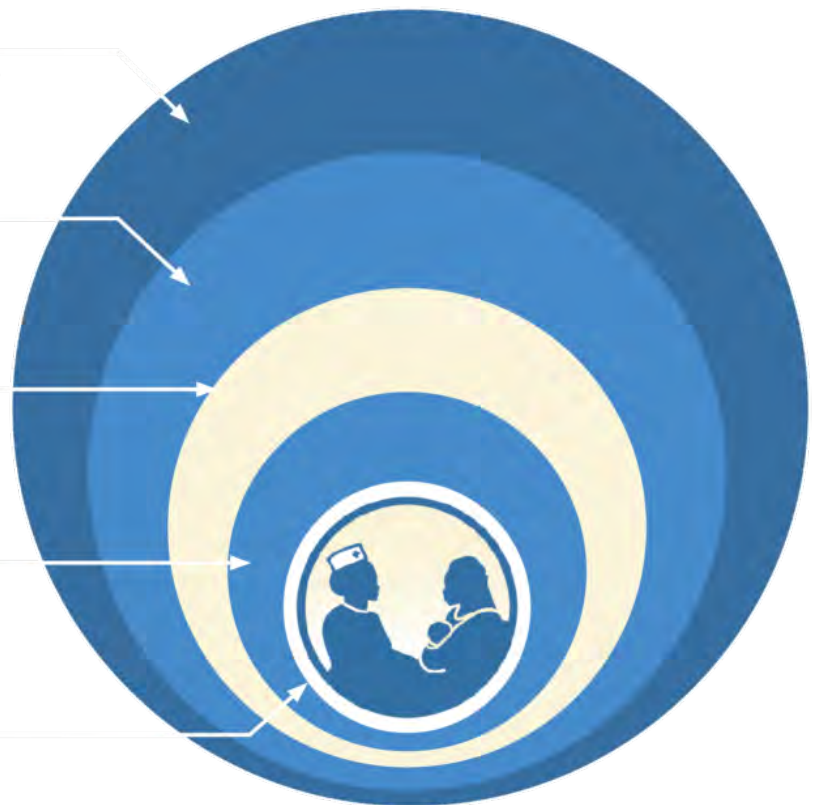
- Leadership
- Access to Information
- Social Capital
- Collective Efficacy

Family and Peer Networks

- Peer Influence
- Spousal Communication
- Partner and Family Influence
- Social Support

Individuals

- Knowledge
- Skills
- Beliefs and Values
- Self-Efficacy
- Perceived Norms
- Emotions



The table below summarizes the roles service communication plays at each level of the Socio-Ecological Framework across the three stages of service delivery.

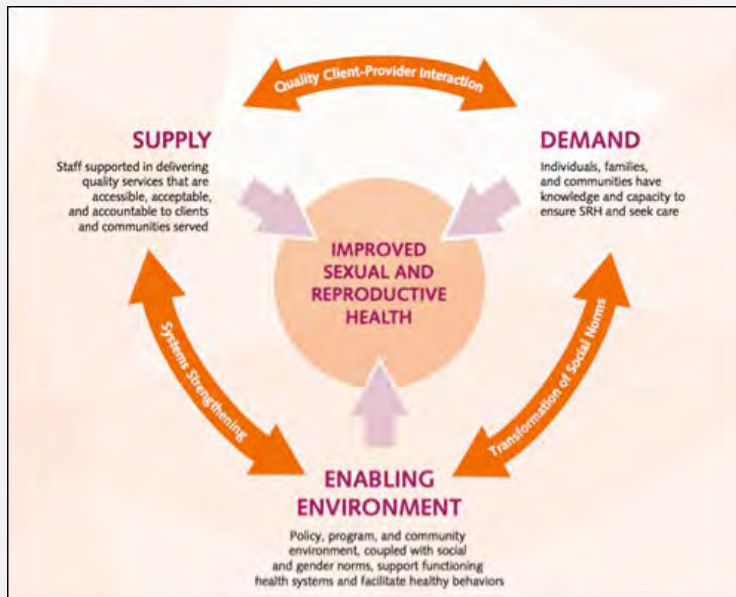
SBCC's Role in Service Delivery

BEFORE	DURING	AFTER
National/Policy Level <ul style="list-style-type: none"> Advocate for supportive policies and legislation Communicate policies and protocols Demand generation, outreach campaigns Develop brand/communication strategy for services Address beliefs and misinformation 	National/Policy Level <ul style="list-style-type: none"> Develop job aids Plan, implement campaign 	National/Policy Level <ul style="list-style-type: none"> Create SBCC indicators for M&E framework
Community/Facility Level <ul style="list-style-type: none"> Address social, gender norms, practices Cultivate community champions Provide accurate information Support/improve providers' image in community Address provider biases and attitudes Address beliefs and misinformation Combat stigma Conduct outreach Informed referrals 	Community/Facility Level <ul style="list-style-type: none"> Reinforce community-facility linkages Align demand strategies with supply Expand demand for services among underserved, hard-to-reach through community outreach Develop SBCC support supervision tools for providers 	Community/Facility Level <ul style="list-style-type: none"> Reinforce community-facility linkages for follow up Advise implementation of SBCC component of support supervision tools Collect monitoring data, process evaluation for SBCC indicators Reinforce supportive community and social norms to maintain supportive community and family environment
Interpersonal/Peer Level <ul style="list-style-type: none"> Cultivate client champions Address power dynamic and gender norm-related barriers 	Interpersonal/Peer Level <ul style="list-style-type: none"> Assist support groups Promote coaching within health teams 	Interpersonal/Peer Level <ul style="list-style-type: none"> Assist support groups as maintenance strategy

<ul style="list-style-type: none"> ▪ Facilitate interpersonal communication skills ▪ Informed referrals 		
Individual <ul style="list-style-type: none"> ▪ Address individual barriers tied to knowledge, skill, attitudes and motivation ▪ Highlight cost/benefits of change ▪ IPC, outreach, social media other ICT to address more complex barriers 	Individual <ul style="list-style-type: none"> ▪ Address provider norms, combat stigma ▪ Improve counseling skills 	Individual <ul style="list-style-type: none"> ▪ Promote behavioral maintenance through tools and messaging

Throughout each stage, communication also helps do the following:

- Address social norms that affect demand, behavior initiation and post-service behavioral maintenance
- Influence perceptions, beliefs, and attitudes related to the health problem and the services and products that prevent or treat it
- Advocate for supportive policies and investment to improve service delivery programs and related SBCC activities
- Strengthen organizational relationships within and between health systems and services, such as between facility- and community-based services



EngenderHealth’s Supply-Enabling Environment-Demand (SEED) Programming Model™ provides one example of how programs can be designed to address behavioral determinants at multiple levels – structural, individual, community, and health systems.

The SEED Programming Model™ can help ensure that: services are available and of high quality, there is sufficient demand for services, supportive norms exist, and health and political systems support services. Read more about the SEED Model™ [here](https://www.engenderhealth.org/files/pubs/family-planning/seed-model/SEED-8pg-English.pdf):

<https://www.engenderhealth.org/files/pubs/family-planning/seed-model/SEED-8pg-English.pdf>.

What Are the Limitations of Service Communication?

Although SBCC plays an important role in improving service delivery and uptake, there are a number of barriers to behavior change that SBCC alone cannot address:

- Inadequate infrastructure or logistical supplies that may lower provider motivation, increase work load, and limit available services
- Insufficient supply of commodities, making high-quality service delivery difficult or impossible

- Client or consumer inability to pay for products and services, reinforcing beliefs that services are inaccessible and out of reach for intended clients

Improving behaviors limited by these barriers requires coordination with other interventions, including health system strengthening, finance reform, and commodities procurement. However, communication techniques can be used to help raise awareness among decision-makers and advocate for additional attention and resources to address these barriers.

What Is the Evidence Base for Service Communication?

SBCC program evaluations have demonstrated how SBCC contributes to improved health outcomes among populations seeking services, including reductions in HIV incidence and increasing contraceptive prevalence rate. It is not always possible, however, to attribute health impact entirely to an individual program or to SBCC alone. This is especially the case if the barriers to behavior change are tied to barriers that communication cannot address on its own (such as poor or restrictive policies, lack of services or limited commodities). As a result, many SBCC programs measure short-term, intermediate results, such as increased knowledge, decreased stigma, increased self-efficacy and increased intention to seek services.

There is a growing body of evidence from program evaluations that have demonstrated SBCC's role, specifically with attempts to identify positive correlation between exposure to SBCC and reported changes in intermediate results across a range of health areas, including family planning, HIV prevention, malaria, and maternal and child health. The following are some successful examples of SBCC's impact in improving access to health services.

Family Planning

A number of studies have shown that mass media and interpersonal interventions, coupled with service provision, have increased intention to use and demand for modern contraceptives, and raised contraceptive prevalence, contributing to lower fertility rates. To achieve these outcomes, family planning programs have integrated SBCC to:

- Create informed and voluntary demand for family planning products and services
- Ensure that individuals can use contraceptives correctly and appropriately
- Improve client/provider interaction
- Provide accurate information about sex, sexuality, and fertility
- Address misconceptions about contraceptives and their effects
- Increase societal acceptance for family planning

The Nigerian Urban Reproductive Health Initiative (NURHI) is funded by the Bill & Melinda Gates Foundation and managed by Johns Hopkins Center for Communication Programs (CCP). NURHI integrates high-quality services and effective SBCC throughout the three phases of service delivery. During the first phase of the project (2009–2014) in six urban centers, the project demonstrated an increase in knowledge about modern family planning methods and where services were available, and an increase in contraceptive prevalence rates in every city where the project was implemented.

Main RH service client was seeking	Abuja		Benin City		Ibadan		Ilorin		Kaduna		Zaria	
	Baseline	Endline	Baseline	Endline	Baseline	Endline	Baseline	Endline	Baseline	Endline	Baseline	Endline
Family planning	16.7	51.3	11.9	24.7	5.9	43.4	9.9	43.7	8.0	42.4	1.8	37.7
Antenatal care	30.4	8.7	30.9	27.1	38.8	18.1	39.2	25.0	48.4	34.7	91.8	40.3
Delivery services	0.5	0.2	0.2	0.0	0.6	0.6	0.7	1.6	2.6	0.0	0.0	0.4
Postnatal care	2.6	0.0	2.8	0.3	2.1	0.9	0.4	0.9	5.2	0.2	0.0	1.4
Postabortion care	0.6	0.0	0.1	0.0	0.1	0.1	0.4	0.1	0.5	0.1	0.0	0.3
Child health ¹	35.1	38.7	46.0	42.1	38.9	21.1	36.6	18.3	20.1	12.6	6.4	12.5
STI management, HIV/AIDS management, VCT	0.2	0.0	0.6	0.1	0.4	2.8	0.1	0.0	1.8	0.4	0.0	0.3
Curative services	13.5	0.5	7.0	5.7	12.9	12.9	10.6	10.2	13.4	9.4	0.0	7.2
Other	0.5	0.7	0.5	0.1	0.2	0.1	2.1	0.1	0.0	0.1	0.0	0.0
Number of clients	855	600	818	794	1362	1339	809	977	812	959	784	722

¹Child health includes growth monitoring and child immunization.

More information on the [NURHI Project](http://www.nurhitoolkit.org/) (<http://www.nurhitoolkit.org/>) | [NURHI Case Study](#) (Appendix M)

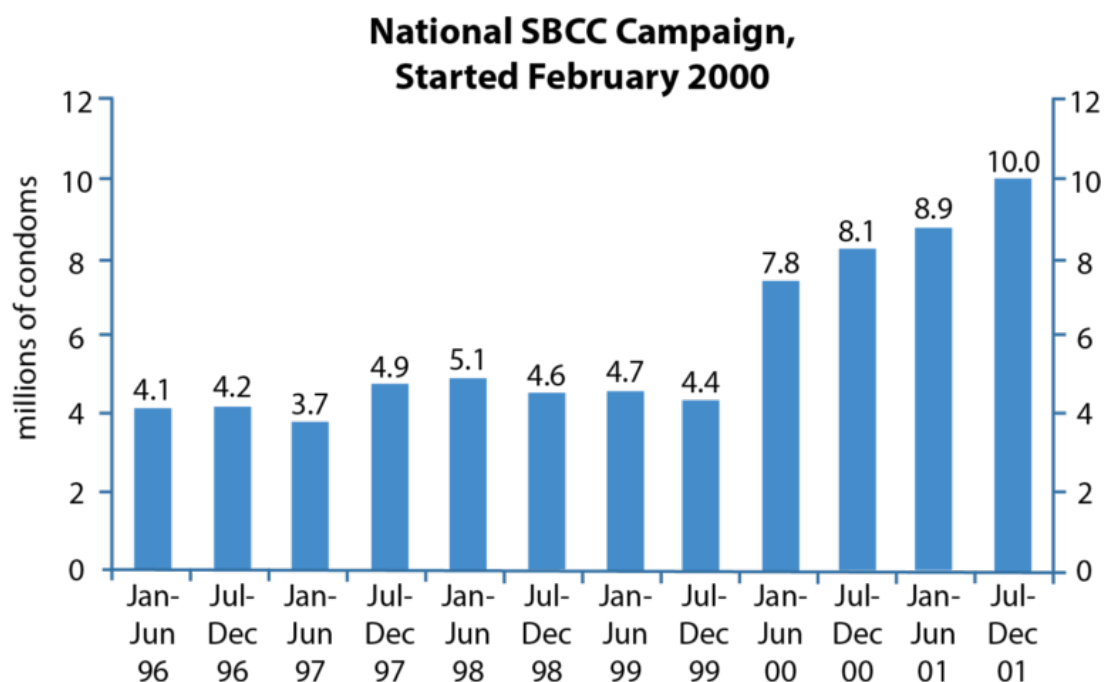
For additional family planning-related evidence on the impact of integrating SBCC and health services, see the following resources:

- [Health Communication: Enabling Voluntary and Informed Decision-Making](https://www.fphighimpactpractices.org/resources/health-communication-enabling-voluntary-and-informed-decision-making)
(<https://www.fphighimpactpractices.org/resources/health-communication-enabling-voluntary-and-informed-decision-making>)
- [Interventions Delivered by Mobile Phone to Support Client Use of Family Planning/Contraception](http://www.cochrane.org/CD011159/FERTILREG_interventions-delivered-by-mobile-phone-to-support-client-use-of-family-planningcontraception)
(http://www.cochrane.org/CD011159/FERTILREG_interventions-delivered-by-mobile-phone-to-support-client-use-of-family-planningcontraception)
- [Behavioral interventions for improving contraceptive use among women living with HIV](http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD010243.pub3/full)
(<http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD010243.pub3/full>)
- [Cluster Randomized Controlled Trial Evaluation of a Gender Equity and Family Planning Intervention for Married Men and Couples in Rural India](http://www.ncbi.nlm.nih.gov/pubmed/27167981)
(<http://www.ncbi.nlm.nih.gov/pubmed/27167981>)
- Family Planning Evidence Database (coming soon)

HIV Prevention

HIV prevention programs providing voluntary medical male circumcision (VMMC) have sought to coordinate demand creation and service delivery. Communication has increased awareness of services and addressed barriers linked to fear of pain, misinformation, and social norms.

Service communication has also been successfully used to increase condom sales and use. For example, in 2000 a multichannel SBCC campaign was implemented in Ghana involving mass media and community level approaches, integrating advocacy with leaders. Right after the campaign was implemented there was a 3.2 million increase in condom sales, and sales continued to rise at an average rate of 1.2 million per year.

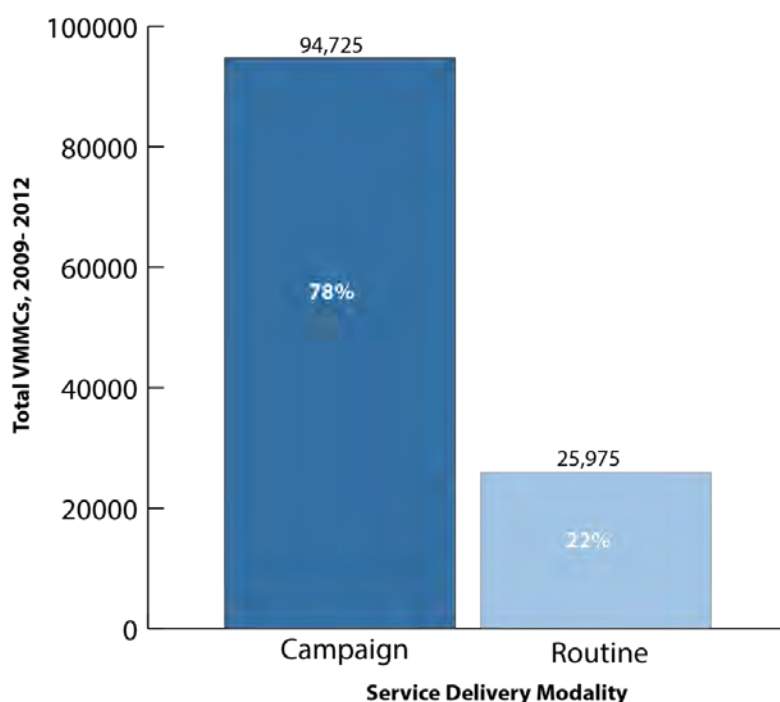


HIV prevention programs providing voluntary medical male circumcision (VMMC) have sought to coordinate demand creation and service delivery. Communication has increased awareness of services and addressed barriers linked to fear of pain, misinformation, and social norms.

Communication has also reinforced good post-operative behavior (short-term abstinence, wound care, and issues tied to gender and sexual relations). Between 2009 and 2012, demand creation campaigns for VMMC in Iringa, Tanzania, resulted in a considerable increase in services uptake, compared with non-campaign

periods. [Complete case study](#)

(<http://www.mchip.net/sites/default/files/AIDSTAR%20case%20study%20on%20VMMC.pdf>).



Source: Kanagat, Natasha, Amelia Rock, Hally Mahler, Karin Hatzold, C. Sophia Magalona, and Tigistu Adamu. 2013. *Matching Demand with Supply: Scaling Up Voluntary Medical Male Circumcision in Tanzania and Zimbabwe. Case Study Series*. Arlington, VA: USAID's AIDS Support and Technical Assistance Resources, AIDSTAR-One, Task Order 1, and MCHIP-Maternal and Child Health Integrated Program.

For additional HIV-related evidence on the impact of integrating SBCC and health services, see the following resources:

- [Impact of Health Communication on the HIV Continuum of Care](http://healthcommcapacity.org/wp-content/uploads/2015/04/SBCC-HIV-Evidence-Continuum-of-Care-Feb20151.pdf)
(<http://healthcommcapacity.org/wp-content/uploads/2015/04/SBCC-HIV-Evidence-Continuum-of-Care-Feb20151.pdf>)
- [Making the Case for SBCC for Reproductive Health Among Youth](http://www.healthcommcapacity.org/wp-content/uploads/2015/02/BCC-Infographic-mb.pdf)
(<http://www.healthcommcapacity.org/wp-content/uploads/2015/02/BCC-Infographic-mb.pdf>)
- [HC3 HIV Evidence Database](http://healthcommcapacity.org/hiv-evidence-database/) (<http://healthcommcapacity.org/hiv-evidence-database/>)

- [Compendium of Evidence-Based Interventions and Best Practices for HIV Prevention](http://www.cdc.gov/hiv/research/interventionresearch/compendium/index.html)
(<http://www.cdc.gov/hiv/research/interventionresearch/compendium/index.html>)

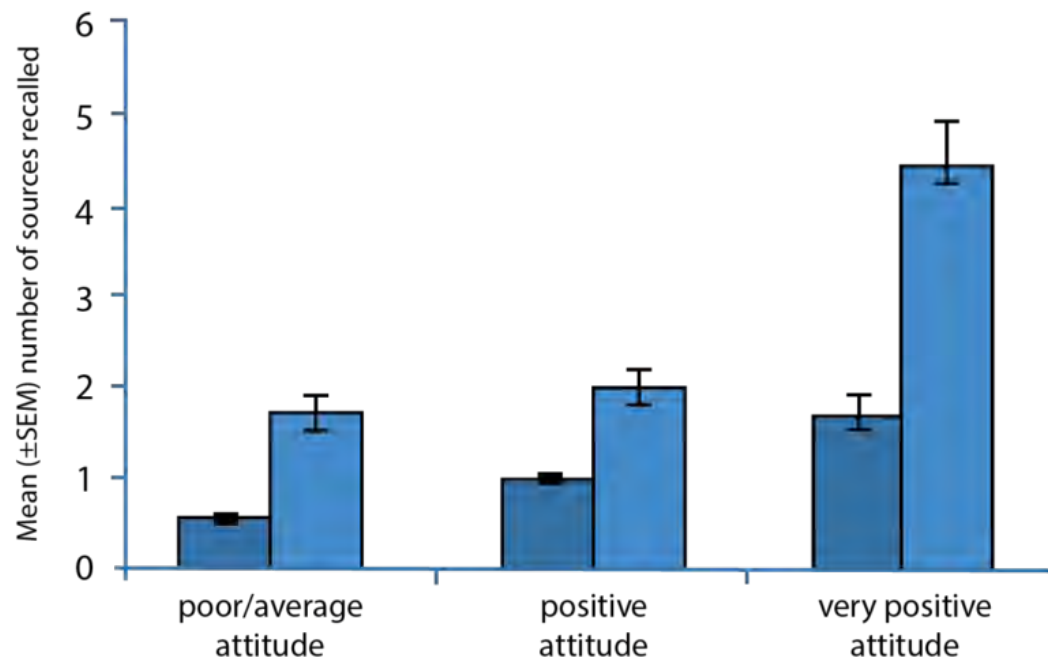
Malaria

Service communication has helped improve malaria-related health outcomes. Malaria-related service communication has been used to:

- Increase demand for and use of insecticide-treated nets
- Change provider behavior related to diagnosis and treatment of malaria
- Improve adherence to ACTs
- Address myths and misconceptions about malaria
- Change norms around health-seeking behavior

For example, a facility-based cluster randomized trial in Tanzania found that a communication intervention was associated with improved prescriber adherence to rapid diagnostic test results, and reduced over-prescription of antimalarials to almost zero.

In Uganda, service communication was used to improve net durability. The activities – designed by a group of health workers, school teachers, district leaders, and SBCC experts - included mass media, community mobilization, and clinic posters. The evaluation showed that the intervention resulted in improved knowledge and attitudes towards care and repair, which impacted positively on net condition.



Source: *Impact of a behaviour change communication programme on net durability in eastern Uganda* (<http://www.malariajournal.com/content/14/1/366/abstract>)

Results below from a facility-based cluster randomized trial in Tanzania found that a communication intervention was associated with improved prescriber adherence to rapid diagnostic test results, and reduced over-prescription of antimalarials to almost zero. Communication activities included interactive small group workshops, feedback and motivational SMS to providers, and patient leaflets and clinic posters in the facilities. Each of the activities led to incremental improvements in over-prescription of antimalarials. Provider behavior was changed through this combination of communication interventions.

The table below shows the results of the communication intervention.

Effect of Interventions on Antimalarial Prescribing, RDT Use and Antibiotic Prescribing

OUTCOME	ARM	NUMBER OF PATIENTS	PREVALENCE NUMBER (%)	CRUDE RD ^A (95% CI)	ADJUSTED RD ^B (95% CI)	P-VALUE
Patients with fever treated with rAM	Control	9,231	2180 (24%)	0	0	
	HW	9,752	1700 (17%)	0.07 (0.004, 0.13)	0.03 (-0.04, 0.10)	0.44
	HWP	7,887	1,304 (16%)	0.07 (0.01, 0.14)	0.05 (-0.002, 0.10)	0.06
Patients with no fever treated with rAM	Control	4,863	82 (2%)	0	0	
	HW	6,062	193 (3%)	-0.003 (-0.02, 0.01)	0.002 (-0.01, 0.01)	0.52
	HWP	5,984	40 (1%)	0.01 (-0.01, 0.03)	0.002 (-0.01, 0.01)	0.73
RDT Uptake						
Patients with fever tested with RDT	Control	9,297	4960 (53%)	0	0	
	HW	9,825	5374 (55%)	-0.04 (-0.15, 0.07)	-0.04 (-0.20, 0.10)	0.57
	HWP	7,963	5153 (65%)	-0.12 (-0.21, -0.03)	-0.02 (-0.13, 0.09)	0.72
RDT eligible (fever and no obvious alternate	Control	8,241	3697 (45%)	0	0	

diagnosis) not tested						
	HW	9,064	4000 (44%)	0.04 (–0.07, 0.15)	0.06 (–0.11, 0.23)	0.44
	HWP	7,292	2459 (34%)	0.12 (0.04, 0.21)	0.18 (0.05, 0.32)	0.01
RDT ineligible (no fever) tested	Control	4,874	587 (12%)	0	0	
	HW	6,083	955 (16%)	–0.01 (–0.07, 0.04)	0.01 (–0.06, 0.07)	0.86
	HWP	6,000	518 (9%)	0.02 (–0.05, 0.09)	0.02 (–0.04, 0.09)	0.43
Presumptive Treatment						
RDT eligible treated presumptively for malaria	Control	8,241	471 (6%)	0	0	
	HW	9,064	374 (4%)	0.02 (–0.01, 0.05)	0.01 (–0.02, 0.04)	0.40
	HWP	7,292	256 (4%)	0.02 (–0.003, 0.05)	0.02 (–0.004, 0.05)	0.09
RDT ineligible treated presumptively for malaria	Control	4,874	42 (1%)	0	0	
	HW	6,083	47 (1%)	0.004 (–0.001, 0.01)	0.003 (–0.001, 0.01)	0.15

	HWP	6,000	12 (0.2%)	0.007 (0.003, 0.01)	0.004 (– 0.0001, 0.01)	0.05
Adherence to RDT negative						
RDT negative receiving AM	Control	4,015	762 (19%)	0	0	
	HW	4,539	250 (6%)	0.14 (0.08, 0.20)	0.10 (0.03, 0.17)	0.01
	HWP	4,330	189 (4%)	0.15 (0.09, 0.21)	0.10 (0.04, 0.16)	0.002
RDT negative receiving AM (among those with fever)	Control	3,488	723 (21%)	0	0	
	HW	3,793	235 (6%)	0.16 (0.08, 0.23)	0.11 (0.03, 0.19)	0.01
	HWP	3,897	177 (5%)	0.21 (0.04, 0.17)	0.12 (0.05, 0.19)	0.002
RDT negative receiving AM (among those with no fever)	Control	527	39 (7%)	0	0	
	HW	746	15 (2%)	0.05 (– 0.01, 0.10)	0.03 (0.01, 0.05)	0.004
	HWP	433	12 (3%)	0.04 (– 0.01, 0.10)	-	-

Source: Cundill et al. *BMC Medicine* (2015) 13:118.

For additional malaria-related evidence on the impact of integrating SBCC and health services, see the following resources:

- [The Impact of BCC on the Use of Insecticide Treated Nets: A Secondary Analysis of Ten Post-Campaign Surveys from Nigeria](http://malariajournal.biomedcentral.com/articles/10.1186/s12936-016-1463-7) (<http://malariajournal.biomedcentral.com/articles/10.1186/s12936-016-1463-7>)
- Malaria Evidence Database (coming soon)

Child Health

Service communication has been used in the child health area to increase vaccination coverage, improve child nutrition through positive feeding practices, increase care-seeking for life threatening conditions, and improve use of life-saving treatments.

For example, an intensive radio campaign in Burkina Faso addressed key lifesaving family behaviors for child survival. The radio campaign had a high reach. Results from a cluster randomized trial showed that in intervention areas, care seeking for diarrhea and getting treatment for rapid/labored breathing improved more than in control areas. [Read more](http://www.ghspjournal.org/content/3/4/557.full.pdf+html) (<http://www.ghspjournal.org/content/3/4/557.full.pdf+html>).

For additional child health-related evidence on the impact of integrating SBCC and health services, see the following resources:

- [Role of Social Support in Improving Infant Feeding Practices in Western Kenya: A Quasi-Experimental Study](http://dx.doi.org/10.9745/GHSP-D-15-00197) (<http://dx.doi.org/10.9745/GHSP-D-15-00197>)
- [Behavior Change Interventions and Child Nutritional Status](http://www.iycn.org/files/IYCN_comp_feeding_lit_review_062711.pdf) (http://www.iycn.org/files/IYCN_comp_feeding_lit_review_062711.pdf)
- [SBCC Evidence in Child Survival Programs - Journal of Health Communication](http://www.tandfonline.com/toc/uhcm20/19/sup1) (<http://www.tandfonline.com/toc/uhcm20/19/sup1>)
- [Demand Generation for 13 Life Saving Commodities - A synthesis of the evidence](http://healthcommcapacity.org/wp-content/uploads/2015/04/Demand-Generation-A-Synthesis-of-the-Evidence-FINAL.pdf) (<http://healthcommcapacity.org/wp-content/uploads/2015/04/Demand-Generation-A-Synthesis-of-the-Evidence-FINAL.pdf>)
- [Engaging Communities with a Simple Tool to Help Increase Immunization Coverage](http://www.ghspjournal.org/content/3/1/117.full.pdf+html) (<http://www.ghspjournal.org/content/3/1/117.full.pdf+html>)

- [Evidence of Effective Approaches to Social and Behavior Change Communication for Preventing and Reducing Stunting and Anemia](https://www.spring-nutrition.org/sites/default/files/publications/series/spring_sbcc_lit_review.pdf)
(https://www.spring-nutrition.org/sites/default/files/publications/series/spring_sbcc_lit_review.pdf)
- [Lactation counseling increases exclusive breast-feeding rates in Ghana](http://www.ncbi.nlm.nih.gov/pubmed/15987851)
(<http://www.ncbi.nlm.nih.gov/pubmed/15987851>)
- [Effect of counseling on nutritional status during pregnancy](http://www.ncbi.nlm.nih.gov/pubmed/16936363)
(<http://www.ncbi.nlm.nih.gov/pubmed/16936363>)

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 style="list-style-type: none"> ▪ Strategically segment audiences ▪ Seek to understand clients and what matters to them ▪ Design activities based on an understanding of what motivates client behavior ▪ Address provider bias and how providers treat clients ▪ Tailor messages to different audiences ▪ Address underlying norms and attitudes 	<ul style="list-style-type: none"> ▪ Audience analysis, including effective segmentation, prioritization, and profiling ▪ Identifying and selecting the most relevant determinants of behavior change ▪ Addressing providers as an audience for behavior change ▪ Designing and tailoring messages for different audiences ▪ Community outreach and mobilization
Helping clients adopt desired behaviors and use products	<ul style="list-style-type: none"> ▪ Strategically segment audiences ▪ Seek to understand clients and what matters to them ▪ Offer clear benefits for adopting behaviors and using products, based on what the clients care about ▪ Address provider bias and how providers treat clients ▪ Design activities that address the true determinants of behavior ▪ Foster support systems ▪ Design activities that address the true determinants of behavior ▪ Seek to understand clients and what matters to them 	<ul style="list-style-type: none"> ▪ Audience analysis ▪ Determining key benefits ▪ Addressing providers as an audience for behavior change ▪ Identifying and selecting the most relevant determinants of behavior change

Helping clients maintain desired behaviors and adhere to treatment regimens	<ul style="list-style-type: none"> ▪ Foster support systems ▪ Design activities that address the true determinants of behavior ▪ Seek to understand clients and what matters to them 	<ul style="list-style-type: none"> ▪ Community mobilization ▪ Identifying and selecting the most relevant determinants of behavior change ▪ Audience analysis
Reaching the desired audience with messages	<ul style="list-style-type: none"> ▪ Tailor messages to different audiences, based on a clear understanding of the audience ▪ Use appropriate communication channels 	<ul style="list-style-type: none"> ▪ Designing and tailoring messages for different audiences ▪ Selecting an appropriate channel mix based on communication landscape and audience preferences
Getting the audience to respond to communication efforts	<ul style="list-style-type: none"> ▪ Seek to understand clients and what matters to them ▪ Tailor messages to different audiences, based on a clear understanding of the audience ▪ Offer clear benefits for adopting behaviors and using products, based on what the clients care about ▪ Use appropriate communication channels 	<ul style="list-style-type: none"> ▪ Audience analysis ▪ Designing and tailoring messages for different audiences ▪ Determining key benefits ▪ Selecting an appropriate channel mix based on communication landscape and audience preferences
Achieving positive client-provider interactions	<ul style="list-style-type: none"> ▪ Address provider bias and how providers treat clients ▪ Create counseling and job aids ▪ Improve the work environment ▪ Empower clients 	<ul style="list-style-type: none"> ▪ Address providers as an audience for behavior change ▪ 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.

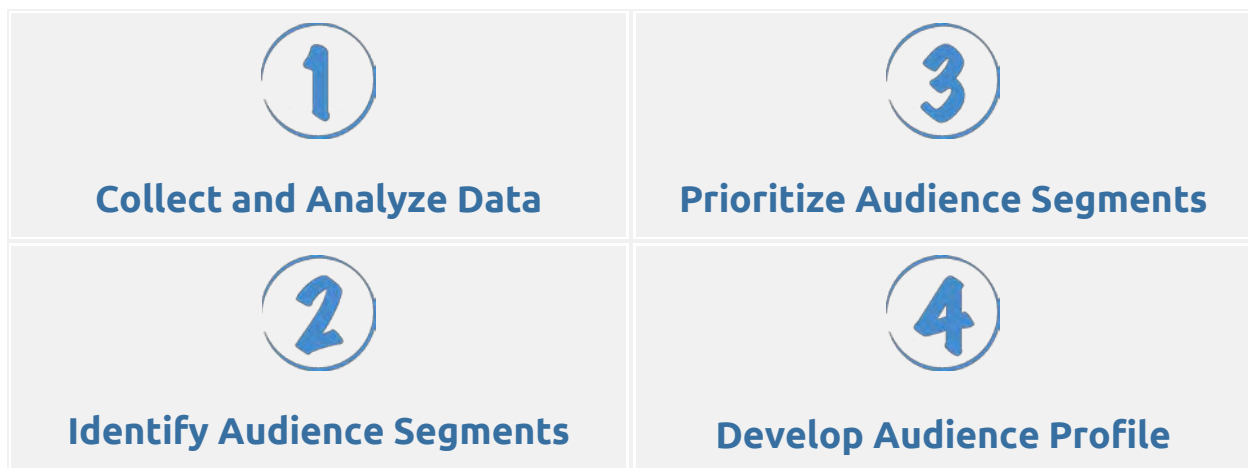
What Is the Audience Analysis Process?

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 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) (<http://www.thehealthcompass.org/how-to-guides/how-do-audience-analysis>).



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-vision 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://design toimprovelife.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  Because they do not access family planning due to a fear of side effects.	Men  Because they control financial decisions in the household and don't understand benefits of family planning.
Policymakers  Because there is no budget at the national level for family planning commodities.	Health Care Providers  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	<ul style="list-style-type: none"> Married, rural women ages 30-40 who are worried about side effects Female, urban, single university students aged 18-30
Adolescents	<ul style="list-style-type: none"> Unmarried girls aged 15-19 living in rural areas, in school Unmarried girls in urban areas, aged 20-24, out of school
Male youth	<ul style="list-style-type: none"> Urban males, ages 15-19, who want to be seen as fearless and care about status Rural males, ages 15-19, in school, currently not using condoms in casual sexual encounters
Health providers in rural areas	<ul style="list-style-type: none"> Clinical officers in rural areas with less than 5 years of experience 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) (<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: <ul style="list-style-type: none"> ▪ 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: <ul style="list-style-type: none"> Mobila clinics Youth Outreach ✓ CBD and Education 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.

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) (<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) (<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](http://sbccimplementationkits.org/service-communication/lessons/addressing-providers-as-a-behavior-change-audience/) 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 Zion (Primary Audience)

Demographics: Zion 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: Zion is familiar with most modern contraceptive methods and understands the benefits of having a smaller family. With only a primary school certificate, Zion 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: Zion is hesitant to discuss contraceptive methods with her husband, but they have talked about how they can plan well for their family. Zion is a lapsed contraceptive (pill) user, and they are not using any method right now.

Barriers/Facilitators to Desired Behavior: Zion 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/) (<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	<ul style="list-style-type: none">▪ Community radio▪ Women's group meetings▪ <i>WhatsApp</i> 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	<ul style="list-style-type: none">▪ Community radio▪ Newspaper▪ 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/](https://www.utwente.nl/cw/theorieenoverzicht/Theory%20Clusters/Health%20Communication/))

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 communautaire) 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?

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/)
(<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	<ul style="list-style-type: none"> ▪ Conduct Community mobilization/ meetings with parents/partners ▪ Direct outreach to spouse/parent to encourage involvement 	<ul style="list-style-type: none"> ▪ Couples counseling services 	<ul style="list-style-type: none"> ▪ 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	<ul style="list-style-type: none"> ▪ Introduce branded strategy to promote “friendly, welcoming” services and providers ▪ Train providers in effective consultative techniques 	<ul style="list-style-type: none"> ▪ Provide job aids and counseling tools that encourage interaction ▪ Create branded materials to communicate friendly clinic atmosphere ▪ Provide ongoing support and supervision to ensure providers are more interactive and friendly and maintain positive behaviors ▪ Reward and celebrate providers who adopt and maintain new behaviors in media, community meetings 	<ul style="list-style-type: none"> ▪ Provide tools to allow clients to communicate with providers after the visit (mHealth, SMS) ▪ Conduct outreach through home visits and community mobilization, referral and follow-up

Primary audience or behavior is stigmatized	<ul style="list-style-type: none"> ▪ Conduct community sensitization activities about behavior and target group ▪ Provider sensitivity training ▪ Engage “positive deviants”/opinion leaders who challenge social stigma in community and mass media activities 	<ul style="list-style-type: none"> ▪ Provide confidential clinical counseling through designated, discretely branded services ▪ Provide peer-based counseling ▪ Provide counseling through trained/sensitive providers 	<ul style="list-style-type: none"> ▪ Encourage clients to return for follow-up and maintain contact using mHealth and interpersonal communication
Health area and/or service is considered taboo	<ul style="list-style-type: none"> ▪ Conduct community sensitization about the health area/service ▪ Provide information to address misinformation ▪ Conduct provider sensitivity training 	<ul style="list-style-type: none"> ▪ Provide information to address misinformation ▪ Conduct provider sensitivity training 	<ul style="list-style-type: none"> ▪ Use mass media and community mobilization to address misinformation
Cultural beliefs reject some modern medical practices	<ul style="list-style-type: none"> ▪ Increase knowledge and awareness of medical practice ▪ Conduct community and mass media activities to address misinformation 	<ul style="list-style-type: none"> ▪ Increase knowledge and awareness of medical practice and counter misinformation through community sensitization and clinic-based information sessions 	<ul style="list-style-type: none"> ▪ Increase knowledge and awareness of medical practice and address misinformation ▪ 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/Pnadi383.pdf) (http://pdf.usaid.gov/pdf_docs/Pnadi383.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). (<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](https://www.nih.gov/institutes-nih/nih-office-director/office-communications-public-liaison/clear-communication/plain-language/plain-language-getting-started-or-brushing) 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	<ul style="list-style-type: none"> ▪ Does the message stand out? Does your audience think it does? ▪ 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	<ul style="list-style-type: none"> ▪ Is the message simple and direct? ▪ Remember, less is more! Stay focused only on what the audience needs to know.

3. Communicate a benefit	<ul style="list-style-type: none"> ▪ What will the audience get in return for taking action? ▪ 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	<ul style="list-style-type: none"> ▪ Activities and materials convey the same message and become mutually supportive in creating recall and change. ▪ "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	<ul style="list-style-type: none"> ▪ Is it better to appeal to the audience's emotions, intellect, or both? Emotional appeals are often more convincing than facts.
6. Create trust	<ul style="list-style-type: none"> ▪ 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	<ul style="list-style-type: none"> ▪ What do you want the audience to do after seeing the communication? What action is realistic as a result of the communication? ▪ The call to action should focus on a concrete and realistic action and help achieve your objectives.

IMPORTANT NOTE ON PRE-TESTING MATERIALS

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) (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.changeprogram.org/sites/default/files/sbcc_module3.pdf) (https://www.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) (<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.	<ul style="list-style-type: none"> One-on-one meetings between peers or between client and health provider Community group meetings, mother-to-mother groups, peer groups 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	<ul style="list-style-type: none"> 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.	<ul style="list-style-type: none"> TV soap opera incorporating service uptake into a popular storyline Radio talk shows with health providers as on-air guests to address myths and misconceptions 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.	<ul style="list-style-type: none"> Facebook page to build interest for the service and provide follow-up information Demonstration videos on new skills to be shared among clients or newly trained providers 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
		<ul style="list-style-type: none"> 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/): <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 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=lgUWB9EYvLQ>) 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



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](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): <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/) (<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/) (<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

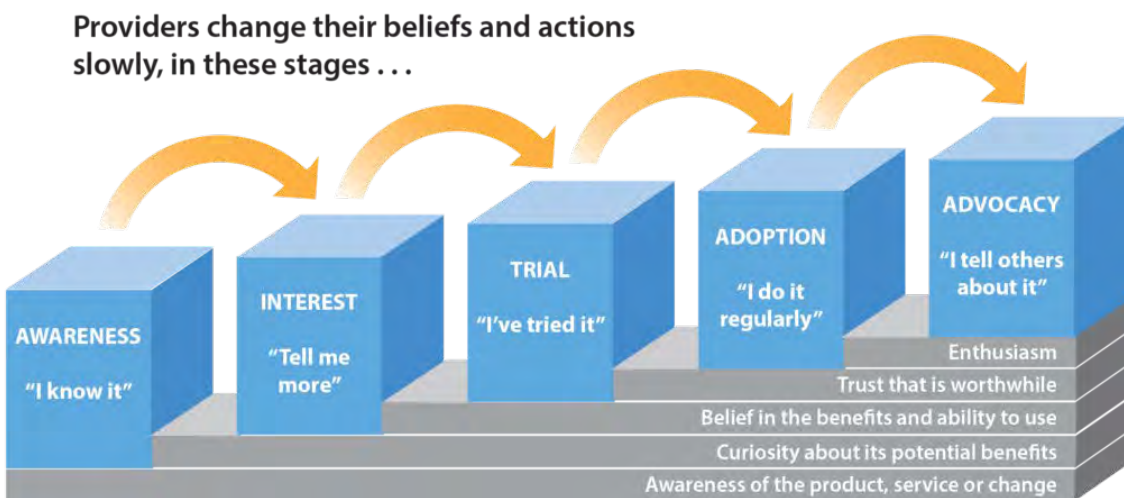
PSI developed and implements a system for provider behavior change in its social franchise clinics based on the : **Stages of Change (Transtheoretical Model):** <http://www.orau.gov/hsc/theorypicker/ttm.html>. PSI uses the process to address gaps in a wide range of provider behaviors and health areas.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



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.

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](http://www.ghspjournal.org/content/4/2/311.full.pdf+html)



OPERATIONAL CONSIDERATIONS FOR COORDINATING SBCC AND SERVICE DELIVERY PROGRAMS

In service communication, effective coordination is the key to ensuring desired behavioral outcomes – increased demand, improved uptake, and consistent long-term maintenance – across the three stages. The Design section of this I-Kit covers principles that service delivery programs can follow when designing and implementing their own communication activities and materials. This Operational Considerations section covers principles service delivery programs can follow when coordinating with SBCC partners.

Coordinating SBCC with service delivery often involves partners with different timelines, objectives and ways of working. It requires investment in planning, participatory message development, regular check-ins during implementation, revision of approaches and messages, and joint monitoring and evaluation (M&E) of activities. This all requires time and communication at a project management and implementation level.

The table below summarizes key collaboration points for service delivery and SBCC partners.

BEFORE	DURING	AFTER
<ul style="list-style-type: none">▪ Collaborate on formative research to understand key audiences and behavioral drivers▪ Ensure balance between demand and supply (mobilizing for services that are available and accessible)▪ Use participatory design processes for strategy and messaging.▪ Define roles and boundaries for all stakeholders (service	<ul style="list-style-type: none">▪ Meet and coordinate regularly to monitor activities, highlight what's working, and establish platforms for collective problem solving▪ Coordinate supportive supervision to identify and correct issues with supply-side and demand-side activities	<ul style="list-style-type: none">▪ Measure SBCC's impact on service delivery and the impact service quality has on demand▪ Share lessons learned

providers, SBCC actors, civil society organizations/community-based organizations) <ul style="list-style-type: none"> ▪ Create tools and processes for referral and linkages 	<ul style="list-style-type: none"> ▪ Monitor impact of messages and activities and revise accordingly ▪ Ensure balance between supply and demand 	
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Why Is Coordinating SBCC with Service Delivery Important?

Coordination between service delivery and SBCC partners helps programs achieve desired behavioral and health outcomes by ensuring smooth operations and a balance between supply and demand for services. If strategies and messages are out of sequence, clients could show up at the facility for services that are not available, or services could be underutilized because clients do not understand their value or where to access them. If messages are not harmonized, potential contradictions between what is communicated in the community and at the clinic can confuse clients and undermine services. If a client returns home without understanding where to find support or what to do next, he or she may not adopt or sustain the new behavior.

Common SBCC/Services Coordination Models

Some of the most common scenarios in which service delivery and SBCC partners may coordinate include the following:

SBCC and services implemented through separate projects or organizations –

In this arrangement, partners may aim to collaborate in overlapping geographies, with common audiences, or for the same health intervention. In some cases, they may have a formal agreement designating partner roles, such as a memorandum of understanding. Each organization has its own scope of work, budget, and organizational chart. An example is the [Communication for Healthy Communities](https://www.fhi360.org/projects/communication-healthy-communities-chc) (CHC) project in Uganda (<https://www.fhi360.org/projects/communication-healthy-communities-chc>).

- **SBCC and services implemented through a single project with separate organizations** – In this scenario, one partner leads SBCC and another partner

leads services, although the project has one overall budget and organizational chart. Often, the technical partner seconds managers or advisors for SBCC and services. Examples include the [Nigerian Urban Reproductive Health Initiative](http://www.nurhitoolkit.org/) (<http://www.nurhitoolkit.org/>) and [Tupange](http://fptoolkit.or.ke/about-tupange/) (<http://fptoolkit.or.ke/about-tupange/>).

- **SBCC and services implemented through a single project with one lead partner** – The project has one overall budget and organizational chart. All staff members, regardless of their roles, are employees of the same organization.

The types of organizations that partner also vary. Some common scenarios are listed below:

- The national or state-level Ministry of Health coordinates public family planning services with an NGO partner responsible for demand creation.
- An international NGO providing HIV testing and referrals for treatment collaborates with another NGO with SBCC expertise.
- An international NGO contracts smaller CBOs for a variety of services and communication activities for orphans and vulnerable children delivered at community level.
- An NGO with SBCC expertise partners with a group of socially franchised or networked providers to create demand for a package of essential health services.

Coordination between service delivery and SBCC may also take on different structures in order to maximize coverage and reach, strengthen linkages to designated clinics and leverage individual organizational capacity. These models may include geographical or cross-sectoral coordination.

Geographical Coordination:

- An SBCC partner designs a national communication campaign to increase demand for services. The services partner implements community outreach and/or mobilization activities to encourage clients to visit designated clinics. The clinics are those supported by the service delivery partner at sub-national and/or community level. An example is the Jhpiego and the Tanzania Capacity and Communication Project (TCCP) partnership **AIDSFREE Tanzania VMMC** (<https://aidsfree.usaid.gov/countries/tanzania-vmmc>).
- An SBCC partner implements community mobilization and some outreach in select regions or communities to create demand, provide specific services at community level, and make referrals. The service delivery partner builds capacity among providers who accept referrals from community agents and who provide health services that cannot be delivered by community health workers due to national policy limitations or capacity gaps. Two examples from Nigeria are the **Expanded Social Marketing Project** (<http://sfhnigeria.org/projects/expanded-social-marketing-project-in-nigeria-esmpin>) and **SHOPS** (<http://www.shopsproject.org/>).

Coordination Across Sectors:

- An SBCC partner collaborates with the public health sector to provide facility-based communication in or around selected facilities. Activities include health talks and clinic outreach events to drive demand for services provided through the public sector.
- A service delivery partner collaborates with community-based organizations that drive demand for select services, either provided directly by the service delivery partner or provided by private or public facilities supported through training and capacity building by an NGO service delivery partner. An example is the **Letlama project in Lesotho** (<http://www.thehealthcompass.org/campaign-kit-or-package/letlama>)

Donors play an important role in helping SBCC and service delivery partners coordinate efforts. Donors set technical priorities and determine funding cycles. They also set project cycle and workplanning schedules. The way donors design projects can help establish partner roles and can ensure that communication activities reach both the national and the community or service center level. Donors can also help encourage or maintain a knowledge management system that enables project partners to access service communication materials and summaries of activities.

Applying Key Coordination Principles

Whatever the model, effective coordination between services and SBCC relies on the following key principles:



Develop Joint Strategies

To better align supply and demand, SBCC and service partners should confirm that their programs are compatible. This is often done through co-creating overall project strategies before the program is designed and aligning work plans.

Communication for Healthy Communities (CHC)

(<https://www.fhi360.org/projects/communication-healthy-communities-chc>), an SBCC project operating in Uganda, works to improve uptake of key health services (malaria, HIV treatment and care, family planning, TB, and maternal and child health) delivered by a range of health partners in the public and private sectors in 112 districts.

CHC co-developed the project's main campaign strategy in collaboration with service delivery partners, the relevant Ministry of Health technical working groups, and the Uganda AIDS Commission. Partners contributed to formative research, participated in the strategy design workshop and reviewed the resulting strategy and materials before they were finalized. The result is an umbrella campaign, *Obulamu?* ("How's life?"), which aims to address barriers to service uptake and drive demand to high-volume health facilities that meet quality standards for service delivery.



For *Obulamu*, CHC consults with service delivery partners through monthly and quarterly meetings to review service statistics, revise demand-creation strategies and review work plans. Each high-volume clinic has service targets. If a clinic does not meet one of the targets, the partners use the periodic meetings to jointly revise demand-creation strategies for the next month. For example, when partners determined that demand for services was below targets in some clinics, CHC met with implementing partners to develop a revised strategy that increased engagement of village health teams to address identified client barriers to uptake. The project also increased media intensity through community radio stations, with modified messages on the specific days and times services were available.

Once such strategies are developed, it is important to align SBCC and service delivery work plans. In aligning work plans, it is necessary to consider sequencing and timing:

- **Sequencing:** Ensure the order of implementation for SBCC and service delivery activities is *appropriate for the program*. For example, will job aids be ready in time for the campaign launch? Will providers be identified in time for training on materials and good counseling techniques? Will interpersonal communication agents be trained and in place in time to generate demand for the new health service?
- **Timing:** Ensure the program schedule accounts for other events that are happening in the community, region, or country, such as school breaks, national holidays, cultural events, political events, and elections.

Source: [C-Change C-Module 4 Implementation and Monitoring](https://www.c-changeprogram.org/sites/default/files/sbcc_module4.pdf) (https://www.c-changeprogram.org/sites/default/files/sbcc_module4.pdf)

Often, due to funding streams and project cycles, SBCC and service delivery projects do not begin at the same time. This makes it difficult to sync workplans or co-create strategies. In these circumstances, it can be effective to review whatever project's strategy is in place and decide how a new project could build off or coordinate with existing messages, activities, materials, or approaches. In this case, the projects' strategies would not be the same, but the strategy and workplan would be informed by what is currently taking place. It can take advantage of lessons learned, fill in gaps, and harmonize messages.

Define Partners' Roles

To avoid duplication or gaps in any program, each implementing partner's role must be clearly defined. This is especially important in service communication, because of the opportunities for overlap and confusion. While it is usually most effective to define partner roles at the beginning of a project, sometimes circumstances do not allow that.



Reviewing and setting roles can be helpful at any stage of the collaboration. In fact, often roles need to be revisited as implementation moves forward. Partners working collaboratively under one project have a somewhat easier task. For projects where two or more partners collaborate through a looser structure, it is important to answer several key questions to determine partner roles:

What specific roles will partners and other stakeholders play in designing and reviewing the strategy and communication materials? Partners may include government partners, community-based organizations and other parastatals, depending on the size and scope of the project. Determine the role each partner can or must play during the intervention. Key questions to ask include:

- Which government ministry or office is responsible for health communication? Is it an overall health promotion and education office or are those responsibilities divided by health area (nutrition, malaria, HIV and AIDS)?
- Are there active technical working groups organized by either the government or donors that review and give input to materials?
- What role does any government office, technical working group, or other partner play in development and/or approval of materials and strategies? What is needed for each submission, and what are reasonable expectations for how quickly this process can be completed?

What is the extent of the SBCC partner's role in service

communication activities? It is important to clarify whether the SBCC partner will lead development, production and/or implementation of all communication activities. Will the SBCC partner develop clinical counseling materials and job aids in addition to the larger campaign? Who will train providers on the use of communication materials? Who will lead community outreach efforts?

Who is leading clinic-based demand creation? It is important for service communication to drive demand to facilities targeted by service delivery partners. These are often facilities where the service partners have built capacity (trained staff, secured appropriate supplies, supported infrastructure improvements) and are accessible to clients. The SBCC partner may not have sufficient resources, staff or time to create targeted demand for all designated clinics, so partners will need to determine how to address any gaps in coverage for demand creation and who will address those gaps – the SBCC team, service delivery partner or some other structure, such as community health workers or village health teams supported by the local government.

How are communication capacity building strategies integrated into service delivery? SBCC capacity gaps may be identified throughout implementation. Those that present additional barriers to client service uptake (provider stigma, poor counseling skills or lack of motivation) must be addressed. Determine which partner – SBCC or service delivery – will address them. In Kenya, the KURHI Tupange project



identified that poor family planning counseling was a determinant of implant discontinuation. In response, the Tupange project conducted “whole site orientation” workshops that divided capacity building roles among the SBCC and service delivery partners. The training addressed specific performance gaps in provider clinical skills and communication. The SBCC partner implemented a two-tiered approach to address this capacity gap in service delivery: first, a workshop for health providers in designated clinics on improved client counseling skills; and second, training for district-based government health promotion officers on the principles of good interpersonal communication and client counseling.

More information on Tupange: <http://fptoolkit.or.ke/about-tupange/>

Collaborate on Formative Research

To leverage limited resources, shorten the time between program design and implementation, and deepen understanding of the service delivery and demand creation context, SBCC and service delivery partners should identify ways to collaborate on formative research. This collaboration should involve jointly identifying the key



issues that need deeper understanding, existing data, and gaps in knowledge and insight about the intended audience, behavioral drivers, situation and context. [CHC in Uganda](https://www.fhi360.org/projects/communication-healthy-communities-chc) (<https://www.fhi360.org/projects/communication-healthy-communities-chc>) took a multi-step approach to conducting formative research to improve HIV treatment and care communication, which involved service delivery partners throughout the process:

1. An initial meeting with treatment partners to understand the key challenges related to service delivery
2. A literature review, including project reports, studies and relevant papers developed by service delivery partners and key stakeholders
3. A review of partners' service delivery statistics

4. A summary of gaps in understanding about client behavior and barriers to behavior, with findings presented to service delivery partners
5. Engaging service delivery partners to mobilize study participants and participatory research with clients to better understand client and provider behavior

Define Linkages and Referral Mechanisms

Referral and linkage systems are key components of improved service demand and accessibility. Effective referral systems combine high-quality communication and operations (structure, monitoring systems and referral tools). Doing this well requires collaboration between the SBCC partner (often responsible for the look and feel of



a referral system, particularly if it is branded) and the service delivery partner (responsible for acknowledging and accepting referrals for services). Both partners must agree on the management structure and procedures, timeline, key responsibilities, monitoring system and referral tools that comprise the system. Since SBCC and service delivery both have a role in this process, this requires collaboration. If a brand is developed, all partners should participate in the brand design and be oriented to the final brand strategy.

The NURHI project developed an entire referral system for public, NGO and private providers in Nigeria. The system is structured such that referrals are generated through a number of channels: community-level social mobilizers, non-clinical providers (pharmacies and proprietary patent medical vendors) and facilities, which are defined as referrals made within a facility or between different facilities.

The new One Community project in Malawi is taking a proactive approach to designing its referral system. The project is actively consulting service delivery partners to understand their needs and challenges with demand creation.

For a link to the NURHI Referral Manual, see the [NURHI Referral Guidelines:
http://www.nurhitoolkit.org/sites/default/files/tracked_files/NURHI Referral Manual.pdf](http://www.nurhitoolkit.org/sites/default/files/tracked_files/NURHI%20Referral%20Manual.pdf).

Coordinate Demand-Side and Supply-Side Activities

A fundamental requirement for increasing and sustaining demand for health services is harmonizing supply and demand activities. Collaboration between SBCC and service delivery partners will ensure coordinated design and rollout of communication strategies, branding, provider training, commodities and supplies. This means that demand is



generated for services that are currently available and adequately resourced, and that services are introduced once the intended audience understands their importance and is ready and willing to access them. Doing this well requires service delivery and SBCC partners to coordinate timelines and locations.

Demand creation activities should not take place before the following service-related supply concerns are in place:

- Getting the facility prepared for the new or expanded service – Are providers trained? Are the appropriate materials in place? Is signage up to direct individuals to the correct service delivery point? Are job aids complete, and have the providers been adequately trained to use them?
- Preparing providers (and all personnel) for an increased workload – If demand creation is done well, it will increase client load at designated clinics and add to providers' workloads if new staff have not or cannot be hired. If providers are unable to meet the increased workload, they may turn clients away. Consider provider motivational techniques, such as rewarding high performers with promotional items (caps, t-shirts, mugs), "high flier" and "provider of the month" recognition, or clinic parties and events to recognize hard work. When demand increased for early infant male circumcision in Tanzania through the project's peer promoters beyond the level of existing

capacity, providers resisted. Jhpiego created motivational incentives for providers and reduced the number of days the services were available each week. It is important to communicate these changes to the SBCC partner.

More information on [AIDSFREE VMMC in Tanzania](https://aidsfree.usaid.gov/countries/tanzania-vmmc):

<https://aidsfree.usaid.gov/countries/tanzania-vmmc>

- Making sure necessary commodities are available – Does pricing for the service and/or commodity reflect what is known about consumers' ability and willingness to pay?

At the same time, SBCC partners need to ensure that:

- Community mobilizers and interpersonal communication agents, drama groups, traditional leaders and opinion leaders are adequately deployed and active in the target area as soon as services are ready
- Communication materials clearly guide clients to the correct facilities – or to the correct departments within the facility – at the correct times

Services and SBCC teams alike need to ensure that they have management systems in place to address quality concerns and client feedback. SBCC partners should be able to respond quickly to service delivery feedback about the mobilization activities. To manage this coordination with service delivery partners on a consistent basis, CHC and KURHI both deployed regional or district-based SBCC coordinators to meet regularly with service partners (weekly, monthly and as needed) to develop real-time strategies for harmonizing demand and supply.

Share Monitoring Data to Track Progress and Make Change

SBCC and service delivery partners collect routine program data. This information is most useful to service delivery if it is collected in a timely fashion to allow for rapid changes that can improve the program's effectiveness. The information gathered through routine monitoring may include client feedback on providers and services, insights on perceptions of service quality, levels of provider stigma, gaps in linkages and



referral systems, changes in beliefs and attitudes among providers or clients, and effective demand-creation channels and techniques.

Collecting this information is important for service communication because it can be used to make the following types of program changes:

- **Determining whether effective referrals are being made and, if not, how messaging can address gaps** – For example, do referred clients represent the intended audience? Are they adequately informed about key information about the service once they arrive?
- **Modifying the content of counseling sessions/job aids to address clients' questions or concerns about the service or health area** – In Zimbabwe, for example, routine client satisfaction surveys revealed dissatisfaction in how VMMC providers talked about pain during the clinical encounter. This decreased the likelihood that men who received the service would recommend it to others. A new job aid, the "Pain-o-Meter," was prototyped to help providers communicate pain expectations more accurately.
- **Modifying or changing channel selection, intensity or frequency** – Routine monitoring data including clinic records and counseling feedback can provide information about which communication channels are driving service uptake the most. For example, do clients come because of a radio spot, community-based activities, peer agents? This information can help programs to realign resources to change the intensity or frequency of various channels or discontinue those that don't result in any clinic visit.
- **Improving personnel decisions, provider support supervision and coaching strategies** – Routine client feedback and observation can indicate any concerns clients may have with providers. These concerns could include discomfort with the types of personnel providing service (for example, male VMMC clients are uncomfortable with female providers, youth prefer younger providers) or the ways in which providers engage with the client. While personnel changes may not be possible, feedback can be used to develop routine support supervision and coaching systems to [improve provider behavior \(http://sbccimplementationkits.org/service-communication/lessons/addressing-providers-as-a-behavior-change-audience/\)](http://sbccimplementationkits.org/service-communication/lessons/addressing-providers-as-a-behavior-change-audience/).

In order to act on this information, SBCC and service partners should regularly review service statistics and client feedback to identify performance gaps and opportunities for improvement. This can be done through regular meetings to review monthly or quarterly reports on community activities and service statistics.

In Ghana, the EPPICS project created giant community scoreboards to track performance against maternal and child health indicators. Each month, they update the scoreboards with green (positive outcome) or red (negative outcome) sticks to show how the community is doing. In addition to monitoring progress, the scoreboards also help educate community members about healthy practices and motivate community members to adopt healthy behaviors.



In its VMMC demand-creation program in Tanzania, Jhpiego learned from routine monitoring data that if providers talked about the importance of follow-up after the procedure, they experienced a considerable spike in clients' attending follow-up visits (the wanted at least 80% of all VMMC clients to return for follow up care). Jhpiego used real-time data gathered from clinic records and observing counseling sessions to conduct supportive supervision visits that focused on improving that one behavior – getting providers to discuss the importance of follow-up with every client.

The project also used routine clinic data summarized in a data dashboard to communicate to peer mobilizers how they were performing against monthly demand-creation targets. The dashboards were displayed in the health facility and reviewed by each facility team on a weekly basis and at annual regional data summits. This data also guided quarterly support supervision visits with regional and national representatives from the Ministry of Health. During these meetings, the project team regularly reviewed the dashboards for the number of monthly VMMC services provided, the number of adverse events and the number of follow-up visits. Collectively, they then identified opportunities for improvement and celebrated successes.

Harmonize Messages

Audiences are more likely to change their behavior when they hear a message multiple times. They are even more likely to change when they hear the message from different sources. But in order for these principles to work, messages must be consistent. All sources must be communicating the same message. Conflicting messages from different projects or individuals will confuse audiences and make it less likely that they will change their behavior.



SBCC and service delivery partners should harmonize their messages to ensure they:

- Recommend the same action (for example, breastfeed exclusively for 6 months)
- Do not provide conflicting technical information
- Use similar terms and language

Harmonizing messages can be done at various stages and through several methods.

One method, which usually happens at the beginning of an activity or project, is to create a **message guide**. Several organizations – including SBCC, service delivery and private sector organizations – come together to determine key messages for a topical area (such as malaria). Often there is a message harmonization workshop that helps partners decide the content for the messages, key actions they want the audience to take, benefits the audience will get from taking the action, and support points. Then the group (or a sub-group) develops the draft messages. Sometimes another workshop is held to present and refine the messages. Once all organizations have agreed on the messages, they put together a complete message guide with all the messages and any other relevant information. The message guide is reviewed and updated as necessary. Any organization working in that area can

include messages from the guide as they develop communication activities and messages.

Click to access sample message guides on

- **Pandemic influenza:**
http://avianflu.fhi360.org/docs/Ethiopian_Message_Guide_June09.pdf
- **Nutrition:**
http://www.coregroup.org/storage/Nutrition/ENA/Booklet_of_Key_ENA_Messages_complete_for_web.pdf
- **Family planning:**
http://www.thehealthcompass.org/sites/default/files/project_examples/Pamphlet_%5BEnglish_Language%5D_1.pdf

If projects have already developed messages and are implementing communication activities, one method is to do a **consistency review** of existing messages. Service delivery and SBCC partners can gather existing service communication materials and review the key messages given in each material. Partners can create an inventory of key message content and recommended actions, divided by audience. Technical experts can review the messages to ensure they are accurate. Once the inventory is complete, partners meet to discuss messages that are inconsistent, conflicting, or inaccurate. They come to a consensus of what needs to be changed and partners can revise materials and messages. Cost should be considered when discussing changes that need to be made. An example of a consistency review from Guatemala can be found [here](http://healthcommcapacity.org/wp-content/uploads/2016/02/WHIP-SBCC-Materials-Consistency-FINAL-10-1-15.pdf): <http://healthcommcapacity.org/wp-content/uploads/2016/02/WHIP-SBCC-Materials-Consistency-FINAL-10-1-15.pdf>

TEMPLATES

Appendix A: Audience Characteristics and Behavioral Factors Template

Appendix B: Client Journey Worksheet

Appendix C: Segmentation Table

Appendix D: Checklist to Assess Proposed Segments

Appendix E: Influencing Audience Template

Appendix F: Matrix for Change Worksheet

Appendix G: Channel Mix Table

Appendix H: Provider Profile Template

Appendix A: Audience Characteristics and Behavioral Factors Template

1	2	3	4	5	6	7	8
Priority Audience	Demographic & Psychographic Characteristics	Preferred Media	Other Opportunities	Current Behaviors	Knowledge, Attitudes & Perceptions	Barriers to Improved Behavior	Facilitators of Improved Behavior
<i>Example:</i>							
Married women of reproductive age	Rural Age 18 to 35 Primary education Low to semi-literate Poor Logandian language	Radio Mobile Phone Community Media	Friday market Church	Does not use family planning Does not talk to her husband about health related issues Talks to her peers about health and family issues	Wants to use family planning Afraid of side effects Believes her husband wants more children Believes her community is against family planning	No transportation Health center is far Bad experience with the health center	Sister is on family planning and likes it Family planning is free








Appendix B: Client Journey Worksheet

Touchpoint	Expectation	Observation

Appendix C: Segmentation Table

Potential Audience(s)	Socio-Demographic Differences	Geographic Differences	Behavioral Differences	Psychographic Differences
Potential Audience	<ul style="list-style-type: none"> Sex Age Education Occupation Income Marital status Family size Ethnicity/language Religion 	<ul style="list-style-type: none"> Urban, rural, peri-urban Region, district, community 	<ul style="list-style-type: none"> Relevant behavior Stage of change/readiness to change Frequency of behavior Consistency of behavior Duration of behavior 	<ul style="list-style-type: none"> Benefits sought Values Activities Interests Attitudes, opinions Personality Preferences

Appendix D: Checklist to Assess Proposed Segments

Homogeneous	 Yes	What it means: The members of the audience segment are similar in a relevant way.	Why it is important: This is the basis of audience segmentation – that the members of each segment are similar in terms of needs, values and/or characteristics.
Heterogeneous	 Yes	What it means: Each segment is relatively unique, as compared to the other segments that have been identified.	Why it is important: This demonstrates that the broader audience has been effectively divided into sets of differing communication needs.
Measurable	 Yes	What it means: Data from the situation analysis or other research should indicate the size of the audience segment.	Why it is important: Measurements allow programs to evaluate whether to focus on a particular segment.
Substantial	 Yes	What it means: The audience segment is large enough, in terms of potential impact on public health, to warrant the program's attention.	Why it is important: Programs should have a minimum expectation for the impact of their investment. Therefore, programs should only consider segments that are big enough or important enough to impact public health.
Accessible	 Yes	What it means: The audience segment is reachable, particularly in terms of communication and access to products or services needed to address the problem.	Why it is important: Each segment needs to be able to be reached and communicated with efficiently.
Actionable/ Practical	 Yes	What it means: The program is able to implement a distinctive set of messages and interventions for each audience segment.	Why it is important: The program must have the resources and ability to address the segments identified.
Responsive	 Yes	What it means: Each audience segment can be expected to respond better to a distinct mix of messages and interventions, rather than a generic offering.	Why it is important: If the segment will not be more responsive to a distinct approach, then the segment can probably be combined with another similar segment.

Appendix E: Influencing Audience Template

Who influences the priority audience?	How much influence do they have (strong, moderate, weak)?	What behaviors do they currently influence the priority audience to do?	Why would they encourage the desired behavior?	Why would they discourage the desired behavior?	What media channels do they use most?
<i>Example</i>					
Priority Audience: Married Women of Reproductive Age (18 – 35)					
Mother-in-law	Very strong	Have many children Have a son Have a child immediately after marriage	The mother-in-law cares about the health of the baby	Traditionally the number of children a family has provides status in the community and signifies wealth Having a child immediately after marriage shows fertility	Storytelling Radio Peer to Peer

Appendix F: Matrix for Change Worksheet

Audience Segment (As Determined in Audience Analysis)	Desired Behavior Change by Service Delivery Stage (Before, During, After)	Behavior Type (One-Time, Repeated but Finite, Permanent Change)	Key Barrier(s) to Address (Environmental, Knowledge or Skill, Ideational)
Example: Married women in urban settings, lapsed family planning users	Seek family planning counseling at a nearby health clinic (<i>before</i> stage)	Repeated but finite	<p>Belief that contraceptive methods have too many negative side effects</p> <p>Improve ability to discuss family planning with health provider</p>



Appendix G: Channel Mix Table

Selected Channel (radio, TV, newspaper, IPC, etc.)	Preference (is the program's preference for reach or intensity?)	Cost (anything known about the overall cost, the cost per person reached in comparison to total budget	Audience Reach (which audience segment does this channel reach?)	Timing and Frequency Planned (When should communication start? how long should it run, how frequently, i.e. daily, monthly, weekly?)

Appendix H: Provider Profile Template

Provider Name	
Age	
Gender	
Education	
Type of Services Provided	
Years in Service	
Type of Health Provider (public, private, community, facility-based, etc.)	
Perceived Benefits for Health Work (salary, recognition, respect, etc.)	
Current Behavior in Relation to Health Service (high/low performer)	
Known Barriers to Adopting Target Behavior: (ability, expectation, motivation)	
Attitudes about Current Job and Clients	

CASE STUDIES

Appendix I	<p>ZIMBABWE: Challenges in Getting Clients to Services</p> <p>(http://sbccimplementationkits.org/service-communication/case-study-1-challenges-in-getting-clients-to-services/)</p> 
Appendix J	<p>KENYA: Client/Provider Challenges</p> <p>(http://sbccimplementationkits.org/service-communication/case-studies/case-study-2-clientprovider-challenges/)</p> 
Appendix K	<p>BANGLADESH: Behavioral Maintenance and Follow-Up</p> <p>(http://sbccimplementationkits.org/service-communication/case-study-behavioral-maintenance-and-follow-up-in-bangladesh/)</p> 
Appendix L	<p>UGANDA: Coordination Challenges</p>  <p>(http://sbccimplementationkits.org/service-communication/case-studies/case-study-coordination-challenges-in-uganda/)</p>

Appendix M

NIGERIA: Service Communication Strategy in Action



(<http://sbccimplementationkits.org/service-communication/case-studies/case-study-service-communication-strategy-in-action/>)

Appendix I – Zimbabwe: Challenges in Getting Clients to Services

Before services can be delivered, a client needs to access them. How does that happen? It seems straightforward enough: the Ministry of Health uses posters and perhaps radio spots to announce the service and where to get it. Then, clients who need the service will simply come. But it is rarely that easy. Just communicating information is often not enough to get clients to services.

Challenge

If people acted rationally based on what is proven to be best for them, everyone would avoid sugary snacks, immunize their children, get enough exercise and never start smoking. The truth is that people are not wholly rational actors; we make decisions based on our beliefs and emotions, even when those beliefs and emotions contradict overwhelming evidence. The challenge is to communicate effectively about a service in a way that motivates the desired behavior. People need not only to know about the service, but also to understand its value to them, feel like they can access it, know where to get it and feel able to navigate the barriers to access.

Barriers to access extend beyond individual knowledge, ability or attitudes. Relationships and communities can also influence individual willingness and capacity to go to health services. This could be through actively obstructing an individual or the general perception that the

Barriers to Young People Accessing Sexual and Reproductive Health Services

Individual barriers – Lack of understanding of reproduction and sex. Desire to “become a woman or man” by having a child. Belief that healthcare is for women only. Poor experience/stigmatizing behavior by providers who believe young people should not access sexual and reproductive health services.

Community norms – Parents feel inhibited from talking about sexuality with their children. Belief among adults that talking about sex encourages promiscuity. Cultural norms that encourage early marriage for girls or cross-generational relationships.

Policy barriers – Condom distribution sales are restricted by age. National sexual and reproductive health curriculum is not comprehensive (abstinence based). Government does not prioritize youth as a key population for family planning. Policies require a woman to be married to access family planning.

services are inappropriate or wrong. Lastly, external conditions such as physical or logistical barriers and gender and cultural norms can prevent service uptake.

Response

By using social and behavior change communication (SBCC) techniques rooted in behavioral science, service communication can inform and motivate individuals to access services and create an environment that promotes health-seeking behaviors.

Commercial marketing has long appreciated the power of emotion to sell products and services. SBCC has adapted commercial marketing techniques to go beyond demographics or behavioral data, seeking to understand **why** clients invest their time and money and associating services and health behaviors with client values and aspirations. Effective communication uses these insights in developing messages, selecting approaches and channels, and sequencing their delivery.

In using the [socio-ecological model \(page 16\)](#), SBCC recognizes the influence that a client's environment has on decision-making. Family, friends and community all play a part in encouraging (or deterring) a client. At a higher level, policies can influence the availability of services, and advocacy – a component of SBCC – can be used to make services available.

The [Demand Generation SBCC Implementation Kit](#) (<http://sbccimplementationkits.org/demandrmnch/>) provides a step-by-step process to build demand for key services and products.

Audience Insight - VMMC in Zimbabwe

Challenge

Voluntary medical male circumcision (VMMC) is a priority for HIV prevention in Zimbabwe. The national policy aimed to reach 80 percent of 13- to 29-year-old Zimbabwean males (about 1.3 million young men) between 2011 and 2015. PSI provided technical and financial support to the Ministry of Health and Child Welfare to reach that goal. The program has 20 fixed sites, multiple outreach sites and mobile teams across all 10 provinces and offers VMMC through routine and

campaign service delivery models. Launched in 2011, the *Pinda muSmart* (Get Smart) campaign positioned VMMC as a lifestyle choice of the *smart, clean man*. It used celebrity endorsements, appealing to trendsetters to be “ahead of the pack.” Despite this effort, results lagged. A World Health Organization progress brief calculated that by the end of 2014, Zimbabwe had circumcised more than 412,000—only 22 percent of the country’s target of 1.3 million men. This situation was not unique to Zimbabwe; many countries were falling short of their VMMC targets.

PSI has long used commercial marketing techniques – most of their products and services are branded for maximum appeal to the intended audience – and they conduct multi-level promotional campaigns using mass media and social mobilization to share their messages. But these techniques were proving inadequate.

Response

In a demand-creation meeting in 2013, the Gates Foundation engaged the market research firm Ipsos to work with the Ministries of Health in Zambia and Zimbabwe to gain insights as to why these well-executed campaigns were not achieving the expected results. The research sought to:

- Understand the decision-making process for men intending to undergo VMMC (including the impact of influencers)
- Identify physical and emotional drivers and barriers for VMMC uptake and the impact of the social environment
- Identify existing awareness, knowledge, perceptions and gaps related to VMMC
- Design a tailored communication and service approach for men seeking VMMC services
- Identify and map key stakeholders’ information gaps and use this research in the strategy

Qualitative country-level research enabled Ipsos to segment Zimbabwean men based on their level of awareness, belief and commitment to action. In particular, they identified **cognitive dissonance** in many men who understood the benefits of VMMC and health-seeking behavior, but had not been circumcised

(<http://www.simplypsychology.org/cognitive-dissonance.html>). The research identified key factors that influence real action and, based on these factors, Ipsos quantified the potential opportunity for each group based on current circumcision rates among:

1. VMMC enthusiasts
2. VMMC **neophytes**
3. Scared rejecters
4. Embarrassed rejecters
5. Highly resistant

In 2015, PSI convened a workshop to review the research and map out how best to utilize it. Based on the potential opportunities presented by each segment, Zimbabwe decided to prioritize VMMC enthusiasts, VMMC neophytes and embarrassed rejecters.

The PSI team identified common motivators between neophytes and embarrassed rejecters, who were collectively estimated to represent 56 percent of uncircumcised men. Because the research went beyond gathering the typical demographic data (e.g., age, education, geographic location) and explored men's unique values, motivations and feelings often not captured in formative research, the resulting messages for mass media, IPC and advocacy, were based on the **functional** and **emotional** benefits identified for each group (<http://sbccimplementationkits.org/service-communication/case-study-1-challenges-in-getting-clients-to-services/>).

In other words, the research asked potential clients what they believed the utility – functional benefits – of VMMC would be (e.g., reduced risk of HIV infection), as well as what positive feelings they associated with VMMC (e.g., feeling sexually attractive or feeling like a responsible sexual partner).

In the past, PSI used its highly trained researchers to collect additional information in the field and bring it back to the SBCC experts, who would design messages through a marketing strategy design workshop called “Delta.” The draft messages would then be pre-tested and rolled out at a national level. Using a new approach, PSI employed techniques adapted from human-centered design to develop

strategies and messages. The PSI team shadowed their intended audiences, spending time with them to observe an average day's routine.

Results



My name is Zivai and I am 24 years old. I live in Murambinda, Zimbabwe. I work as a dealer in cellphones, airtime, laptops, etc. I have 3 family members including my mum, sister and brother. I am single but I can have multiple partners at one time. For fun I like to drink and *braai* with my friends.

"The other boys, my friends, are advocating for male circumcision in the area. We even have a song to encourage each other. I never thought of withdrawing from doing the procedure."

Zivai's values:

- He's strongly motivated by the "sex drive" benefits of getting circumcised
- He's very concerned about how his life will change after the procedure
- Sees himself as a "leader of the pack" and has strong social support behind him

Market research, combined with the human-centered design process, has enabled the PSI marketing and communication team to develop archetypes based on attitude and behavior toward VMMC. The image above offers an example of an "enthusiast" archetype.

Field staff are adapting a tool [see version] created during the research (a series of questions set up like a decision tree) to quickly segment clients into archetypes. This typing tool allows mobilizers to tailor their messages most persuasively. The tool, which is based on psychographics rather than typical demographic data, uses color-coded guidance to help mobilizers categorize each potential client into one of the key segments and then tailor messages that speak to the specific motivators and barriers of each segment. This helps ensure that one-on-one and small-group interactions are more efficient and effective in addressing the real needs of men.

The tool uses colors instead of segment labels (e.g., blue instead of "VMMC neophyte") as an internal guide for mobilizers. This system has been piloted since February 2016 with plans for national rollout in July. Community mobilizers report

that the approach has made their efforts more efficient. They no longer have to give a whole speech, but can confidently start with a few highly effective messages based on the potential client's segment.

Ipsos' research noted common themes among the determinants of VMMC-seeking behavior among men. One was the importance of former clients' becoming VMMC champions and advocating for the service among their peers. Unfortunately, very few men were converting to VMMC champions after receiving the procedure. Another common barrier noted in the research was that messages minimized discussion of the pain men would experience, both during the procedure and throughout the healing process. Further probing found that some clients were surprised when they did feel pain and felt deceived. This left them less likely to advocate with their friends to go for circumcision. Because word of mouth was identified as a powerful way to get men into VMMC services, it was important to address the issue of pain directly. Using human-centered design approaches, the PSI team brainstormed around this challenge, creating prototypes and testing them with clients. Using feedback and input from real men, the *Pain-o-Meter* job aid was born. The Pain-o-Meter allows mobilizers to talk honestly about pain so potential clients have clearer expectations about pain during the procedure and in the healing period.

The Ipsos findings also indicated that if men became champions, they preferred to use their own words to describe their experiences. They

What is Human-Centered Design?

Human-centered design is a creative approach to problem-solving ... that starts with the people you're designing for and ends with new solutions that are tailor made to suit their needs. Human-centered design is all about building a deep empathy with the people you're designing for, generating tons of ideas, building a bunch of prototypes, sharing what you've made with the people you're designing for, getting their feedback and consistently refining and reiterating, and eventually putting your innovative new solution out in the world.

Human-centered design consists of three phases. In the Inspiration Phase you'll learn directly from the people you're designing for as you immerse yourself in their lives and come to deeply understand their needs. In the Ideation Phase you'll make sense of what you learned, identify opportunities for design and prototype possible solutions. And in the Implementation Phase you'll bring your solution to life, and eventually, to market. Throughout the work, you've kept the very people you're looking to serve at the heart of the process. [More: <http://www.designkit.org/human-centered-design>](http://www.designkit.org/human-centered-design)




asked the researchers to provide triggers rather than messages. Clients suggested that a mug or cap could be a conversation starter that allows the champion to tell his story, describe why circumcision was important to him, and talk about its benefits.

Engagement of field-level workers and the clients provided PSI with invaluable feedback to optimize the effectiveness of their tools and messages. PSI has begun to embrace the concept, popular in design work, of “failing fast,” which refers to using prototypes and iterative development to allow for rapid adaptation based on feedback and experience. Prototypes, which are simple, rough, facsimiles of the tools, materials or experiences, are taken out and used (rather than pre-tested with a focus group). Prototypes differ from pre-tests in that the materials are far less fully formed and the ideas can go through major changes and transformations, even being thrown away entirely, without large sunk costs for design and human resources. The prototyping process also allows messages to go through constant adaptation as the experiences and needs of the mobilizers and clients are better understood.

Application

Understanding the intended audience is critical to effective communication, not just to understand their barriers and motivators, but also to empathize with their situations and engage them in finding solutions. Large-scale research can provide good documentation, and solid data can provide trends and rates, but careful observation, curiosity, and empathy can generate even deeper insights that allow for co-creation of effective messages and tools.

Prioritized Audience Segments and Their Potential for Seeking VMMC

- 1**  **VMMC Enthusiasts**
Large potential (21% of uncircumcised men) and high commitment already; need to overcome some dissonance issues
- 2**  **VMMC Neophytes**
Large potential (19%) but lack of knowledge is key to informing their commitment; addressing knowledge gap is relatively easy
- 3**  **Embarrassed Rejecters**
Moderate potential (16%) but commitment is rather low and knowledge, embarrassment and fears are high; need a lot of support

ADDITIONAL RESOURCES

Demand Generation I-Kit for Underutilized, Life Saving Commodities

Field Guide to Human-Centered Design

Male Circumcision Demand Generation Meeting Report. January 2015. Bill & Melinda Gates Foundation.

Bukuku, M. Presentation from SBCC Summit. February 2016. How to Link Demand Creation and Health Services: Experiences from Tanzania.

EngenderHealth and Promundo. 2008. Engaging Men in HIV and AIDS at the Service Delivery Level: A Manual for Service Providers. The ACQUIRE Project. Washington DC: USAID.

Research Triangle Institute and Population Services International. 2014. Voluntary Medical Male Circumcision (VMMC) Demand Creation Toolkit. Washington DC: US Centers for Disease Control and Prevention.

Sutton, SM, Baich GI, and Lefebvre RC. nd. Strategic Questions for Consumer-Based Health Communications.

Appendix J – Kenya: Client/Provider Challenges

The *during* stage of service communication comprises the interactions and communication (verbal and nonverbal) that take place while services are being offered. These interactions involve the client and service provider, as well as receptionists, schedulers, security personnel, and even those who clean the facility. Client/provider interactions may take place in a facility setting, but could include outreach and mobile services. Effective interactions usually reflect a client-centered approach to service delivery, which views a patient holistically rather than as a body part, disease, or condition; promotes courteous treatment of clients; and ensures clear and accurate communication tailored to the client's needs.

Challenge

In the real world, there are many constraints to effective client/provider interactions. The facility environment can be challenging; a busy practice, lots of patients, and heavy workloads push staff to deal with clients as quickly as possible. Medical training can focus on pathologies and conditions rather than viewing a patient as a whole person, and clinical data collection promotes this notion by reporting on services rendered or test results rather than health outcomes. In addition, providers naturally make assumptions based on experience and personal attitudes resulting from cultural and traditional norms and personal beliefs. These biases can negatively influence care and result in stigma, discrimination, or even abuse of clients. Similarly, clients' expectations have an impact on client/provider interaction; it is hard to appropriately diagnose and treat clients if they are too deferential, do not understand what information is important and why, or are afraid to be honest. Client expectations may implicitly or explicitly push providers to give injections or prescribe antibiotics, even if such treatment is not indicated. Lastly, if clients don't understand why they received a service or what they need to do for follow-up, they may not get better or return to the health facility.

Response

Communication cannot address all of the problems tied to the physical environment or availability of products and services, but it can improve interactions between clients and providers. Counseling skills are critical—not just being able to

provide information, but also being able to listen and respond to client concerns in a way that makes the person feel heard and accepted and helps the client feel able to make healthy choices after they leave. Training to address sensitive topics, such as sexuality, gives providers technical skills and helps them overcome the social and cultural biases that impede effective service delivery. Effective counseling also helps clients articulate their expectations and gives the provider an opportunity to address and manage those expectations in a respectful way. Finally, coaching and supportive supervision with the provider can create a positive environment for service providers to adopt new behaviors and refine new skills. Well-designed materials reinforce messages for the client and act as job aids for providers. Such materials can also provide reminders and support to clients after they leave.

Case Study: Men's Sexual Health and Rights Program – Kenya

Challenge

Key populations – men who have sex with men (MSM), sex workers and people who inject drugs – are disproportionately affected by HIV and AIDS. Societal attitudes about their behaviors, including criminalization, have made it difficult to openly discuss their risks or address their needs. For example, HIV prevention messages rarely discuss same-sex practices and behaviors, so some MSM are not even aware that their behavior could put them at risk for HIV. Prevention and treatment services to address the specific health needs of MSM are beginning to roll out across Africa, but too often services are inappropriate; service providers don't know what questions to ask, lack skills to provide care, and may unwittingly or purposefully stigmatize and discriminate. Even providers who are willing to work with MSM, often have no training on how to ask about client history using appropriate language or how to identify, manage and treat STIs. When some providers are respectful, other facility staff members can be abusive, leaving clients unwilling to continue care or treatment. In turn, service providers face risks of marginalization within the facility or from the wider community or law enforcement.

Response

The Men's Sexual Health and Rights Project (SHARP) was designed to reduce the spread and impact of HIV among MSM and build healthy MSM communities in Kenya, Tanzania, Uganda, and Zimbabwe. Coordinated by the International HIV/AIDS Alliance with funding from the Danish Department for International Development, SHARP ran from December 2012 to November 2015. The project provided a basic package of sexual health services tailored to country contexts, including education and small group discussions, condoms and lubricants, HIV testing and counseling, sexual and reproductive health and rights counseling, and referral for HIV treatment.

SHARP's partners—Seven community-based organizations led by MSM for MSM—established partnerships with health facilities (mostly public sector) to ensure access to a comprehensive package of health services. The challenging country contexts required significant investments to sensitize, build, and strengthen relationships. SHARP developed intensive clinical training to cover social, biomedical, and community-based elements relevant to holistic MSM health, including management and treatment of HIV and other sexually transmitted infections (STI).

The Men Against AIDS Youth Group (MAAYGO) works in western Kenya to promote the health, acceptance, and well-being of MSM and other sexual minorities. Through SHARP, MAAYGO and the Kenya AIDS NGO Consortium (KANCO) hosted a training delivered by [Health4Men](#), a South African NGO responding to HIV among gay, bisexual and other MSM, to ensure that service providers could offer competent and non-discriminatory healthcare and support to MSM (<http://www.health4men.co.za/>). Training topics included locally appropriate diagnosis and treatment of the STIs that are most common in the MSM community, a review of the comprehensive package of services for key populations established by the Kenya National HIV/AIDS Strategic Plan, and the impact of stigma and discrimination on MSM, particularly on individual health status. Training sessions emphasized the importance of principles of confidentiality, non-judgmental care, and cultural competence, and how those translate into healthcare services for MSM. For instance, trainers delved into appropriate language to use in clinical




notes. Recognizing that training one or two individuals in a clinic is not sufficient enough to change the clinical environment, training was conducted with key facility staff from Kisumu District Hospital and 12 other facilities in the region.

Involving all staff (including senior management and support personnel working on the clinic compound) ensured that MSM received respect from the moment they arrived for services. Repeated training gave hospital staff multiple opportunities to assess and build their knowledge, understanding, and clinical practices.

As a first step, MAAYGO asked healthcare workers to explore their own biases. The values inventory gave facility staff an opportunity to reflect on their personal norms and judgments around issues of sex and sexuality, how these values could affect the quality of service delivery, and how these values might come into conflict with ethics of healthcare (such

as universal right to health or “do no harm”). The training environment gave providers a safe space for questions that would be inappropriate or intrusive to ask clients. In addition, to the trainings, MAAYGO worked with clinicians to expand access to services, creating moonlight services set up near “hotspot” areas where MSM typically gathered. MAAYGO used trained peer mobilizers to promote HIV testing and STI screening, with confidence that services would be respectful and appropriate. By sensitizing local law enforcement, MAAYGO was also able to better guarantee client safety, a serious concern for many potential clients. Other SHARP partners in East and Southern Africa have created feedback mechanisms to assure and improve service delivery. Using a “mystery shopper” approach, SANA in Tanzania and GALZ in Zimbabwe sent a volunteer unannounced to receive services, as any client would, to examine how friendly and competent the services were or to

Course outline of training offered by Health4Men

SECTIONS	MODULES	ELEMENTS
 MSM sensitisation	Opening and Key Populations	<ul style="list-style-type: none"> • Definition of terms • Key populations and ‘at risk’ populations globally and in East Africa • Differential risk • MSM and the general population
 MSM medical management	Sex, sexuality and sexual identity	<ul style="list-style-type: none"> • Relationship between sex, sexuality and sexual identity • Sexuality and sexual identity • Links and discontinuities between sexual identity and sexual behaviour • MSM sexual identities and sexual behaviours
 MSM community outreach and NGO/CBO development	Healthcare provider and MSM	<ul style="list-style-type: none"> • MSM right to healthcare • Impacts of stereotypes and prejudice • Necessity for MSM to be able to access healthcare
	A sex positive approach	<ul style="list-style-type: none"> • Health4Men’s non-judgemental approach to MSM healthcare • Terminology • Recommended actions when engaging MSM in healthcare setting

follow up on reported problems with a trained service provider. Such feedback allows service communication programs to refine counseling training to reflect client feedback and enables supportive supervision to focus on specific areas for provider behavior change.

Results

Pre- and post-tests from the Health4Men training showed that participants increased their basic psychosocial knowledge and more advanced biomedical knowledge from 64–88 percent. Homophobic stigma decreased by one-third among participants (from more than 18 points to 12 points on a scale adapted from a [2012 study on MSM and healthcare services](http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3852129/):

<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3852129/>).

By being sure that MSM would receive respectful care, SHARP partners were able to increasingly support and refer clients for critical HIV services, including HIV testing and STI screening. By the end of the project, SHARP had reached almost 15,000 MSM in the four countries (exceeding the project target by 80 percent—a sevenfold increase from the baseline). This included more than 2,500 MSM in Kenya whom MAAYGO mobilized to receive their HIV test results and more than 2,000 MSM who were screened and tested for STIs.

Application

Although the healthcare situation for MSM may seem exceptional, healthcare workers often encounter individuals who are marginalized by society or feel vulnerable because of their health condition. Client-centered service communication delivers messages that acknowledge these vulnerabilities, ensures that messages resonate more with the prioritized population, and addresses these barriers. Client-centered service provision requires mutual respect, which can be difficult in the unequal power dynamic that is often present in a clinical setting. Counseling techniques that emphasize the importance of active listening, acknowledge the client's experience, seeks to understand, uses the client's language, and reserves judgment are the keys to addressing those power imbalances. Because providers are often unaware of their own biases, providing opportunities to reflect on them is the first step to discovering how to break down,

mitigate, or work around prejudice that can negatively influence client/provider interaction.

More information about the SHARP Program (<http://www.aidsalliance.org/our-impact/the-sharp-programme>)

Long-Acting Reversible Contraceptives Materials
(<http://healthcommcapacity.org/new-materials-help-providers-counsel-young-women-benefits-larcs/>)

Health Care Improvement Project. November 2011. *Cultural Sensitivity Builds Confidence in Maternal and Neonatal Health Services in Huehuetenango Guatemala*. Washington DC: USAID. (http://www.urchs.com/sites/default/files/Guatemala_Cultural_sensitivity_maternal-neonatal_services_Nov11.pdf)

Health Initiatives for the Private Sector. July 2008. *Effective Interpersonal Communication: A Handbook for Healthcare Providers*. Washington DC: USAID. (http://ccp.jhu.edu/documents/EffectiveInterpersonalCommunication_HandbookforProviders_0.pdf)

Murphy E. and C. Steele. 2000. *Client-Provider Interactions in Family Planning Services: Guidance from Research and Program Experience*. Washington DC: USAID. (<https://www.k4health.org/sites/default/files/vol2.pdf>)

PATH. July 1999. *Improving Interactions with Clients: A Key to High-Quality Services*. Seattle, Washington: USAID. (https://www.path.org/publications/files/eol17_2.pdf)

Appendix K – Bangladesh: Behavioral Maintenance Follow-Up

When a client's health status changes (for the good, such as with a planned pregnancy, or for the worse, such as being diagnosed with diabetes), the person often is highly motivated to make changes in their life and may succeed in adopting a new behavior. But daily life comes with myriad challenges that complicate clients' ability to sustain behavior change.

Challenge

Motivating clients to start healthy behaviors is a necessary first step toward achieving positive health outcomes. However, it is difficult to maintain those initial gains over time. Chronic conditions such as tuberculosis (TB) or diabetes require vigilance and strict adherence to a treatment regimen, but clients often stop taking drugs or continue eating sugary foods. The rise in drug resistance further demonstrates that people don't regularly complete their prescribed courses of treatment.

Research shows that between 30 and 70 percent of clients do not adhere effectively to treatment recommendations. Non-adherence to difficult behavioral recommendations, such as smoking cessation or following a restrictive diet, **more than 80 percent of patients** (<http://www.ncbi.nlm.nih.gov/books/NBK43749/>). The reasons are varied: providers may confuse the client with unclear instructions, or clients may not fully appreciate the consequences of not maintaining behaviors, or they may not believe that they can follow the behavior change or regimen as instructed. Some behavioral changes interfere with daily activities, such as medications that require multiple doses each day or those with special instructions (e.g., "take with food"). Side effects of treatment can also cause embarrassment. Families or communities may not maintain their support of behavior change, finding the changes uncomfortable or inconvenient. Stigma, discrimination, and social norms also strongly influence behaviors. Illnesses such as TB, HIV, and cancer all have social stigma attached to them, so patients may not want to be open about their condition, complicating behavior changes or behavioral maintenance.



Chronic disease management also challenges overburdened health systems. It is important to monitor chronic conditions, but service providers may struggle to fully engage in managing stable clients when crises or emergencies arise.

Response

Service communication supports long-term behavior change through a number of strategies and tactics that encourage continued adherence to changed behaviors. These can include tools such as SMS prompts or reminder calls for daily medications and client support group meetings.

Ongoing counseling can provide clinical support to clients, while community-based initiatives (e.g., support groups or clubs) encourage clients to overcome challenges and have been demonstrated to encourage adherence. Social and behavior change communication (SBCC) at the community level can also reinforce healthy behaviors such as correct and consistent condom use (to prevent HIV, other sexually transmitted infections, and unwanted pregnancy) or bednet repair and maintenance to prevent malaria.

Increasingly, information and communication technology makes it possible to reach target audiences instantaneously and privately. Hotlines, chat rooms, and SMS can quickly answer questions, eliminating the need for a visit to the facility. “Push” messages that are sent unprompted can provide information and remind clients of important behaviors, such as taking medication or keeping a medical appointment. A **2015 Cochrane review of mHealth** in family planning concluded that “evidence indicates that a series of voice messages and counselor support can improve contraception amongst women seeking abortion services not wanting to get pregnant again at the current time, and data suggest that daily educational text messages can improve continued use of the contraceptive pill”

(<http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD011159.pub2/abstract;jsessionid=ECEA91F832E56A8D7CFB270C695DCD5F.f01t02>). An earlier **review of text messaging and antiretroviral therapy (ART) adherence** noted that “Weekly mobile phone text messages to patients on ART can help them to take their medication every day. It can also help to reduce the amount of HIV in their bloodstream” (<http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD009756/full>).

Case Study – Aponjon in Bangladesh

Challenge

Since the 1990s, Bangladesh has made great strides to reduce maternal and infant mortality, reducing maternal mortality ratio from 574 to 194 between 1990 and 2010. But gaps remain, particularly for poor women. In 2011, only 20 percent of women were attending the recommended four prenatal visits and almost half of pregnant women had anemia. Among women in the poorest quintile, 71 percent had their first child before age 18 and only 9 percent delivered with a medically trained provider. Meanwhile, trained providers were scarce, with just **3 doctors and 2.8 nurses for every 10,000**



Bangladeshis (<http://siteresources.worldbank.org/INTPRH/Resources/376374-1303736328719/Bangladesh42111web.pdf>).

Response

Whereas 55 of every 100 people have access to health services in Bangladesh, 64 out of 100 Bangladeshis are mobile phone subscribers. This high-level mobile phone penetration allowed the Mobile Alliance for Maternal Health Action (MAMA) to use mobile phone technology to reach pregnant women and new mothers with maternal and child health education. MAMA was a public-private partnership launched in May 2011 by USAID and Johnson & Johnson that operated in India, Bangladesh and South Africa. In Bangladesh, the not-for-profit social enterprise Dnet initiated the service and continues to run the initiative, known as Aponjon (“Dear One” in Bangla).

Aponjon is a subscriber service that targets expecting and new mothers and their guardians (husbands, mothers-in-law, and other family members) to communicate important health information about all stages of pregnancy and a child’s first year. Pregnant women, new mothers, and their families are recruited to join and pay a small fee (the service is free for poorer households). After registration, Aponjon delivers SMS or voice messages twice a week to pregnant women and delivers a

weekly message to a caregiver. These messages counter common misconceptions, highlight potential health dangers and warning signs, locate nearby healthcare services, and highlight the benefits of family planning. The messages are tailored to the stage of pregnancy or the child's age and, depending on a subscriber's location in an urban or rural setting, different types of messages are sent, contextual to subscriber's surroundings.

Messages use different formats to convey information, with messages delivered by an engaging female doctor character, "Daktar Apa," who is seen as a trusted source of health information for women. Voice messages use a dramatic and engaging format, featuring local actors playing the roles of doctors, women, and families discussing issues like the importance of iron-rich food and reminding pregnant woman about medical checkups. Text messages communicate information about medical emergencies and warning signs during pregnancy.

After a successful pilot in four districts, Aponjon began scaling up, expanding to more than 35 districts in Bangladesh in 2012. In 2013, Aponjon introduced a hotline that allowed doctors to give advice to registered mothers and family members. The mobile app, Aponjon Shogorbha (Pregnancy), which has been developed to reach mothers with smartphones, provides a more comprehensive platform for expecting and new mothers to learn about prenatal and neonatal health (available on [Google Play](#), in the [Apple App Store](#) and [Windows Phone App Store](#)). The app helps women monitor their pregnancies, estimating due dates, monitoring weight gain, and keeping track of appointments and reminders. The app even suggests healthy menus for pregnant women, allowing them to create healthy menus that cover calorie requirements, and describes how the baby is developing during pregnancy.

Aponjon promotes its services through branded buses, information, education, and communication materials, and community events such as health fairs.

Results

In 2016, four years since the pilot, Aponjon had reached more than 1.5 million subscribers.

A [quantitative evaluation conducted in September 2015](#) found that women who participated in Aponjon attend the recommended number of antenatal check-ups

at rates more than three times the national average (<http://www.tractionproject.org/resources/key-findings-mama-study-traction-supported-study-conducted-international-center-diarrheal>). These same women are more than twice as likely to give birth in a health facility. Results also indicated that respondents who had used Aponjon for a minimum of 6 months, received at least three messages per month, and carefully listened to most of the messages not only showed increased knowledge, but also were more likely to adopt good maternal and newborn healthcare practices.

Aponjon has also launched an app targeting adolescents with sexual and reproductive health information, as well as a hotline and web chat. The app also engages caregivers by allowing them to monitor the information Aponjon provides to their adolescents.

Application

Mobile technology is one strategy that responds to a number of health maintenance challenges, automating reminders and supporting those who are tasked with maintaining specific health behaviors. mHealth provides more interaction than the standard flipchart and prompts providers to touch on all important points, and can assist with supportive supervision by speeding data collection and analysis and providing supervisory job aids.

mHealth shows promises for reducing service providers' workload and improving health outcomes. The possibility of anonymity can help reach hidden, sensitive, or otherwise hard-to-reach populations with information tailored to different audiences.

ADDITIONAL RESOURCES

mHealth Evidence Website (<https://www.mhealthevidence.org/>)

HIP. **mHealth: Mobile technology to strengthen family planning programs.**

Mobile for Reproductive Health (m4RH)

(https://www.fphighimpactpractices.org/sites/fphips/files/hip_mhealth_brief.pdf)

Global Health Learning Center. **mHealth Basics: Introduction to Mobile**

Technology for Health. (<https://www.globalhealthlearning.org/course/mhealth-basics-introduction-mobile-technology-health>)

Appendix L – Uganda: Coordination Challenges

Challenge

Service communication activities often require partnership and coordination. As described in the [coordination section](http://sbccimplementationkits.org/service-communication/service-communication-implementation-kit/operational-considerations/coordinate-demand-side-and-supply-side-activities/) (<http://sbccimplementationkits.org/service-communication/service-communication-implementation-kit/operational-considerations/coordinate-demand-side-and-supply-side-activities/>), often a social and behavior change communication (SBCC) organization collaborates with a service delivery organization to develop communication that will contribute to improving health outcomes. Coordination has to occur before service delivery to generate demand for services, during service delivery to ensure that supply/services meet demand and that messages are harmonized, and after service delivery to support behavioral maintenance when clients are out of the clinical environment.

Response

With most productive partnerships, coordination among actors in service communication should leverage the comparative advantages of each partner, expanding their scope and reach. Formal arrangements such as memoranda of understanding and coordination mechanisms such as regular planning meetings operationalize the partnership and clarify roles and responsibilities. Joint planning and execution is of particular importance for campaign-style communication efforts and multi-year campaigns.

Coordination of service communication requires participatory processes that include intended populations in strategy development, implementation, and monitoring and evaluation (M&E). This will ensure that messages are well understood (including the rationale for sequencing and selection of channels), that activities are collaboratively planned and executed, and that monitoring allows partners to adjust activities and messages based on field experience. Joint evaluation can document the impact/relationship/influence of communication on service delivery.

Case Study: Stop Malaria Project – Uganda

Challenge

Due to high rates of malaria and a lack of affordable testing facilities, health programs in Uganda have told providers and caregivers to treat all fevers as malaria for more than a decade. With uptake of prevention measures such as indoor residual spraying and long-lasting insecticidal nets, malaria incidence has dropped, but presumptive treatment continues. This has made over-diagnosis of malaria an increasing concern. The 2011 Demographic and Health Survey showed that only 26 percent of children under 5 with fever were tested for malaria, while 46 percent received treatment with artemisinin combination therapy (ACT). Ninety-six percent of those who tested positive for malaria received an anti-malarial, but so did 48 percent of those who tested negative. This means that frontline antimalarial drugs (ACTs) were being over-prescribed, resulting in stock-outs for those who actually needed the drugs. Unnecessary ACT also risks creating resistance to artemisinin-based treatments – already the case with quinine-based treatment.



Identifying the true cause of fever could lead to more effective treatment and ultimately better health outcomes. In 2012, the Government of Uganda adopted World Health Organization guidelines recommending that all individuals exhibiting malaria symptoms be tested and that only those who test positive receive malaria treatment. The National Malaria Strategic Plan 2011-2015 aimed to ensure that 90 percent of all suspected malaria cases in Uganda are tested before treatment is initiated.

Unfortunately, many providers continue to rely on their own clinical judgment and experience rather than on diagnostic tests, and treatment is often given to patients with negative test results. Providers' reasons range from distrust of test results, lack of confidence in diagnosing and treating non-malaria fevers, and perceived or

actual patient demand for malaria medicine, despite test results. Qualitative research has suggested a need for clear guidelines, a supportive environment, trust in the capacity of the laboratory staff or equipment, and the skills to manage fevers and navigate patient expectations to ensure the adoption of parasite-based treatment.

Response

The USAID-funded Stop Malaria Project (SMP), led by Johns Hopkins Center for Communication Programs (CCP), collaborated with the Ugandan government and multiple health partners to design and execute the “Test and Treat” campaign. The campaign sought to 1) build trust in malaria test results among clients and health providers; 2) increase the proportion of clients with fevers who are treated appropriately; and 3) encourage community members to get children under 5 tested for malaria before treatment. The campaign was rolled out in 24 health districts where malaria is highly endemic.

The campaign targeted caregivers of children under 5 and clinical public health workers with the slogan, *“Don’t Guess, First Test,”* which promoted two behaviors: 1) all individuals exhibiting symptoms of malaria should get a malaria test, and 2) only those who test positive for malaria should receive treatment for malaria.

Individuals who receive a negative test result for malaria should try to identify and treat the actual source of their symptoms.

Activities carried out during this campaign included:

- Mass media – Posters, billboards and radio spots to reach a large proportion of the intended audiences.
- Training and support supervision – Health providers were trained to improve their skills in managing fevers and communicating with caregivers about the importance of testing and adherence to test results. Training was reinforced by support supervision visits.
- Interpersonal communication – Group health education talks and one-on-one discussions between caregivers and Village Health Team members or other health providers gave caregivers more opportunities to learn about and discuss the new recommendations.

The Test and Treat campaign built on an existing campaign that promoted testing in Uganda. The “Power of Day One” campaign, implemented by the AFFORD Project for a year before this campaign, promoted testing and treatment for malaria within 24 hours of fever onset. The Power of Day One campaign contributed to increased uptake of ACT and rapid diagnostic testing in private sector health facilities, pharmacies and drug shops in four districts, which were part of the 24 districts covered by SMP.

- The Ministry of Health’s National Malaria Control Programme (NMCP) provided overall direction for the campaign. In addition to advising the partners on the Ministry’s strategic areas of interest, the NMCP helped ensure that diagnostic commodities were available to public health facilities in the participating districts. District health officials were positioned as master trainers to train clinical staff in their regions and provide supportive supervision in the rollout of the new protocol.
- As the lead implementing partner for SMP, CCP provided technical leadership for the design, implementation and M&E of the communication strategy
- Malaria Consortium (an SMP partner) designed and conducted provider training, developed training materials (intermittent parasite clearance [IPC] guides for national and district trainers), provider workbooks, a checklist for diagnosis of fever among children under 5 and a continuing medical education guide. Malaria Consortium also participated in support supervisory visits to participating health facilities.
- Mango Tree developed a flipchart for providers to use during patient counseling.
- Uganda Health Marketing Group and their contracted advertising agencies led the design, production and placement of media materials, including posters, billboards and radio spots. Pretesting was done in collaboration with SMP and NMCP. Uganda Health Marketing Group also led training of private-sector providers in diagnostic capacity, and led rollout of the campaign in private-sector facilities in six districts.
- World Vision integrated the Test and Treat messages in its distance radio learning program for village health teams, which are made up of community volunteers who provide basic health education and referrals for services.

Results

The combination of a designated coordinator, clear guidelines, access to tests and ACTs, the promotion of testing and appropriate treatment to providers and caregivers, and efforts to increase providers' ability to manage febrile cases and communicate effectively with caregivers all contributed to the campaign's success.

The evaluation of the campaign found a demonstrated a shift in provider practices. Providers with any exposure to the campaign were more likely to test all children who reported with fever (91-97 percent vs. 81 percent) and were less reliant on clinical diagnosis. Providers who were trained and exposed to the media campaign were more likely to conduct a differential diagnosis (86 percent vs. 76 percent) and less likely to prescribe antimalarial drugs for children with fever who tested negative for malaria (15-25 percent vs. 37 percent). Finally, providers who received clinical training that included IPC and counseling skills were more likely to tell caregivers that antimalarial treatment was not necessary after a negative test result (80 percent vs. 50 percent) and more likely to provide alternative diagnosis (86 percent vs. 76 percent). The campaign also improved availability and stocking of malaria drugs. Because service providers only treat when test results are positive, drugs are available for people who actually have malaria.

Application

Coordination is crucial when introducing new technology or services that require a shift in provider and client behavior. As the national governing bodies, the Ministry of Health is the appropriate body to establish protocols and policies and to be responsible for training public health sector staff. Development partners can contribute by supporting training and education and generating demand through communication and social mobilization. Civil society's role is often to mobilize communities and advocate for equity, accessibility and appropriateness of services.

Appendix M – Nigeria: Service Communication Strategy in Action

Nigerian Urban Reproductive Health Initiative

This case study illustrates how the elements of service communication can be applied in a real-world situation, and how use of social and behavior change communication (SBCC) approaches can significantly improve access, uptake and quality of health services, in turn leading to better health outcomes. The Nigerian Urban Reproductive Health Initiative (NURHI) applied best practices in SBCC throughout the stages of service delivery to revitalize Nigeria's family planning program in urban areas. The program sought to gain maximum insight about its intended audiences and developed an appealing branded campaign that shared the functional and emotional benefits of family planning. The project developed the skills of public and private sector providers to ensure that clients understood benefits of different contraceptive methods, and conducted mobile outreach to reduce barriers to access. The project also worked to create a supportive environment that encouraged households and communities to discuss family planning openly, enabling more individuals to explore the benefits of family planning, identify the best method for them and sustain its use over time.

About NURHI

NURHI is funded by the Bill & Melinda Gates Foundation and managed by Johns Hopkins Center for Communication Programs (CCP). The Association for Reproductive and Family Health and Centre for Communication Programs, Nigeria are key partners, along with collaborating organizations such as the African Radio Drama Association, the Health Reform Foundation of Nigeria, Advocacy Nigeria, Development Communications Network, the Futures Institute and Marie Stopes International Nigeria.

The project was designed to assist the Nigerian government in revitalizing its family planning program and increase the contraceptive prevalence rate by 20 percentage points. NURHI focused its efforts on promoting contraceptive methods for birth spacing and limiting births, with a particular aim of increasing access to family

planning among the urban poor. The first phase of the project ran from 2009 to 2014 in six urban centers: Abuja, Benin City, Ibadan, Ilorin, Kaduna and Zaria.

NURHI originally had five objectives:

1. Develop cost-effective interventions for integrating high-quality family planning into maternal and newborn health, HIV and AIDS, postpartum, and post-abortion care programs
2. Improve the quality of family planning services for the urban poor, emphasizing high-volume clinical settings
3. Test novel public-private partnerships and innovative private-sector approaches to increase access to and use of family planning by the urban poor
4. Develop interventions for creating demand for and sustaining the use of contraceptives among marginalized urban populations
5. Increase funding and financial mechanisms and a supportive policy environment for ensuring access to family planning supplies and services for the urban poor

A sixth objective was added in 2012:

6. Identify potential “gateway behaviors” and test the effect of interventions designed to increase these behaviors and their downstream impact.

Challenge¹

One in every six Africans is Nigerian. As the continent’s most populous country, Nigeria is also experiencing a “youth bulge,” with more than half of the population under 24 years old. This is due in part to the country’s high fertility. On average, a Nigerian woman has six children, placing the country’s birth rate at 12th highest in the world. Compounding this situation, Nigeria’s poverty and health statistics are among the worst in Africa. When NURHI began in 2009, the World Bank estimated

¹ Statistics in this section are from <https://www.cia.gov/library/publications/the-world-factbook/fields/2212.html> and <http://datatopics.worldbank.org/hnp/HNPDash.aspx>.

that 83 million Nigerians (62 percent of the population) lived on less than \$1.90 per day, and infant and maternal mortality rates were alarmingly high (85 deaths per 1,000 live births, and an adjusted maternal mortality ratio of 610 per 100,000 live births, as of 2010).

Gateway Behaviors Study

There seem to be unique moments in time when individuals are particularly receptive to new information and motivated to make changes. NURHI's Gateway Behaviors Study used formative research that identified two gateway behaviors – completing at least four antenatal care visits during pregnancy and interpersonal communication on family health matters – that influence other health behaviors, such as family planning, exclusive breastfeeding and immunization. Piloted in Ilorin South from September 2013 to December 2014, the study used SBCC and social mobilization to engage pregnant women, their partners and their mothers-in-law. The project created profiles for each intended audience and leveraged key life events, such as naming ceremonies and weddings, as gateway moments to promote antenatal care and communication about family health matters. Advocacy and provider training ensured services were welcoming and competent. Registration of pregnant women in the pilot area increased substantially as a result of these interventions.

Nigeria is also increasingly urban. Estimates place some 48 percent of Nigerians in urban environments, with the rate of urbanization at just under 5 percent. There are at least 10 cities with more than 1 million residents, and 15 percent of the population lives in the country's six largest cities. Poverty and slum conditions pose health threats to Nigeria's fast-growing urban centers. More than 51 percent of urban dwellers live below the poverty line, and many lack adequate housing, sanitation, and waste management.

Despite a thriving family planning program in the 1980s and early 1990s, Nigeria suffered from changing donor priorities and funding. This contributed to stagnating trends in fertility, contraceptive use, and method mix over the past 10 years. In 2009, with contraceptive prevalence at only 10 percent, a total fertility rate of 5.7, and unmet need at 20 percent, there was a pressing need to reinvigorate family planning efforts at national, state, and city levels. Meanwhile, policies and programs

remained mostly on paper. There were a few national working groups focused on policy implementation, but family planning received little attention at state and local levels. Consequently, the family planning program was largely funded by external donors, the health system paid little attention to family planning, and many journalists and local leaders were vocally opposed to family planning. Unsurprisingly, government health facilities were poorly staffed, minimally equipped, and riddled with contraceptive stock-outs. Many couples obtained family planning services from proprietary and patent medicine vendors (PPMV), who can only dispense condoms and refill oral contraceptives to current users or pharmacists. Access to implants and IUDs were restricted to a few hospitals.

Response

NURHI's SBCC approaches were employed throughout the three stages of service delivery, with specific roles in each stage:

- **Before** services were delivered by raising general awareness about family planning and available services, addressing community and social norms, and reviving demand for family planning
- **During** services by ensuring that all service providers (clinical and non-clinical, private and public sector) were able to provide high-quality family planning counseling and services and increasing access through mobile outreach
- **After** services by promoting open discussion about family planning within couples and peer groups and soliciting the support of community leaders and local government to sustain commitment to family planning efforts

NURHI's approach to improving access to and quality of family planning services led with demand generation efforts that applied a "consumer lens" to communicate about and deliver services. The hypothesis was that creating demand would, in turn, drive supply, thereby creating a sustainable response. As the graphic below illustrates, the project's approaches to demand generation and service delivery mutually reinforced one another.



NURHI systematically used research, consumer feedback (through pre-testing) and monitoring data to revise and refine its messages.

Before: Bringing Clients to Services

To create interest and demand for family planning services, NURHI used the situation analysis and audience insight to design a multi-phased, multi-channel demand generation strategy built around a highly visible umbrella brand, “**Get It Together.**” (<http://www.nurhitoolkit.org/program-areas/demand-generation/get-it-together-campaign#.V1WBFfkrKhc>) For more information on how to develop a brand, see [How-To Create a Brand Strategy Part 2](#).

Step 1: Segmenting, Prioritizing, and Profiling the Intended Audience

In assessing the family planning situation, NURHI used qualitative and quantitative research, including focus group discussions, a [Baseline Household Survey](http://www.nurhitoolkit.org/program-areas/rme/formative-research#.V1WDJvkrKhc) (<http://www.nurhitoolkit.org/program-areas/rme/formative-research#.V1WDJvkrKhc>), secondary analysis of the 2008 Nigerian Demographic and Health Survey and a social mapping exercise to learn about community members’ attitudes toward family planning services and identify points of entry for social mobilization activities. NURHI used the concept of ideation to identify beliefs, emotions and



behaviors that contributed to individual family planning use and worked to influence those factors.

In 2010, NURHI held a participatory design workshop to analyze research findings and draft the demand generation strategy.

Step 2: Draft a Demand Generation Strategy

The demand strategy linked closely with NURHI service delivery, advocacy and public-private partnership activities. In its branded media campaign (see below), NURHI used a variety of mass media channels, community-level activities and referrals for family planning services led by social mobilizers, and an “entertainment-education” radio drama featuring satisfied users who modeled family planning use and promoted services.

Step 3: Design and Test Materials and Interventions

Branding: NURHI worked with an advertising agency to develop a campaign brand and materials based on audience insights. A **creative brief** guided the agency to develop a campaign targeting 15- to 45-year-old women and 20- to 50-year-old men living in slums (http://www.nurhitoolkit.org/sites/default/files/tracked_files/Mass Media Creative Brief.pdf). The brand logo, finalized after pre-testing, included a tagline (“Know. Talk. Go.”) that encouraged the target audience to know about family planning, talk with partners about family planning, and go for family planning services. NURHI also worked with the agency to produce a package of branded radio and television spots and print materials.

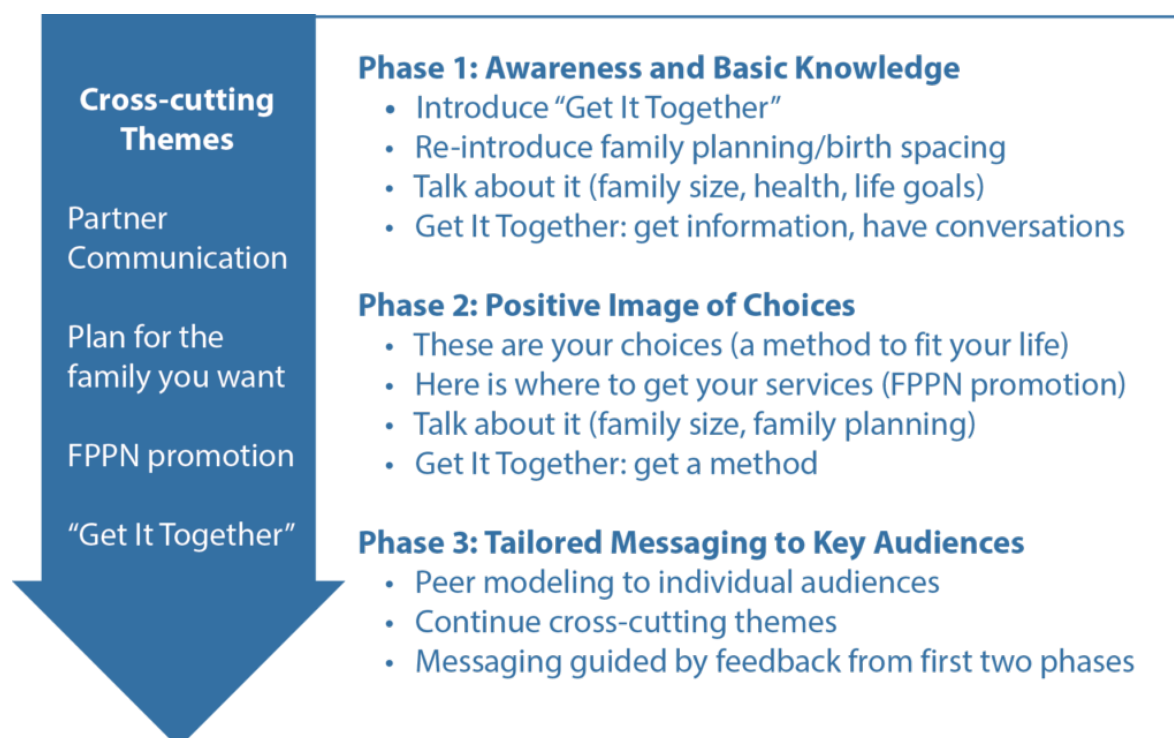
Community mobilization: NURHI and partner Centre for Communication Programs, Nigeria designed a **social mobilization strategy** that engages young (18- to 35-year-old) barbers, tailors, hairdressers and motorcycle delivery people to discuss family planning with individuals and groups (<http://www.nurhitoolkit.org/node/145#.V1WEqvkrKhc>).

Entertainment-education: NURHI and partner African Radio Drama Association produced three seasons of a weekly radio program in each target city. See a **step-by-step narrative of the radio design process**: [http://www.nurhitoolkit.org/program-areas/demand-generation/radio-drama -.V1WFW_krKhc](http://www.nurhitoolkit.org/program-areas/demand-generation/radio-drama-.V1WFW_krKhc).

The illustration below depicts how the campaign rolled out messages in three phases. The first phase built awareness and introduced the topic of family planning among targeted communities; the second phase introduced the range of modern contraceptive options to motivate informed choice; and the third phase encouraged behavior change through tailored messages for specific audience segments.

Reaching Urban Youth

The **Urban Adolescent SBCC Implementation Kit** (I-Kit) provides a selection of essential elements and tools to guide the creation or strengthening of sexual and reproductive health SBCC programs for urban adolescents aged 10 to 19. The I-Kit is designed to teach these essential SBCC elements and includes worksheets to illustrate each element and facilitate practical application (<http://sbccimplementationkits.org/urban-youth/>).



Step 4: Campaign Launch

NURHI launched Get It Together in four cities in October 2011, with television and radio spots and posters in high-traffic areas. Service providers received branded job aids, print materials, and promotional items. Social mobilizers also received

branded promotional and educational materials. Trained mobilizers facilitated radio listening groups, conducted visibility parades, leveraged key life events for points of discussion, spearheaded neighborhood campaigns and referred clients to Family Planning Providers Network (FPPN) services with Go Referral Cards. After six months of the campaign, radio programs began weekly broadcasts. Each program included a serial drama episode, interviews, music, and a weekly quiz, plus a live call-in session with a family planning expert. Listeners could win prizes by answering weekly questions through text messaging.

During: Client-Provider Challenges

NURHI's service delivery strategy focused on facilities with high-volume services – defined as public or private health facilities with the highest volumes of antenatal, delivery, family planning and immunization clients. Most were tertiary or teaching hospitals, secondary facilities or general hospitals, military hospitals, and hospitals that provide free maternity services. Research showed that pharmacies and PPMVs were additional points of access for family planning services and information, so NURHI developed criteria to select pharmacies and PPMVs, including their willingness to join the [FPPN \(http://www.nurhitoolkit.org/node/15\)](http://www.nurhitoolkit.org/node/15).

NURHI adopted three approaches to address the challenges of service delivery.

- 1. Improving the quality and accessibility of services:** NURHI provided robust training for service providers in family planning counseling and IUD and implant insertion and services. The project also worked at facility level to improve contraceptive logistics and management systems. Training included in-person, on-site clinical training, on-the-job training for counseling, distance learning via mobile platforms, and supportive supervisory visits. NURHI used mobile teams of service providers from Marie Stopes International Nigeria to reach additional clients. NURHI also helped upgrade services with additional equipment, using a **“clinic makeover” approach** to rapidly make each site more inviting and pleasant for clients (<http://www.nurhitoolkit.org/program-areas/service-delivery/72-hour-clinic-make-over#.V1WGgvkrKhc>).
- 2. Integrating family planning with existing maternal, neonatal, and child health and HIV services:** NURHI developed an integration strategy , provided

onsite training for high-volume service providers in family planning counseling and strongly promoted postpartum IUD services. Because these services were already at capacity, NURHI created an active referral program to route clients to dedicated FP services.

3. **Strengthening relationships and referrals between public and private sector family planning providers:** NURHI enhanced referrals systems to ensure that clients who need family planning services have access to them. Social mobilizers received branded Go cards to refer community members to high-volume services sites and allow service providers to know who referred the client, gave mobilizers the ability to follow up with clients and enabled the project to collect data for analysis. NURHI also used existing referral mechanisms to track clients when they were sent to a different facility within the network. The referral strategy articulated roles and responsibilities among service providers, facility management, community mobilizers, NGOs and NURHI staff.

Engaging Private Providers (<http://www.nurhitoolkit.org/program-areas/service-delivery/public-private-partnerships/ffpn/>)

NURHI created the FPPN to establish a platform where family planning providers could interact and work together to increase access, referrals, and family planning service quality. This public-private initiative supported clinical and non-clinical service providers to improve contraceptive logistics management, increase the quality of family planning service delivery through training, strengthen referrals between service delivery points, and use branding and promotion to increase access to and uptake of family planning services. In 2014, the FPPN became the Sustainable Family Planning Providers Association and developed a strategic plan, through 2018, with goals to increase utilization, expand and sustain the family planning method mix, improve service quality, and win support from local leaders.

After: Maintaining Behavior

NURHI's advocacy strategy focused at the state and local levels to engage local government officials, community leaders and the media to support family planning efforts. Partners with expertise in local advocacy assisted the project in needs

assessment and identified stakeholders to participate in advocacy efforts. NURHI's Advocacy Core Groups assembled leaders from each city to identify high-priority policy issues and develop advocacy plans to address them. NURHI facilitated the creation of national and site-specific **advocacy kits** with position papers, policy briefs and fact sheets to support local advocacy efforts (<http://www.nurhitoolkit.org/program-areas/advocacy/advocacy-tools/advocacy-kits#.V1WGovkrKhc>).

Futures Institute created tools to stimulate dialogue on the impact of population on the environment, social services and economic development. Advocates were trained to use a number of advocacy tools (Spitfire training materials, budget projections and tracking) to push local governments to prioritize family planning in development plans and budgets. NURHI also targeted media outlets using its **media advocacy strategy** (<http://www.nurhitoolkit.org/program-areas/advocacy/media-advocacy#.V1WGsfkrKhc>) to enhance the quality and quantity of media coverage of maternal and child health issues, with a focus on family planning.

NURHI identified and engaged community leaders and community groups to increase their support of and involvement with family planning, providing them with messages and strategies to address health concerns and the fear of side effects. The project also formed interfaith forums in each city to bring together religious leaders once a year to collaboratively develop messages and strategies to increase family planning use in their communities.

Service communication and behavioral maintenance was further supported through the Get It Together campaign's focus on dispelling myths and promoting open discussion about family planning among couples and peer groups, making the use of family planning more acceptable and desirable.

Coordination

A complex array of partners contributed to NURHI's success, working under varied partnership models—formal partnerships, contracting and procurement, creation of new platforms and leveraging of existing structures. These partnerships allowed NURHI to expand the scope and scale of its activities. Clear roles and

responsibilities in planning, implementation, and M&E ensured that all partners understood expectations about their contributions to the project. NURHI supported national, state, and local government structures to set the strategic direction of activities and monitor progress toward goals. The FPPN provided a platform to engage the service providers, particularly those in the private sector.

NURHI employed an advocacy and behavior change officer to monitor and coordinate the mass media radio program and social mobilization activities through regular meetings with partners, radio program monitoring, and tracking referrals by social mobilizers for family planning services.

Results

NURHI showed immediate results and continuous progress. The **midterm assessment survey** conducted after one year of implementation showed that 83 percent of men and women knew about the NURHI 'Get it Together' campaign (https://www.urbanreproductivehealth.org/sites/mle/files/nurhi_baseline_household_survey.pdf). The NURHI **midterm survey results** showed an increase of 3–15 percent in contraceptive prevalence rates in the four initial cities in less than two years. The data also revealed that the proportion of women who intend to use family planning increased from 7.5–10.2 percent (https://www.urbanreproductivehealth.org/sites/mle/files/nigeria_midterm_twp2_2013.pdf).

The 2013 National Demographic Health Survey showed an increase in family planning contraceptive prevalence rate in cities where NURHI operated.

Endline results showed significant increases in knowledge about family planning and increased contraceptive prevalence rates in every city where NURHI intervened (https://www.urbanreproductivehealth.org/sites/mle/files/mle_twp2-2015_nigeria.pdf), with significant increases in use of modern methods. These results demonstrate that the project was able to communicate effectively about family planning and motivate women to use modern methods.

Executive Summary table of key indicators at baseline and endline

Percent distribution of women for select key indicators, Nigeria 2010/2011, 2014

	Abuja		Benin City		Ibadan		Ilorin		Kaduna		Zaria	
	Baseline	Endline	Baseline	Endline	Baseline	Endline	Baseline	Endline	Baseline	Endline	Baseline	Endline
Knowledge of FP (spontaneous)												
Any method	66.9	95.0	83.6	89.3	87.0	95.3	77.1	97.6	63.7	96.5	62.0	95.0
Modern method	65.4	94.5	82.6	88.1	86.4	94.6	76.6	97.3	63.3	96.0	61.6	94.2
No knowledge of modern method	34.6	5.5	17.4	11.9	13.6	5.4	23.4	2.7	36.7	4.0	38.4	5.8
Number	2126	1338	2512	1321	2928	1714	2449	1702	2850	1995	3279	2602
CPR among all women in union												
Modern method	32.2	40.4	23.3	32.7	33.5	45.9	27.0	34.5	19.9	30.5	5.9	24.0
Traditional method	11.7	11.4	17.4	19.8	13.3	15.5	8.9	19.9	6.6	10.4	2.5	8.2
No use	56.1	48.4	59.3	47.5	53.3	38.6	64.1	45.6	73.5	59.1	91.5	67.8
Number	1347	873	1293	762	1979	1229	1563	1217	1583	1302	2284	1981
Contraceptive method switching between baseline and endline												
	Baseline→Endline		Baseline→Endline		Baseline→Endline		Baseline→Endline		Baseline→Endline		Baseline→Endline	
Adopted modern method	21.4		19.3		23.4		22.8		19.5		18.0	
Continued modern method	17.0		10.0		16.1		9.8		9.4		1.9	
Continued trad/nonuse	48.5		55.4		47.0		56.1		64.2		77.2	
Discontinued modern method	13.1		15.3		13.5		11.4		6.9		2.9	

Other results include establishing the FPPN as the Sustainable Family Planning Provider Association and increased budgetary support for family planning from state and local governments. Media reporting is now more pro-family planning, and national leaders are more vocally supportive of family planning. NURHI's channel analysis determined that radio and community mobilization activities were the best investments, in terms of cost effectiveness.

Next Steps

Phase II of the NURHI project commenced in October 2015. This five-year phase is being implemented at the state level in Lagos, Kaduna and Oyo. NURHI II continues to use the premise proven under NURHI I: that demand for family planning is a requirement for increased contraceptive use and that will lead to increased contraceptive supply and available services

ADDITIONAL RESOURCES

NURHI project website: www.nurhitoolkit.org

Measurement, Learning & Evaluation Project, Urban Reproductive Health

Initiative: <https://www.urbanreproductivehealth.org/projects/nigeria>

APPENDIX N: RESOURCES

Addressing Providers As A Behavior Change Audience

(<http://sbccimplementationkits.org/service-communication/lessons/addressing-providers-as-a-behavior-change-audience/>)

- Community Health Worker Provider Behavior Change I-Kit
(<http://sbccimplementationkits.org/provider-behavior-change/courses/for-community-health-workers/>)
- Facility-Based Provider Behavior Change I-Kit
(<http://sbccimplementationkits.org/provider-behavior-change/courses/for-facility-based-providers/>)
- Provider Behavior Change Communication Approach (http://www.respond-project.org/pages/files/4_result_areas/Result_1_Global_Learning/LA_PM_CoP/Provider-Motivation-Mary-Warsh.pdf)
- Strategies for Changing Private Provider Behavior
(<http://www.shopsproject.org/resource-center/strategies-for-changing-the-behavior-of-private-providers>)

Counseling and Job Aids

- REDI Framework (https://www.engenderhealth.org/files/pubs/acquire-digital-archive/10.0_training_curricula_and_materials/10.2_resources/fp_curric_ph_main_text.pdf)
- The Balanced Counseling Strategy Plus
(<http://www.popcouncil.org/research/the-balanced-counseling-strategy-plus-a-toolkit-for-family-planning-service>)
- Mobile FP Job Aid
(<http://www.ghspjournal.org/content/4/2/300.full.pdf+html>)
- Maternal and Newborn Quality of Care Framework
(<http://www.mcsprogram.org/wp-content/uploads/2016/06/Maternal-and-Newborn-QoC-Framework-.pdf>)
- NURHI Counseling videos: **unsupportive**
(<https://www.youtube.com/watch?v=5LwQHkBJlwQ>), **supportive**
(<https://www.youtube.com/watch?v=gS3EKZZcijs>)

Aligning Communication Channels with Messages

(<http://sbccimplementationkits.org/service-communication/aligning-communication-channels-with-messages/>)

- How To Guide - Developing A Channel Mix Plan (<http://www.thehealthcompass.org/how-to-guides/how-develop-channel-mix-plan>)

Audience Analysis (<http://sbccimplementationkits.org/service-communication/lessons/step-1-audience-analysis/>)

- How To Do An Audience Analysis (<http://www.thehealthcompass.org/how-to-guides/how-do-audience-analysis>)
- How To Do Audience Segmentation (<http://www.thehealthcompass.org/how-to-guides/how-do-audience-segmentation>)
- The DELTA Companion (<http://www.thehealthcompass.org/sbcc-tools/delta-companion-marketing-made-easy>)
- MSI's Marketing Tool (http://sbccimplementationkits.org/service-communication/wp-content/uploads/sites/13/2016/09/MSI_Toolkit_Full_PageNumbers2.pdf)

Develop Audience Profile (<http://sbccimplementationkits.org/service-communication/4-develop-audience-profile/>)

- Developing an Audience Profile (<http://sbccimplementationkits.org/fbo-breastfeeding/lessons/step-3-choose-intended-audiences-2/>)
- How to Do an Audience Analysis (<http://www.thehealthcompass.org/how-to-guides/how-do-audience-analysis>)

Introduction to Service Communication

(<http://sbccimplementationkits.org/service-communication/introduction-to-service-communication/>)

- VIDEO: What is SBCC? (<https://www.youtube.com/watch?v=RN0F7jAFkgw>)

- Designing An SBCC Strategy I-Kit (<http://sbccimplementationkits.org/courses/designing-a-social-and-behavior-change-communication-strategy/>)
- C-Modules (<https://www.c-changeprogram.org/focus-areas/capacity-strengthening/sbcc-modules>)
- SEED Programming Model Brief (<https://www.engenderhealth.org/files/pubs/family-planning/seed-model/SEED-8pg-English.pdf>)
- HIP Briefs (<https://www.fphighimpactpractices.org/resources>)

Key Principles of Designing SBCC for Health Services

(<http://sbccimplementationkits.org/service-communication/courses/key-principles-of-designing-sbcc-for-health-services/>)

- P Process (<http://www.thehealthcompass.org/sbcc-tools/p-process>)
- C-Planning Model (<https://www.c-changeprogram.org/focus-areas/capacity-strengthening/sbcc-modules>)
- UNICEF's Strategic Communication Model (http://www.unicef.org/cbsc/files/Strategic_Communication_for_Behaviour_and_Social_Change.pdf)
- DELTA Companion (http://www.thehealthcompass.org/sites/default/files/strengthening_tools/DELTA-Companion-Social-Marketing.pdf)

Operational Considerations (<http://sbccimplementationkits.org/service-communication/service-communication-implementation-kit/operational-considerations/>)

- C-Change C-Module 4 Implementation and Monitoring (https://www.c-changeprogram.org/sites/default/files/sbcc_module4.pdf)
- NURHI Referral Guidelines ([http://www.nurhitoolkit.org/sites/default/files/tracked_files/NURHI Referral Manual.pdf](http://www.nurhitoolkit.org/sites/default/files/tracked_files/NURHI%20Referral%20Manual.pdf))

- Guatemala Message Consistency Analysis
(<http://healthcommcapacity.org/wp-content/uploads/2016/02/WHIP-SBCC-Materials-Consistency-FINAL-10-1-15.pdf>)
- Pandemic Influenza Message Guide
(http://avianflu.fhi360.org/docs/Ethiopian_Message_Guide_June09.pdf)
- Essential Nutrition Actions Guide
(http://www.coregroup.org/storage/Nutrition/ENA/Booklet_of_Key_ENA_Messages_complete_for_web.pdf)
- Family Planning Message Guide
(http://www.thehealthcompass.org/sites/default/files/project_examples/Pamphlet_%5BEnglish_Language%5D_1.pdf)

Importance of Reinforcing Value (<http://sbccimplementationkits.org/service-communication/the-importance-of-reinforcing-value/>)

- Key Promise section of the PBC I-Kit
(<http://sbccimplementationkits.org/provider-behavior-change/lessons/step-5-determine-the-key-promise-and-support-points-2/>)
- Community Health Worker Behavior Change I-Kit
(<http://sbccimplementationkits.org/provider-behavior-change/courses/for-community-health-workers/>)

The Qualities of Effective Service-Related Messages

(<http://sbccimplementationkits.org/service-communication/the-qualities-of-effective-service-related-messages/>)

- Communication for Better Health: Population Report
(http://pdf.usaid.gov/pdf_docs/Pnadl383.pdf)
- Making Health Communication Programs Work
(<http://www.cancer.gov/publications/health-communication/pink-book.pdf>)
- Plain Language Guidance (<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 Conduct Effective Pretests
(https://www.k4health.org/sites/default/files/AIDSCAP - Conducting Effective Pretest_0.pdf)
- How to Create Good SBCC Messages: C-Module (https://www.changeprogram.org/sites/default/files/sbcc_module3.pdf)
- Why Bad Ads Happen To Good Causes
(<http://www.rwjf.org/content/dam/files/rwjf-web-files/GranteeResources/BadAds.pdf>)
- How to Design SBCC Messages (<http://www.thehealthcompass.org/how-to-guides/how-design-sbcc-messages>)
- How to Conduct a Pretest (<http://www.thehealthcompass.org/how-to-guides/how-conduct-pretest>)

Supportive Supervision (<http://sbccimplementationkits.org/service-communication/supportive-supervision-to-help-maintain-provider-behavior-change/>)

- Stages of Change (Transtheoretical Model)
(<http://www.orau.gov/hsc/theorypicker/ttm.html>)
- Supervision and Feedback chapter of the IPC Toolkit
(<http://sbccimplementationkits.org/provider-behavior-change/wp-content/uploads/sites/10/2015/11/IPC-toolkit-English.pdf>)

Tailoring Messages and Aligning with Communication Channels
(<http://sbccimplementationkits.org/service-communication/lessons/tailoring-messages-and-aligning-with-communication-channels/>)

- How to Design SBCC Messages (<http://www.thehealthcompass.org/how-to-guides/how-design-sbcc-messages>)

Understanding Provider Needs (<http://sbccimplementationkits.org/service-communication/understanding-provider-needs/>)

- How To Conduct An Audience Analysis
(<http://www.thehealthcompass.org/how-to-guides/how-do-audience-analysis>)

What Are the Relevant Social and Gender Norms?

(<http://sbccimplementationkits.org/service-communication/what-are-the-relevant-social-and-gender-norms/>)

- Integrating Gender into Social and Behavior Change Communication I-Kit
(<http://sbccimplementationkits.org/gender/courses/gender-and-social-and-behavior-change-communication/>)

APPENDIX O: EVIDENCE

- Impact of Health Communication on the HIV Continuum of Care (<http://healthcommcapacity.org/wp-content/uploads/2015/04/SBCC-HIV-Evidence-Continuum-of-Care-Feb20151.pdf>)
- Making the Case for SBCC for Reproductive Health Among Youth (<http://www.healthcommcapacity.org/wp-content/uploads/2015/02/BCC-Infographic-mb.pdf>)
- HC3 HIV Evidence Database (<http://healthcommcapacity.org/hiv-evidence-database/>)
- Compendium of Evidence-Based Interventions and Best Practices for HIV Prevention (<http://www.cdc.gov/hiv/research/interventionresearch/compendium/index.html>)
- Health Communication: Enabling Voluntary and Informed Decision-Making (<https://www.fphighimpactpractices.org/resources/health-communication-enabling-voluntary-and-informed-decision-making>)
- Interventions Delivered by Mobile Phone to Support Client Use of Family Planning/Contraception (http://www.cochrane.org/CD011159/FERTILREG_interventions-delivered-by-mobile-phone-to-support-client-use-of-family-planningcontraception)
- Behavioral interventions for improving contraceptive use among women living with HIV (<http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD010243.pub3/full>)
- Cluster Randomized Controlled Trial Evaluation of a Gender Equity and Family Planning Intervention for Married Men and Couples in Rural India (<http://www.ncbi.nlm.nih.gov/pubmed/27167981>)
- The Impact of BCC on the Use of Insecticide Treated Nets: A Secondary Analysis of Ten Post-Campaign Surveys from Nigeria (<http://malariajournal.biomedcentral.com/articles/10.1186/s12936-016-1463-7>)
- Role of Social Support in Improving Infant Feeding Practices in Western Kenya: A Quasi-Experimental Study (<http://dx.doi.org/10.9745/GHSP-D-15-00197>)

- Behavior Change Interventions and Child Nutritional Status
(http://www.iycn.org/files/IYCN_comp_feeding_lit_review_062711.pdf)
- SBCC Evidence in Child Survival Programs - Journal of Health Communication
(<http://www.tandfonline.com/toc/uhcm20/19/sup1>)
- Demand Generation for 13 Life Saving Commodities - A synthesis of the evidence
(<http://healthcommcapacity.org/wp-content/uploads/2015/04/Demand-Generation-A-Synthesis-of-the-Evidence-FINAL.pdf>)
- Engaging Communities With a Simple Tool to Help Increase Immunization Coverage
(<http://www.ghspjournal.org/content/3/1/117.full.pdf+html>)
- Evidence of Effective Approaches to Social and Behavior Change Communication for Preventing and Reducing Stunting and Anemia
(https://www.spring-nutrition.org/sites/default/files/publications/series/spring_sbcc_lit_review.pdf)
- Lactation counseling increases exclusive breast-feeding rates in Ghana
(<http://www.ncbi.nlm.nih.gov/pubmed/15987851>)
- Effect of counseling on nutritional status during pregnancy
(<http://www.ncbi.nlm.nih.gov/pubmed/16936363>)
- Behavior Change After 20 Months of a Radio Campaign Addressing Key Lifesaving Family Behaviors for Child Survival: Midline Results From a Cluster Randomized Trial in Rural Burkina Faso
(<http://www.ghspjournal.org/content/3/4/557.full.pdf+html>)
- Matching Supply with Demand: Scaling Up Voluntary Medical Male Circumcision in Tanzania and Zimbabwe
(http://www.mchip.net/sites/default/files/AIDSTAR_case_study_on_VMMC.pdf)
- Impact of a behaviour change communication programme on net durability in eastern Uganda
(<http://www.malariajournal.com/content/14/1/366/abstract>)

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