C-Modules

FOCUSING & DESIGNING

MODULE

02345

A LEARNING PACKAGE FOR SOCIAL AND BEHAVIOR CHANGE COMMUNICATION

PRACTITIONER'S HANDBOOK

USAID
FROM THE AMERICAN PEOPLE

C-CHANGE
COMMUNICATION FOR CHANGE

C-Modules: A Learning Package for Social and Behavior Change Communication (SBCC)

Communication for Change (C-Change) Project
Version 3

May 2012

This publication is made possible by the generous support of the American people through the United States Agency for International Development (USAID) under the terms of Agreement No. GPO-A-00-07-00004-00. The contents are the responsibility of the C-Change project, managed by FHI 360, and do not necessarily reflect the views of USAID or the United States Government.

C-Change is implemented by FHI 360 and its partners: CARE; Internews; Ohio University; IDEO; Center for Media Studies, India; New Concept, India; Soul City, South Africa; Social Surveys, South Africa; and Straight Talk, Uganda.

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Overview

The *C-Modules* are designed for the use of research and implementing staff with previous experience in communication theory and programs. Module 2 covers Step 2 of C-Planning: *Focusing and Designing.* Its guidance helps SBCC practitioners to focus the results of their formative research and situation analysis and design an appropriate communication approach. Before using this module, it is best that practitioners complete the two previous modules—*Module 0, the introductory module, and Module 1: Understanding the Situation*—either online or in face-to-face facilitated courses. Practitioners completing Module2 will be ready to create materials and interventions that strategically respond to the situation through advocacy, social mobilization, and/or behavior change communication.

Sessions

A Note on Formatting

In the *C-Modules,* the names of theories and models are in **bolded, dark blue text;** concepts are in *dark blue italics.* Focused content on theory, advocacy, and social mobilization are located in text boxes called "corners" throughout the *C-Modules.*

Module 2, Session 1: Communication Strategy

A communication strategy is the bridge between the situation analysis and the actual implementation of the SBCC program, including the creation and rollout of materials, products, and activities. The strategy is the product of Step 2 in C-Planning. The communication strategy will guide the rest of the intervention by providing direction and ensuring that the different products, materials, and activities all ultimately work well together and support each other toward a clear vision of change. It should guide decisions and ensure that the plan is implemented according to the diagnosis and decisions.

In addition to guiding how programs will be implemented, a communication strategy is a useful program management tool.

- If stakeholders have a lot of new ideas for the program after the strategy has been developed, practitioners can go back to the strategy outline and ask these questions:
  - Is this new idea in line with the strategy?
  - Is this new idea in line with the theoretical basis of the program's approach?
- If resources get tight, practitioners can go back to the strategy and decide what to let go without sacrificing what is most important for success.
- If other organizations apply pressure or if the political environment shifts, practitioners can refer to the strategy to re-clarify what the program is trying to accomplish.
- If unexpected challenges emerge, the strategy can be consulted to determine if they affect the way forward.

The communication strategy shouldn't limit a program's ability to shift direction for good reason. But it will keep practitioners mindful of the approach being taken.

A full strategy includes:

1. a summary of the situation analysis
2. the communication strategy itself
3. a draft implementation plan
4. a draft evaluation plan

Developing a communication strategy is not a linear process. In fact, previous decisions are likely to be rethought and refined. All decisions are tentative until a complete and congruent picture emerges. The strategy is done when it all fits together well.

The summary of the situation analysis was completed in Step 1 (Module 1, session 7, page 33). It contains the:

- the problem statement, formulated as a summary of the problem tree and the analyses of people, their context, and cross-cutting factors
- a set of desired changes that are necessary, based on these analyses
- the theory of change and other theories or models that support assumptions about how this change can be achieved

GRAPHIC: The Second Step of a Planning Process for SBCC—Focusing & Designing

SOURCE: Adapted from: Health Communication Partnership, CCP at JHU (2003) the P-Process; McKee et al (2000) the ACADA Model; Parker, Dalrymple, and Durden (1998) the Integrated Strategy Wheel; Roberts et al (1995) the Tool Box for Building Health Communication Capacity; and National Cancer Institute (1989) Health Communication Program Cycle.

Strategy Outline: Overview

Below is an overview of a full strategy. The first part, the summary of situation analysis, was completed in Step 1. Beginning on page 5 is an example of a full SBCC strategy. A strategy outline follows, which is filled in, piece-by-piece, in Step 2.

1. Summary of Situation Analysis	• Problem statement • Research needs • Changes the problem calls for • The theory of change	Completed in Step 1
2. Communication Strategy	• Final audience segmentation • Barriers per audience • Desired changes per audience • Communication objectives per audience • Strategic approach based on the theory of change • Positioning • Key content • Channels (per audience), activities, and materials	• Complete in Step 2 • Feeds into Step 3
3. Draft Implementation Plan	• List of materials and activities by communication objective, with resources and timeline	Feeds into Step 4
4. Draft Evaluation Plan	• Plan, including draft indicators, methods, and tools	Feeds into Step 5

ETHIOPIA EXAMPLE: Communication Strategy for Client Self-Management

1. Summary of the Situation Analysis

Problem Statement For people living with HIV (PLHIV) in Ethiopia, *access* to antiretroviral therapy (ART) and adherence to treatment are major challenges. There are too few trained medical staff and too few ART facilities close by. Drugs are not continuously available, and testing equipment is not regularly serviced. This creates tension between clients and providers and affects the few appointments they have with each other. As long as the *availability* of ART cannot be guaranteed, it does not make sense to use communication to try to motivate more PLHIV to start treatment. Also, healthcare providers do not have the latest ART *information* because the Ministry of Health is not able to provide regular clinical updates and very few available materials explain how to manage HIV as a chronic disease. Although the underlying cause of the problem is the inability of government to halt the exodus of healthcare staff to better-paying positions in other countries, other factors play a role. Stigma and lack of confidentiality continue to be behavioral barriers that prevent PLHIV from disclosing their HIV status and accessing ART services. Another complication is widespread religious *beliefs and norms*, including the belief that holy water is a cure for HIV. In addition, ART, even when free of charge, requires use of personal funds to travel to monitoring visits and purchase the healthy foods that ART clients need be consume. Many cannot afford these costs on a regular basis.

Research Needs

- ***Information*** on providers' feelings about clients who feel empowered to ask questions and who monitor their own ART adherence
- Systematic observations of clients' interactions with providers

Changes the Problem Calls For

Communication should support the following changes:

- ***At the level of people most affected***: Continue client education with a focus on self-management and monitoring of HIV and AIDS as a chronic disease. *Motivate* clients to request the provision of quality services, since pure demand-creation for services would be not be useful in this environment.
- ***At the level of people directly influencing***: *Motivate* and mobilize the community, family members, and peers to support ART clients in their request for quality services. *Motivate* these groups to provide more support for PLHIV in the areas of nutrition, stigma reduction, and religious barriers to treatment. Continue education to help healthcare providers value effective interaction with ART clients and client self-management.
- ***At the level of people indirectly influencing***: Advocate for service strengthening with policymakers and support efforts of higher-level clergy to address religious barriers *(norms)* to treatment. Formative research indicated that university partners are already advocating for service strengthening, so the strategy will address this issue indirectly by supporting existing efforts.

Theory of Change
The underlying assumption is that a possible *tipping point* for change can be found in supporting ART clients to self-manage their treatment and improving client-provider communication. These activities address the key barrier of lack of quality care. Larger care issues are being addressed through existing advocacy efforts of university partners. Theories and models that contribute to this approach include **client–provider communication, disease management, and social norm theories** (guiding provider and client behaviors).

2. Communication Strategy

Final Audience Segmentation

- **Primary Audience** (people most affected)
  - Men and women ages 30–50 already on ART in urban and rural areas
- **Secondary Audience** (people who directly influence the primary audience)
  - Lower-level clergy in urban and rural areas
  - Treatment supporters (PLHIV associations, family, and friends) in urban and rural areas
  - Treatment providers (e.g., physicians, nurses, counselors, and pharmacists) in urban and rural areas
- **Tertiary Audience** (people who indirectly influence the primary audience)
  - Religious leaders at the national level
  - Ministry of Health

Desired Changes, Barriers, Communication Objectives, and Possible Interventions by Audience

- **Primary Audience:** Men and women ages 30–50 on ART
  - **Desired Changes**
    - Know how to self-manage their treatment (i.e., adherence, side effect management, regular clinic visits, and positive living habits, including positive prevention and disclosure to sexual partners, friends, and family).
    - Feel confident and come to appointments prepared to ask providers for the services and information they need.
    - Practice positive living, adhere to ART, seek treatment for opportunistic infections, and understand these actions will improve their health.
  - **Key Barriers:** Lack of relevant and trusted information; stigma associated with being openly HIV-positive; poverty-related hurdles such as food insecurity; providers who lack the time to provide intense counseling; providers not accustomed to assertive clients; lack of social support services
  - **Communication Objective:** By the end of the project, there will be an increase in the proportion of men and women ages 30–50 on ART who become self-managed clients and see the benefit of managing their lives and their treatment actively.
  - **Communication Channels**
    - Targeted print support materials for ART clients (on positive living, adherence, and client self-management and monitoring) distributed in provider settings and through PLHIV network
    - Video modeling of clients who practice self-management and of effective provider-client interaction for waiting rooms
    - Hotline answers that encourage client self-management
    - Radio diaries modeling clients who practice self-management

- Radio spots demonstrating effective client-provider interactions

- **Secondary Audience:** Treatment supporters (PLHIV associations, family, and friends) and lower-level clergy
  - **Desired Changes**
    - Treatment supporters know ART clients have the right to ask questions and come prepared to provider visits.
    - PLHIV associations, family members, and lower-level clergy encourage PLHIV on ART to actively engage service providers.
  - **Key Barriers:** Lack of awareness that assertive clients get better services; overloaded services; providers not used to assertive clients, especially female clients
  - **Communication Objective:** By the end of the project, there will be an increase in the proportion of leaders of PLHIV associations, family and friends of PLHIV, and religious leaders who know that better services could result if PLHIV are actively encouraged to manage their treatment (self-management).
  - **Communication Channels**
    - Targeted print material on client self-management
    - Advocacy PowerPoint presentations about the value of client self-management for religious leaders and PLHIV networks
    - Hotline answers on client self-management practices
    - Radio diaries modeling client self-management

- **Secondary Audience:** ART providers (physicians, nurses, counselors, and pharmacists)
  - **Desired Changes**
    - Know how to counsel their clients on effective drug utilization, adherence, and management of side effects.
    - Value effective interaction with clients, including interpersonal communication/counseling (IP/C) and confidentiality.
  - **Key Barriers:** Overstretched providers; lack of time; providers unaccustomed to assertive clients
  - **Communication Objective:** By the end of the project, there will be an increase in the proportion of providers who value clients who monitor their health and ART as part of self-management and regard this behavior on the part of clients as an indication of the quality and efficiency of their own work**.**
  - **Communication Channels**
    - Interpersonal communication and counseling (IPC/C) training guideline; provider module; peer supervision
    - Hotline promotion of the value of client self-management for providers
    - Public acknowledgment of providers who promote client self-management
    - Job aids on ART and adherence, treatment of opportunistic infections, positive living, and other related areas

- **Tertiary Audience:** Religious leaders at national level
  - **Desired Changes**
    - Actively discourage stigma and misconceptions among lower-level clergy about ART and PLHIV.
    - Know about the benefits of ART for their followers.
    - Actively support ART service utilization and food security.
    - They influence lower-level clergy to encourage ART self-management and provider support for ART self-management .

- **Key Barriers:** Orthodox Christian Church doctrine interpreted to mean that PLHIV are guilty of their status; churches contribute to misconceptions about holy water as a cure; Islamic faith denies that HIV is a problem for followers; insufficient open and strong discouragement of stigma; faith-based misconceptions of Christian and Islamic leaders
- **Communication Objective:** By the end of the project, there will be an increase in the proportion of religious leaders who see themselves as agents of change with regard to HIV and AIDS treatment and care.
- **Communication Channels**
  - Current TV shows with panel discussions
  - TV spots by faith leaders that correct misconceptions
  - Radio spots
  - Revised ART-related curricula and guidelines for main faiths

Strategic Approach and Framing: Although the main issue is structural—clients need to continue medication—the strategic approach focuses on the ***client–provider relationship and encourages client self-management.*** This approach to ART management tries to improve the few encounters that clients have with ART providers due to the overall weakness of available health services. It illustrates the steps providers and clients can take to establish honest, working partnerships with rights and responsibilities. Research-backed observations note a mutual benefit where this happens: assertive and more self-reliant clients get better services. A mutually reinforcing media mix will attempt to improve client-provider relationships, while treatment supporters and religious leaders at national and community levels will be mobilized to encourage *self-management.* Advocacy strategies with the Orthodox Christian Church and Islamic leaders will try to address misconceptions and *stigma* at a higher level.

Positioning: The national ART campaign developed a logo for client ART-related materials with the umbrella slogan, "Engaged Clients, Everyday for Life!" Branding guidelines on the use of this logo—its size and position on materials, fonts, and colors—will help to make the series of materials and activities recognizable as a campaign.

Key Content

- **Primary Audience**
  - *Self-managed clients:* Their right to ask questions; how to manage ART (i.e., adherence; side-effects management; regular clinic visits; positive living, including nutrition, positive prevention, and disclosure to sexual partners, friends, and family); new drug regimens and differences between them; side effects of ART; role of PLHIV in improving ART adherence; when and where to access ART; misconceptions about ART
- **Secondary Audiences**
  - *Religious leaders, PLHIV associations, friends and families of ART clients:* Support self-managed clients; decrease stigma and misconceptions regarding holy water, fasting, and ART; where to find food support and positive living support; adherence; community participation in ART rollout
  - *ART providers:* Counseling and IPC/C skills, including maintenance of patient confidentiality; provider duties and client rights; specific job aids (e.g., fixed-dose combinations) to support client self-management

Channels, Activities, and Materials

These are a combination of targeted print materials, mass media triggers, IPC/C, and hotline services for clients and providers to address individual issues and community norms.

- Radio reaches the majority of the target audience in urban and rural areas.
- TV reaches mostly urban audiences, providers, and some of the community leaders.
- Print materials find good distribution in health facilities, but need to be adapted to semi-urban and rural reading levels and regional languages.
- Preferred print formats of each audience need to be explored.
- Provider training will be piggybacked onto existing training.

3. Draft Implementation Plan

The program will develop a plan that provides detail on each of the management considerations, as well as others deemed important to guide implementation. Based on the budget, the plan names activities and materials to support implementation, including:

- list of materials and activities
- implementers (including partners and allies)
- resources
- timeline

4. Draft Evaluation Plan

Regular monitoring of material distribution will be facilitated by university partners and others. Two surveys will be conducted at representative sites (and especially at busy sites with more client traffic) to record improvements in distribution cycles and whether monitoring has been effective. An impact evaluation is not possible with current funding, but additional funds to support this activity are being sought.

WORKSHEET: Communication Strategy Outline

Sections of the Strategy Document	Your Strategy
1. Summary of Your Situation Analysis (Completed in Step 1)	
Problem Statement (Module 1, session 7) Agree on a problem statement that summarizes the problem tree, population analysis, and context analysis.	
Research Needs (Module 1, session 5) Identify other questions that still need to be answered through more research.	
Changes the Problem Calls For (Module 1, session 7) • What changes (i.e., policy changes, services, products, social norms, and/or individual behaviors) would lessen the problem? • How can communication contribute to these changes through advocacy, social mobilization, and/or BCC? • What change would respond effectively to the current problem?	
Theory of Change (Module 1, session 8) Explore all underlying assumptions about needed changes that have been identified, consulting SBCC theories about what will work and why, and indicating which strategies are likely to be most effective in the short, medium, and long term.	
2. Communication Strategy (Step 2)	
Final Audience Segmentation (Session 2) • Which audiences (primary, secondary, tertiary) need to be addressed for these changes to occur? • Which audience segments are a priority and why?	
Desired Changes (Session 3) What is the intended audience expected to change: *knowledge, attitudes, beliefs, behaviors, skills, self-efficacy, access, perceived norms, socio-cultural norms, policies, legislation,* or something else? Which theories and models contribute to an understanding of how these changes can happen?	

Sections of the Strategy Document	Your Strategy
Barriers (Session 3) What gets in the way of the changes that are needed? From the analysis, identify the main reasons why the audiences currently do not do this.	
Communication Objectives (Session 4) For each audience segment, establish SMART communication objectives—specific, measureable, attainable, realistic, and time-bound— that address these key barriers. (See page 25 for more on SMART objectives.) For example, "By the end of the project, there will be an increase in the proportion of _____ (audience segment) who: • *know* • *feel confident* that • *start* a dialogue about • *do* or *take steps to do* • *learn skills* to.."	
Strategic Approach (Session 5) • How are all communication objectives to be brought together into one approach or one activity platform to work toward change? What is that platform called? • What will be the key strategy? What will support it or link it to other strategies?	
Positioning (Session 5) • How will this approach stand out? • How will people to remember the program or campaign? • What distinctive logo or image will people associate with the program? (Examples include The Blue Circle: Friendly Providers; Break the Chain: Change Is Possible)	
Key Content What is the key content to be communicated through each channel for each audience segment? (Remember, these are not messages; those are developed in Step 3.)	

Sections of the Strategy Document	Your Strategy
Channels, Activities, and Materials Select channels, activities, or materials for each audience based on how to effectively reach a majority of them. Consider how channels reinforce each other to create an environment of change.	
3. Draft Implementation Plan (finalized in Step 4)	
Develop a plan that provides detail on each of the management considerations named below, as well as others deemed important to guide implementation. Name activities and materials to be created, keeping the budget in mind. • List of materials and activities • Implementers (including partners and allies) • Resources • Timeline	
4. Draft Evaluation Plan (finalized in Step 5)	
Think through reasons why the program should be evaluated. Draft an evaluation design, name process and outcome indicators, and plan methods and tools for data collection.	

Module 2, Session 2: Audience Segments, Priorities, and Profiles

The first part of a communication strategy involves naming, segmenting, and prioritizing audiences. Potential audiences were identified in Step 1 (Module 1, session 3, page 9), using the concentric circles of C-Change's Socio-Ecological Model for Change. Answering the following questions can help practitioners finalize decisions about who should be the audiences for the SBCC program: primary (most affected), secondary (directly influencing), and tertiary (indirectly influencing).

- Which group of people would be most important to reach to bring about change?
- Which other groups play key roles in influencing them?
- How do these different groups have an impact on the problem? What groups might provide the tipping point to motivate change?
- What are the power relations between the groups?

Segmenting means dividing and organizing populations into smaller groups or audiences with similar communication-related needs, preferences, and characteristics. Through segmentation, a program can achieve the most appropriate and effective ways to communicate with various groups. Segmentation helps to prioritize limited resources by reaching a defined audience with more intensity and potentially higher impact than would be achieved by attempting to reach the whole population.

Typically, audiences are segmented by geography, demographics, socio-cultural characteristics, and psychosocial issues. Audiences can also be segmented according to what is called psychographics—personality, values, attitudes, interests, level of readiness for change, and lifestyles (Senise 2007). For example, voters can be addressed by their level of participation in the political system instead of by their demographics. Audiences who identify with a particular lifestyle or group membership can also be segmented—e.g., religious sects, gay men, generation X—since this may override the usual segmentation categories. Audiences can also be addressed by their self-efficacy to overcome certain barriers to change.

Each audience segment should be unique and relatively homogenous. For example, youth can be characterized by age, gender, rural/urban lifestyles, and educational status, in-school/out-of school. Practitioners consider how these segments are different or unified, in terms of certain political or religious values, opinions, attitudes, or activities. This continues until information is no longer relevant and differences are so small that continued segmentation does not make sense.

Once audience segments are drafted, practitioners prioritize them, based on ***budget availability*** and answers to questions like the following: How can resources be best spent? Does the program focus on people who are hard to convince, or on people who are ready for change? Who are appropriate partners to reach programmatic scope? Is it possible to link to a group that works with hard-to-reach groups and share materials with them?

Finally, once audience segments are established, it is helpful to develop ***audience profiles*** for each. This helps to personalize audience members and makes it easier to understand them during strategy development.

Advocacy Corner: Tips on segmenting audiences

In advocacy work the focus is on affecting decision-making processes and public opinion. Therefore, key audiences usually revolve around decision-makers and those that can influence them:

Directly affected: Who are the decision makers, the individuals or groups who can take the decisions you want to be taken?

- Government (ministries and parliament), such as presidents and prime ministers, health ministers and their deputies, budgetary decision-makers (for example, cabinet, ministries of finance and, planning), ministers of related sectors and their deputies (for example ministers of education, transport and/or agriculture). But also private sector business leaders, business associations, and multinationals.

Direct influencers: Which individuals or groups can directly influence the decision makers?

- Faith leaders, business leaders, legislative leaders, but also the media, consumer group and powerful professional associations, and donors/funding agencies for low and middle income countries..

Indirect influencers: Which individuals or groups can indirectly influence the decision makers?

- Formal and informal civil society NGOs, faith-based groups, community and business leaders, authors, activists, entertainment and sports personalities**,** teachers, professors and researchers, as well as health-care professionals.

Which groups will appear in the direct or indirect influencer audience depends on how much power these groups or individuals can exert over the decision making process and how well organized their coalitions are. As usual, the more specific practitioners are in identifying the audience, the more effective the communication efforts will be. Different audiences will be at different stages of awareness: some will be ready to work actively on the issues immediately, while others will require more information, motivation, ability to act or supportive social norms around the issues first (World Health Organization 2006).

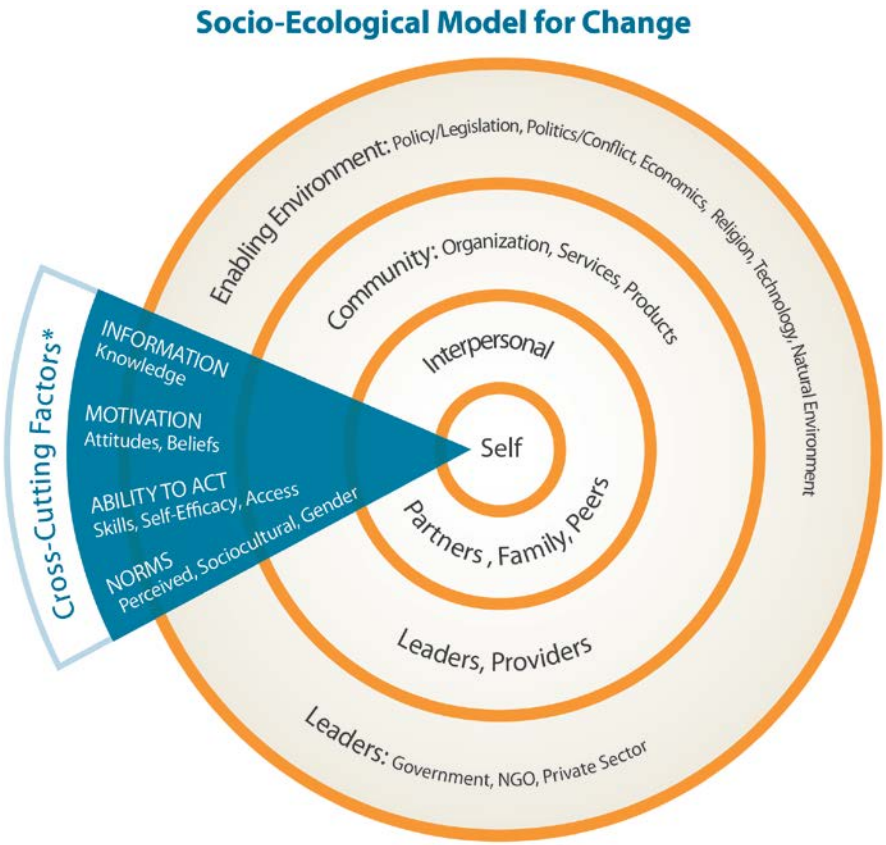
SOUTH AFRICA EXAMPLE: Audience Segmentation Table

More information on the Treatment Action Campaign (TAC) in South Africa is on the TAC website and in the Introduction (Module 0, session 4, page 22), "Combining Advocacy, Social Mobilization, and Behavior Change Communication."

Audience Segmentation Table						
Potential Audiences from the Analysis in Step 1		**Enabling Environment:** Geographic or structural	**Community:** Demographic	**Community:** Socio-cultural	**Interpersonal:** Psychosocial	**Self:** Psychological
Examples		Urban or rural place of residence or work; risk settings; border settings	Age; gender; education; income; marital status	Role in society; religion; ethnicity	Identity, lifestyles, membership in groups such as lesbian, gay, bisexual and transgender;	Knowledge, information, motivation, including attitudes, beliefs, values, perceptions of vulnerability, readiness for change
People most affected by the problem (primary)	People living with HIV and AIDS in need of treatment	Mostly urban	Male ages 25–45, married/single; Female ages 25–45, married/single	Lower and middle class; South African, at the time a majority of white men	By mid 1980, mostly gay men; early activists came from the gay rights movement (GASA)	Only some aware of treatment options in other countries
People who directly influence them positively or negatively (secondary)	Family members	Mostly urban	Spouses and partners; parents	Lower and middle class; South African	Various	Unaware of treatment options
	AIDS care physicians	Urban	Male; Female	Upper and middle class; South African (many of British or Western origin)	Early active physicians overlapped with GASA, human rights, and patient-driven movement	Aware of treatment options in other countries and ready to advocate for change
People who indirectly influence the first group by shaping social norms, influencing policy, or offering financial and logistical support	South African government officials	Urban	Male ages 35–35; Female ages 35–45	High-ranking Ministry of Health officials and advisors to the president; South African	Early on, apartheid government based on institutionalized racism and legal segregation; later ANC government	Aware of treatment options in other countries
	Pharmaceutical representatives	Urban	Male Female	High-level officials involved in pricing discussions with governments in the U.S. and Europe	Corporate business model; strongly identified with western medical model	Aware of pricing discussions and their consequences for treatment access in the developing world

Worksheet adapted from Remington, Nelson, Brownson, and Parvanta (2002).

CHECKLIST: Audience Segmentation



*These concepts apply to all levels (people, organizations, and institutions). They were originally developed for the individual level.

SOURCE: Adapted from McKee, Manoncourt, Chin and Carnegie (2000)

Directions: With a better idea of audience segmentation, practitioners can segment audiences and consider each potential audience one at a time:

- people most directly affected by the problem (primary)
- people who directly influence them, either positively or negatively (secondary)
- people who indirectly influence the first group by shaping *social norms*, influencing policy, or offering financial aid (tertiary)

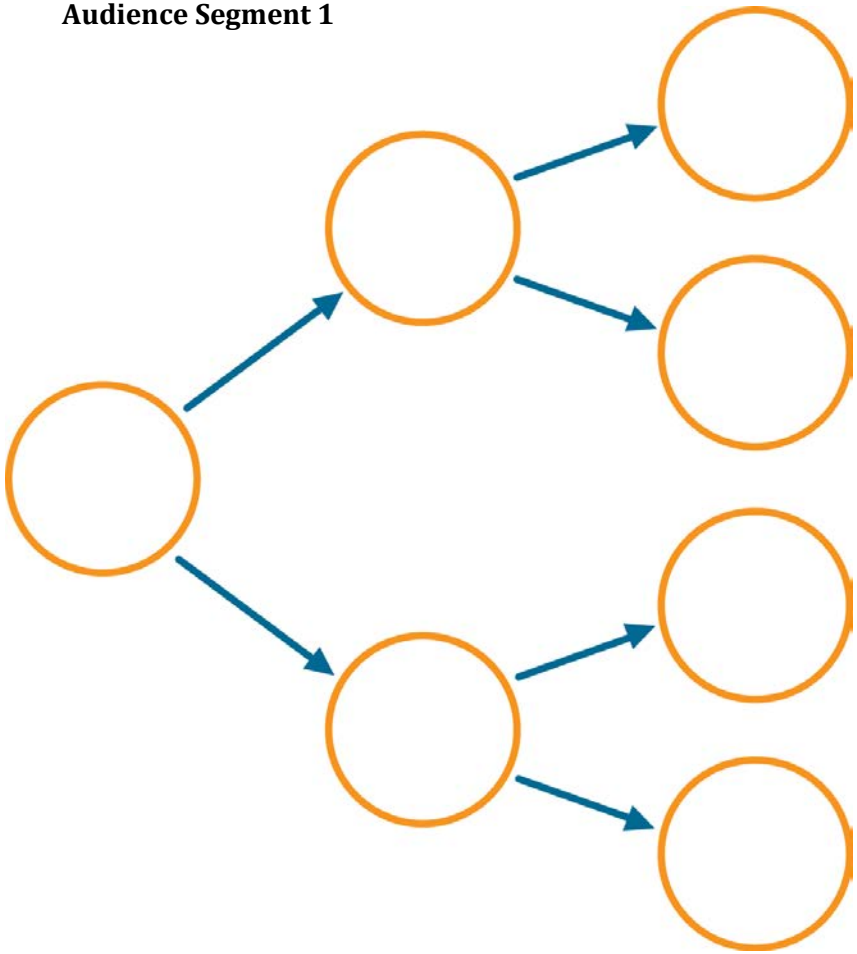
For each audience segment, practitioners then check whether there are *important* differences *within* the group, based on criteria in the Socio-Ecological Model for Change:

- ☐ **Enabling Environment: *Geographic or structural***
  - e.g., urban or rural place of residence or work; risk settings; border settings
- ☐ **Community: *Demographic and socio-cultural***
  - e.g., age, gender, education, income, marital status, and their role in society, religion, ethnicity
- ☐ **Interpersonal: *Psychosocial***
  - e.g., identity, lifestyles, membership in groups (LGBT, post-war generation)
- ☐ **Self: *Psychological issues***
  - e.g., knowledge and information, motivation, including perceptions of vulnerability, the severity of disease; readiness for change, values, attitudes and beliefs with regard to the prevention solution

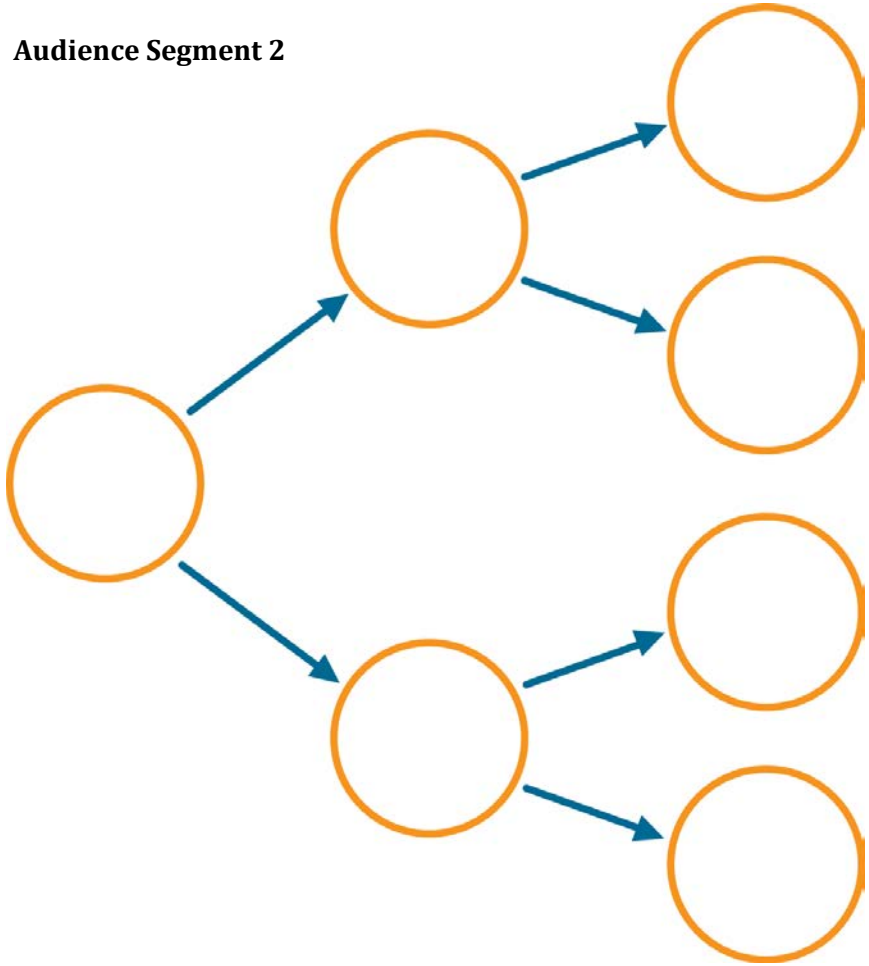
WORKSHEET: Audience Segmentation Map

Directions: It may be helpful to continue to identify audience segments by mapping out the possibilities with a map like this one. Start with a rough set—primary, secondary, and tertiary audiences from the people analysis completed in Step 1 (Module 1, session 3, page 9). Put your first potential audience in the circle on the far left and continue by considering each of these criteria: enabling environment, community, interpersonal, self. Consider these for each of the primary, secondary, and tertiary audiences identified.

Audience Segment 1



Audience Segment 2



CHECKLIST: Audience Prioritization

Once audiences are segmented and mapped, there is likely to be a need to narrow down the possibilities and the sheer number of audience segments. Answering the questions below will help practitioners prioritize and identify the specific audiences on which to focus. Consider reaching certain audiences in phase 1 and others in phase 2 for more impact and be able to mobilize resources.

Potential audience segment	_____
How many people are estimated to be in this group?	
Does this group require specially prepared communication approaches or materials?	
How important is addressing this group to achieve the program goal?	
How likely is it that these audience members will change within the time frame of the program?	
Does the program have the resources to address this group?	

Adapted from O'Sullivan, Yonkler, Morgan, and Merritt (2003).

EXAMPLE: Audience Profile

Model of an Audience Profile

How to use this tool: To help the creative team to develop effective messages and materials, the program team should tell a story about typical audience members. To do this, they create a profile that embodies the characteristics of the audience. The program and creative teams can imagine the audience as a specific person rather than as a collection of statistics.

The BCC program can collect information about the audience from existing data such as Ministry of Health statistics or health and population surveys. The program's formative research can provide detail. Characteristics to consider include age, sex, marital status, place of residence, occupation, income level, years of schooling, religion, ethnicity, number of children, family structure, health beliefs, and degree of readiness to change behavior. Then, in the story the program team should describe the person's important behaviors and some key attitudes about the health behavior that the program needs to address. The following example, created in a workshop to develop a national population communication strategy for Ghana, shows what an audience profile might look like.

"A Man in Ghana"

Meet Kwame. He is a farmer living in the Central Region and is 42 years old. He has two wives and five children ranging in age from 8 to 20. He lives a traditional Ghanaian rural lifestyle. He spends his early morning tending his field and spends the late afternoon with his friends in the chop bar. Although he considers himself to be a family man, he occasionally has extramarital affairs. He cares about his children's well-being and would like them to live a better life than he does. He cares about his two wives because they raise his children. However, he is not at ease communicating with them about intimate matters, such as reproductive health. He assumes that they know what to do. He is also more comfortable having his wives talk to their children about these matters than talking to them himself.

Sources: O'Sullivan et al. 2003 (14), Yonkler 1998 (26), and Younger et al. 2001 (27)

Source: Salem, Bernstein, and Sullivan (2008)

WORKSHEET: Audience Profile

Directions: An audience profile like the one on page 19 may enable you to obtain a personal sense of the people to be reached through your SBCC efforts. Focus first on the primary audience and think about what is known about them. Then draw an outline of a person who is a typical member of this audience and write a brief description of a single person as a composite of the group

For example, you might describe the person's geographic location, gender, age, occupation, literacy level, lifestyle, where she or he gets information, how he or she reacts to the health or development issue and related information, the things he or she cares about or enjoys, and if he or she has anything at stake in the issue at hand. You might write "a day in the life" of the person as a way to capture what is most important about him or her. Keep your audience profile real and include as much detail as possible. ***Try to base these descriptions on data—not assumptions.*** Audience profiles are needed for each audience segment.

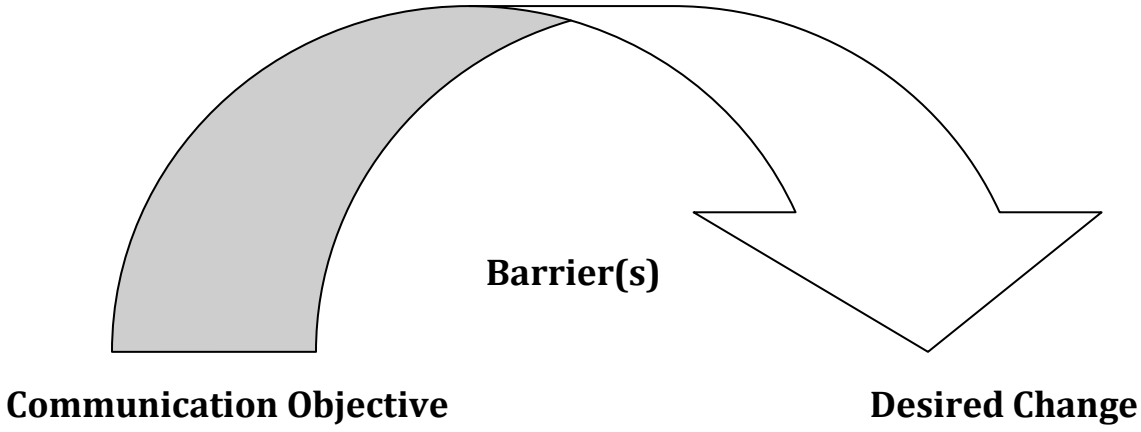
Adapted from O'Sullivan, Yonkler, Morgan, and Merritt (2003).

Module 2, Session 3: Barriers

Programs have been trying to induce change relating to family planning, malaria, HIV prevention, and other development issues for the last 20 to 30 years. ***Why do they still deal with similar problems?*** To begin with, individual or social change is not an easy thing to do and takes time. The reasons people have for ignoring, fearing, or resisting change are grounded in strong beliefs or value systems. These have to be examined closely. ***For example, if people fear the chemicals on malaria nets more than the disease with which they have been living for generations, this fear provides a strong motivator to not use a net.*** Lack of services, alternatives, and opportunities also often limit what people do.

Many theories have been developed about individual and social change to better understand how human beings function and what motivates them to act. SBCC theories and models implicitly or explicitly recognize the existence of barriers that deter people from changing behaviors. SBCC interventions aim to reduce those barriers to facilitate change.

When thinking about barriers, think big. For example, although it may seem that the main barrier that keeps a young woman from protecting herself from HIV is lack of knowledge about condoms, the bigger barriers might be her lack of hope for her future, lack of power, fear of conflict in her relationship with her intimate partner, or her inability to speak her mind. Use data as much as possible to examine real barriers to change!



Theory Corner: Theory of Gender and Power

Members of every society face constraints and barriers, many of which are gender specific (Connel 1987). For example, in most societies there is a *sexual division of labor,* which means that certain types of work are designated for men and women. Men often seek paid employment outside the home, while women work without payment inside the home. In these households, men have more economic power and freedom of movement than women do. In addition, domestic violence and rape can also be viewed as a result of gender-related *inequalities of power*. Understanding the relationship between power and gender is crucial when planning interventions to address issues of gender-related inequality and identify barriers.

Gender and power relations are constructed socially—in other words, men and women are not born into a society with more or less power. Social norms and practice and raising and educating people within these norms reinforce existing *gender norms*. Because *gender inequality* is the result of these institutions and processes, consideration should be given to how gender and power relations may affect participation when designing any communication intervention or activity. Do women have time or need permission to attend? Do they have the ability to act on recommended actions? Can a woman ask her husband to get tested for HIV without him accusing her of cheating on him and/or reacting with violence? The theory of gender and power and other theories can be used as a way to hone in on the barriers people face with regard to changing a problem that a program identifies. (See the table of theories and concepts in the Appendix, beginning on page 49). Practitioners can also use the Socio-Ecological Model for Change, which is based on many theories and models.

Looking at barriers and addressing them head-on allows SBCC programs to create and sharpen communication objectives tailored to the audience's context and, therefore, be more effective.

Advocacy Corner – Opportunities and Barriers

For effective policy advocacy, it is important to think about key factors that either help or hinder a policy commitment from being implemented. Usually four **key issues** affect whether or not a policy is implemented. If those key issues exist, they provide an **opportunity,** if they lack they represent **barriers**:

- knowledge or awareness of the policy and its commitments among policy-makers, or implementing districts and/or the community
- support or opposition toward the implementation of the policy
- availability, access, and type of resources needed for the implementation of the policy commitment
- understanding of institutional constraints that may hinder action

Advocacy assumes that people have rights, and that those rights are enforceable. Advocacy works best when focused on something specific and when it is primarily concerned with rights and benefits to which someone or some community is already entitled (Green and Tones 2010).

Social Mobilization Corner:

Multiple barriers exist to mobilize individuals and groups for action. Below are some barriers that should be considered when mobilizing communities and building coalitions (adapted from Green and Tones 2010; WIN 2009):

Barriers to building coalitions

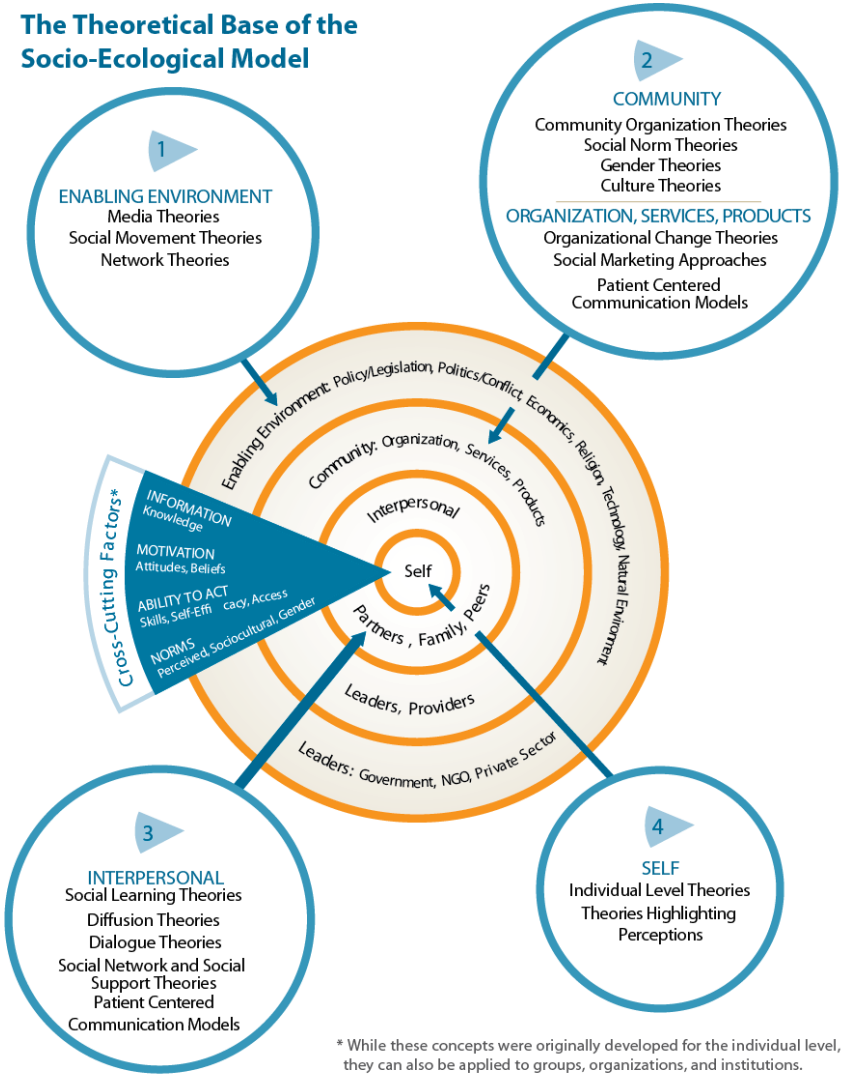
- Lack of vision and shared commitment
- Lack of time
- Competition between individuals and organizations and within and between professional networks and influential professional groups
- Conflicting organizational mechanisms to decision-making and different timescales as to when the coalition's objectives should be carried out.
- Different channels of accountability and communication
- Lack of financial transparency of resources with conflicts over funding
- Only visible member and leaders get credit for successes
- Tendency of more powerful groups to dominate and influence the agenda and join out of self-interest

Barriers to mobilizing communities:

- Lack of information and understanding of relevant decision-making processes
- Lack of transportation to meetings, lack of child care
- Lack of income and time to spent on activities without pay
- Lack of confidence, feeling of discomfort in formal meeting, difficulties using official language
- Doubts as to whether being involved will make a difference, doubts on use of local structures to bring about change about
- Barriers relating to being recognized and accepted for one's differences

SBCC practitioners can try to put themselves in the mindset of each audience segment when contemplating the various levels of analysis and the cross-cutting factors influencing them. They then can ask what is most critical—*motivation, skills, values, norms, policies, or products and services*—how they know; and whether SBCC theories, models, and their concepts can help. The graphic below provides some ideas.

The Theoretical Base of the Socio-Ecological Model



* While these concepts were originally developed for the individual level, they can also be applied to groups, organizations, and institutions.

SOURCE : Adapted from McKee, Manoncourt, Chin and Carnegie (2000)

Concepts of Selected SBCC Theories

1

Media Theories
- Agenda setting
- Framing
- Persuasion
- Media advocacy

Social Movement Theories
- Collective action
- Coalition building
- Policy/legislative change

Network Theories
- Diffusion of innovation
- Structures of social networks
- Functions of social networks and social support
- Social capital

2

Community Organization Theories
- Empowerment
- Participation
- Catalyst
- Dialogue
- Collective action
- Critical consciousness
- Ownership
- Collective efficacy

Social Norm Theories
- Social norms
- Social convention
- Critical mass
- Tipping point

Gender Theories
- Sexual distribution of labor
- Power & gender inequality as social construct

Culture Theories
- Links between culture and structure
- Multiple and shifting contexts
- Cultural relevance/ making meaning
- Community asset

Organizational Change Theories
- Organization development
- Structure of program & services
- Institutionalization

Social Marketing Approaches
- Four Ps: Product, Price, Place, Promotion
- Community based social marketing

Patient Centered Communication Models
- Paternalistic relationship
- Consumerist approach
- Health literacy
- Self- management

3

Social Learning Theories
- Observational learning (modeling)
- Positive/negative reinforcements

Diffusion Theories
- Opinion leaders
- Peer networks

Dialogue Theories
- Consciousness-raising
- Connection

See also: Social Network and Social Support Theories
See also: Patient Centered Communication Models

4

Individual Level Theories
- Knowledge*
- Motivation*
- Attitudes*
- Beliefs*
- Values*
- Past experience
- Psychosocial and life skills
- Self-efficacy
- Accessibility
- Perceived and subjective norms
- Cues to action

Theories Highlighting Perceptions
- Perceived barriers
- Risk perception/vulnerability
- Perceived severity of disease
- Perceived effectiveness of solution
- Perceived benefits of action

* While these concepts were originally developed for the individual level, they can be applied to groups, organizations, and institutions.

EXAMPLE: Matrix for Change

The example is derived from the work of the Treatment Action Campaign (TAC) on HIV and AIDS in South Africa (Module 0, session 4, page 22) and C-Change's family planning program in Albania (Module 0, session 1, page 3, and session 4, page 16).

Audience Segment Examples	**Desired Change** Motivation, ability to act, social norm, policy, service, community structure, or other change	**Barriers** Contextual or behavioral reason(s) why the audience is not doing the desired behavior	**Theory of Change** Underlying SBCC theoretical concepts	**Communication Objectives Addressing Key Barriers**
Men 40 and older in rural South Africa	Use condoms	• Male *gender norms* identify male sexual performance as essential to manliness • Fear that condom use will interfere with sexual performance • *Social norm* among this age group is to not use condoms	• Risk perception of getting HIV • Motivation and self-efficacy in using condoms • Self-efficacy of condoms as prevention • Perceived benefit of using a condom • Perceived norms	By the end of the program, there will be an x increase in the percentage of rural males ages 40 and older in Mphumalanga (rural area of South Africa) who have learned to feel confident when they use condoms.
Journalists and editors who cover social issues in magazines, newspapers, radio, and TV in urban areas in Albania	Improve the quality and increase the frequency of reporting on family planning (FP) and reproductive health (RH) issues	• Lack of training and awareness in FP and RH issues • Lack of incentives for journalists to cover these issues	• Agenda setting • Framing • Correct knowledge and skills • Motivation • Perceived barriers • Perceived norms	By the end of the program, there will be an x increase in the percentage of editors of prominent print products in Albania who consider FP and RH topics worth putting on the agenda under various sections (e.g., politics, health, sports, and culture). By the end of the program, there will be an x percent increase in the number of journalists of prominent print products who have been trained in skills to write correctly about FP and RH issues.

WORKSHEET: Matrix for Change

Directions: Consider two of your audience segments. Name two desired changes for each of them, along with known and real barriers to those changes. If you want to check your logic, think about the underlying SBCC theoretical concepts that support these barriers. This sets you up to create your communication objectives that address key barriers. You will enter these in the column on the far right in the next session.

Audience Segment (previously completed)	**Desired Change** Motivation, ability to act, social norm, policy, service, community structure, or other change	**Barriers** Contextual or behavioral reason(s) why the audience is not doing the desired behavior	**Theory of Change** Underlying SBCC theoretical concepts	**Communication Objectives Addressing Key Barriers***

* For communication to have impact, the objectives need to address key barriers for change and not just reflect a desired behavior.

Module 2, Session 4: Communication Objectives

Strong communication objectives are developed by answering the following critical questions:

- What do you want your audiences to change?
- Why isn't this already happening (i.e., what are the barriers)?
- Which of these barriers will you address with communication?
- Which SBCC theory, model, or approach can help you?

Answers to these questions become the final communication objectives.

Communication objectives name ways to ***address barriers to achieve desired change*** in policies, social norms, or behaviors. The objectives are ***audience-specific.***

- Communication objectives support program objectives and contribute to them.
- They are more specific than desired behaviors. (These often only mirror what programs want people to do, instead of addressing the barriers the audience may face in making changes).
- Communication objectives should be based on theories or models consulted during the analysis of barriers.

The following are examples of strong communication objectives:

- By the end of the program, there will be an x percent increase in the number of rural males age 40 and older in Mphumalanga who have learned to feel confident when using condoms *(self-efficacy).*
- By the end of the program there will be an x percent increase in the number of editors of prominent print products in Albania who consider FP and RH a topic worth reporting under various sections (e.g., politics, health, sports, and culture) *(agenda setting).*
- By the end of the program, there will be an x percent increase in the number of journalists with trained skills to write correctly about FP and reproductive health issues *(skills building).*

Advocacy Corner: How to formulate communication objectives for advocacy (Shannon 1998)

When the primary advocacy issues are identified, they need to be reformulated as program objectives to describe the anticipated accomplishments of the advocacy effort and its long-term vision. For example, the program objective might be to "improve adolescent reproductive health by increasing access to reproductive health education and services". The communication objectives then break it down and show how the intervention will influence decision making to increase access to health education and services. For example the communication objectives might be – At the end of the program, there will be

- an X increase of funds allocated by MOH staff for adolescent reproductive health programs
- an X increase in the number of policy maker's understanding and disapproval of laws or policies hindering young people's access to information and services
- an X increase in the number of ministry department staff supporting and collaboration with, youth-serving organizations
- an X-decrease in the number of identified internal policies in businesses and companies that form barriers to service utilization

TIPS: SMART Communication Objectives

Communication objectives clarify the following issues for SBCC programs:

- What specific policies, services, social norms, and/or behaviors will be addressed for each audience?
- What information *(knowledge), motivation (attitudes, beliefs), ability to act (skills, self-efficacy, access), and norms (perceived, socio-cultural, gender)* should the program address?
- What exactly does the program want the intended audiences to know, feel, or do after being exposed to activities and materials?

Communication objectives will be used in many ways in the SBCC process. For example, they will be used to select indicators to monitor progress and evaluate outcomes.

Practitioners should aim for SMART communication objectives by checking each objective against the following criteria:

(S) Specific	Does the objective specify what it aims to achieve? Does it cover only one activity, rather than multiple activities?
(M) Measurable	Can the objective be measured or counted in some way?
(A) Attainable	Is the objective doable? Can the program attain it?
(R) Realistic	Can the program realistically achieve the objective with the resources and time available?
(T) Time-bound	Does the objective indicate when it will be achieved?

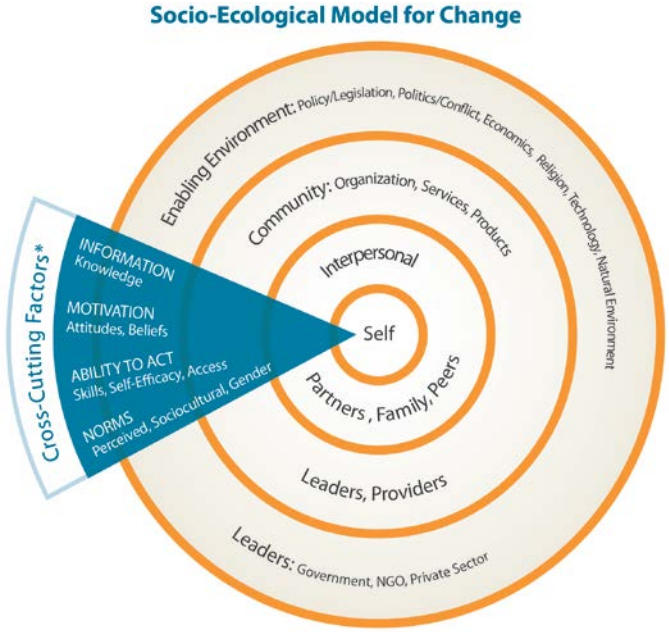
Examples of Communication Objectives within the Cross-Cutting Factors of the Socio-Ecological Model for Change

Information
By the end of the program, there will be an [x percent or number] increase in the number of political advisors to the South African president who know that services to prevent mother-to-child transmission of HIV have shown success in other countries.

Motivation
By the end of the program, there will be an [x percent or number] increase in the number of providers of antiretroviral treatment (ART) who see the benefit of signing petitions and taking part in advocacy activities to mobilize treatment for PLHIV in South Africa.

Ability to Act
By the end of the program, there will be an [x percent or number] increase in the number of ART providers who are skilled in effective advocacy methods.

Norms
By the end of the program, there will be an [x percent or number] increase in the number of ART providers who understand their role as advocates for their patients.



Action verbs that can help break down desired changes into doable and realistic communication objectives are: know, have a positive attitude toward, consider discussing, talk about, see benefit in, try out, practice, and learn skills. Consulting the theory table in the Appendix (page 54) and the graphic "Concepts from SBCC Theories" in Step 2 (session 3, page 24) will help locate the right SBCC concepts to break down communication objectives. The advantage in using action verbs for communication objectives is that they will be formulated in a way that clearly demonstrates realistic results.

WORKSHEET: SMART Communication Objectives

Directions: When developing your SMART communication objectives, think about the audience segments and the barriers they face to achieve the desired behavior. (These were developed in session 3.) Use this worksheet to complete the table by formulating your communication objectives by audience segment.

Audience Segment (previously completed)	**Desired Change** Motivation, ability to act, social norm, policy, service, community structure, or other change (previously completed)	**Barriers** Contextual or behavioral reason(s) why the audience is not doing the desired behavior	**Theory of Change** Underlying SBCC theoretical concepts (previously completed)	**Communication Objectives Addressing Key Barriers***

* For communication to have impact, the objectives need to address key barriers for change and not just reflect a desired behavior.

Module 2, Session 5: Strategic Approach and Positioning

Strategic approach is the way a communication intervention is packaged or framed into a single program, campaign, or platform. It holds together the different interventions, channels, and materials and combines them into a synergistic program: the whole is more than the sum of its activities. The strategic approach drives program coherence and describes *how* communication objectives will be achieved**.**

Since many strategies can be selected to achieve the communication objectives, the approach needs to be decided on the basis of the **theory of change** in Step 1 (Module 1, session 8, page 36). Consider what needs to happen and where the program should focus. Where is the *tipping point* for change that the program aims to affect? What concepts are behind the assumptions? How will the change happen? What is the approach to change?

For example, a strategic approach could take many directions to meet the objective of increasing by 10 percent the number of young adults intending to use voluntary counseling and testing (VCT) services with each new partner in three provinces in Nyanza, Kenya, over two years. The following are three possibilities:

- Focus on the VCT facilities by developing a strategy that emphasizes youth-friendly, accessible, quality services, based on *client–provider communication principles.*
- Concentrate on the audience by stressing activities and messages that focus on risk perception, seriousness of the disease, and self-efficacy, using the **Health Belief Model**.
- Package this information under a healthy lifestyle approach, and focus on coming-of-age and health issues of young males to motivate them to utilize VCT services as a rite of passage to respected young adulthood. Use a combination of elements in the **Theory of Planned Behavior, Positive Deviance,** and the **Culture-Centered Approach**.

In the context of strategic design, ***positioning*** means presenting an issue, service, or product so that it stands out from others and motivates certain reactions, changes, attitudes, and behaviors. Positioning creates a distinctive and attractive image that may be turned into a logo (O'Sullivan, Yonkler, Morgan, and Merritt 2003). A positioning statement describes how a proposed change will be seen in the minds of the audience. It is not a catchy slogan, but rather provides direction for message design. Positioning is the identity that practitioners want their programs to have and hold over time. It is what holds their strategies together!

Notice the use of ***key SBCC strategies*** in strategic approaches: advocacy, social mobilization, and BCC. There is a relationship between audiences and key strategies.

- BCC is the strategy most commonly used to address people most affected by the problem.
- Social mobilization is a strategy often designed for influencing groups.
- Advocacy is often applied with indirect influencers.

The planning continuum in the graphic "Three Key Strategies" on page 30 indicates that practitioners can begin with whichever strategy or strategies they consider to be the most effective tipping point for change at that point in time.

After reviewing whether the assumptions from the theory of change hold, practitioners should refer to the table in the Appendix, "Potential Application of Theories, Models, and Approaches" (page 54) to help choose and ***apply SBCC theories to back up the strategic approach.***

Advocacy Corner: A strategic approach for advocacy often depend on how advocacy interventions are framed

Advocacy relies on the tactical use of persuasive communication. It is not enough to present the evidence, to be effective it needs to be: "logically persuasive, morally authoritative, and capable of evoking passion" (Green and Tones 2012). It is also essential to frame the issue for public consumption and advocate for a specific solution. Framing is the process of identifying how the issue will be depicted and what parts of the story will be included and which left out and how to position the issues in the mind of audiences. This can take on e.g., an individual, or news angle, or an angle showing how an individual story is affected by the greater socio-political or economic decision-making. Public health advocates need to study the patterns of news storytelling to help them determine how to best get the story out.

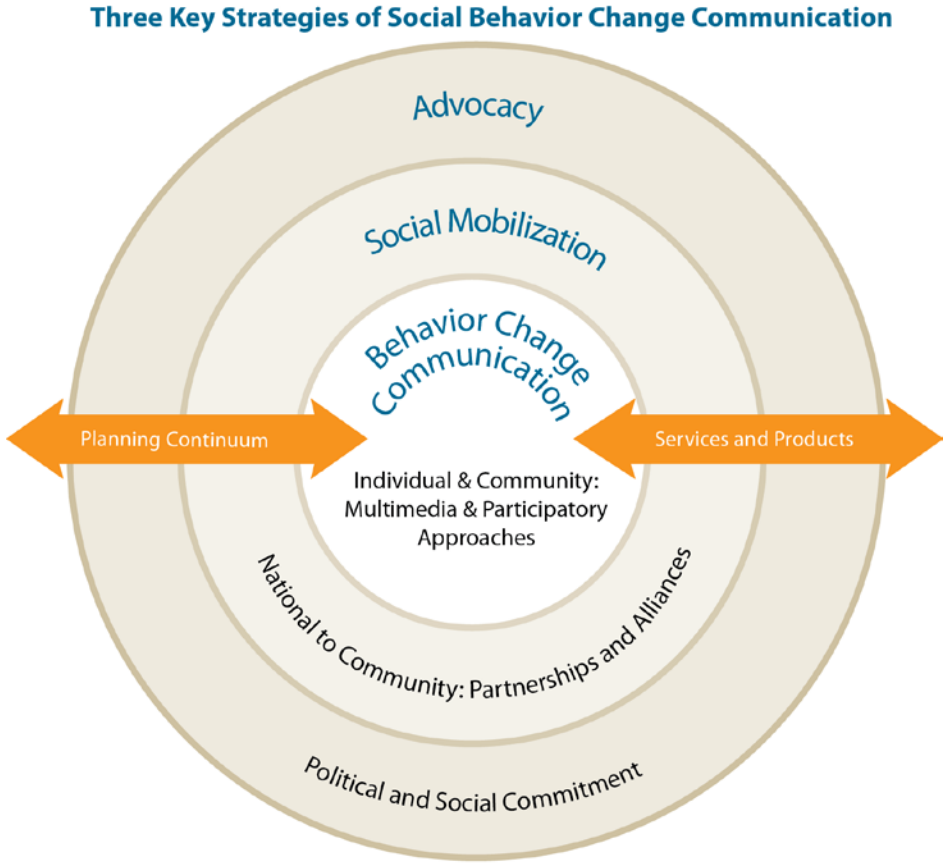
Social Mobilization Corner: Coalition building is a strategic approach

Coalitions provide a structure for allied groups to pursue a unified goal, coordinate strategies, and pool resources. Broad-based coalitions demonstrate wide support for particular policies or programs. Coalitions can serve the purpose of educating policymakers and the public regarding various health and development issues. Coalition members act to lobby policymakers, write letters to the editor, speak with the press, attend community meetings, and give public testimony. By doing so, policy-makers and the public are afforded accurate and compelling information regarding the issue at hand and are therefore more likely to demonstrate support for related policies and programs. Coalitions act to mobilize this support, demonstrating to policymakers that constituents care about improving the issue at hand. Coalitions also provide a powerful counterpoint to organized opposition (Shannon 1998).

Three Key Strategies of SBCC

Remember, SBCC key strategies are mutually reinforcing:

- ***advocacy*—**to raise resources and political and social leadership commitment for development action and goals
- ***social and community mobilization*—**for wider participation, coalition building, and ownership
- ***behavior change communication*—**for changes in knowledge, attitudes, and practices of specific participants or audiences



SOURCE: Adapted from McKee, N. Social Mobilization and Social Marketing in Developing Communities (1992)

ALBANIA EXAMPLE: Strategic Approach, Positioning Statement, and Theory of Change

Please refer to Module 0, session 1, page 3, and session 4, page 16, for some background on C-Change's family planning program in Albania.

The strategic approach is to create a supportive environment for young couples to discuss, select, and use modern contraceptive methods (MCMs). The program will: 1) work with young men and women directly to address misconceptions about MCMs; 2) improve their experiences and self-efficacy when seeking MCMs at pharmacies so they feel more secure and empowered; and 3) increase the quality and quantity of positive media coverage of MCMs (agenda setting and framing).

This is the chosen strategic approach because research showed very low awareness and trust of MCMs among young men and women as well as poor use of available MCM services at pharmacies.

Positioning statement: MCMs are a way to enjoy love-making while living full and long lives.

The theory of change assumes that the tipping point for change will be the result of combining 1) increased individual self-efficacy to use and negotiate MCMs among couples, 2) the increased ease of access to methods through better pharmacist training, and 3) increased frequency and correct reporting about FP in the media to provide a better enabling environment for changing norms with regard to FP use.

These concepts are based on assumptions of the **Health Belief Model, Social Learning Theory, Consumerist Model for Service Providers,** and **Agenda Setting Media Theory.**

WORKSHEET: Strategic Approach

Directions: The strategic approach is the combination of strategies that will be used to achieve the named communication objectives. It reflects how these strategies will work together to produce the desired impact. Use the strategic approach statement to identify any flaws in creative thinking and briefly explain the approach to others as the program unfolds.

Our strategic approach is to…
Because…

WORKSHEET: Positioning

Positioning creates a memorable cue for the audience to recognize program activities as part of an overall campaign or program. It helps people to understand why they should adopt a certain policy, idea, value, or behavior and why they should advocate it to others. Notice in the Albania example how family planning is positioned as a way to enjoy love-making. Positioning provides direction for the program's logo, slogan, or overall message design; you need to make sure you get it right!

Directions: Use this short checklist to make sure your positioning is on track and draft your positioning statement.

A short positioning checklist:

- ☐ Does the positioning resonate with both male and female audiences? What age group likes it? Will it still resonate over time?
- ☐ Is it different from the competition's positioning?
- ☐ Does it represent something better or different than the known alternative?
- ☐ Does it provide a benefit that is worth the cost or effort? Can the program deliver the promise and/or benefit?
- ☐ Other:

(adapted from Piotrow 1997)

Our positioning statement is…

Module 2, Session 6: Activity, Channel, and Material Mix

Now it's time to determine which activities or interventions will be used for each audience to achieve the communication objectives, as well as which channels and materials will support the activities and reach the audience.

"What channel do we use?" is a rather outdated question in SBCC. The greatest impact will be achieved by combining communication activities and channels strategically. Within each category, multiple activities should be used. Ideally, different channels send mutually reinforcing messages. For example, community dialogues with women ages 20 and older in rural areas could be the main intervention, supported by a radio magazine that broadcasts these dialogues. Outreach to religious leaders may also be done to garner their support through their own channels.

It might be helpful to think in terms of three basic intervention types: interpersonal channels, community-based channels, and mass media and social media channels. The following worksheets offer ideas for materials and activities and descriptions of potential benefits and cost and effort estimates for each communication channel.

Here are a few tips to check tentative decisions about channel mix, adapted from McKee, Manoncourt, Yoon, and Carnegie (2000).

- There is no one "super-medium" that can do all things.
- A mix of media is usually more effective than a single medium.
- Channel selection is important, but production quality determines success.
- Passive audiences learn little; active audiences are more receptive.
- Media can reinforce and extend face-to-face communication but cannot replace it.

Before deciding what materials or activities to create, answers to the following questions should be considered carefully

- Which communication channels will best reach each intended audience?
- Which channel/activity mix is best for the strategic approach?
- Is the budget adequate for these choices?

The worksheet on page 35 can be used to draft the final list of products, materials, and activities per channel. While doing this, practitioners should consider these questions about the key content to be communicated through each channel:

- Does the content lend itself to that channel?
- Is there another channel that would be better?

Lastly, practitioners may need to decide if they want a mix that reaches many different people quickly or one that reaches more and more people over a longer period of time. Their answers will affect their broadcasting and distribution plans.

Advocacy Corner: Advocacy Activities and Products

The process for developing an advocacy product is the same as listed in Step 3 of C-Planning. Brainstorm with colleagues and audience representatives in order to create effective, creative, and innovative campaign materials and activities, and make sure they are tailored to each audience and objective. Below are some ideas (adapted from WHO 2006):

- Develop an advocacy toolkit, using research, facts and data for advocacy presentations as well as real life stories of people affected by the issue
- Select powerful spokes people to present with the advocacy toolkit
- Ask supporters to write to your target audiences; provide guidance on content but recommend that letters and e-mails are in their own words.
- A chain e-mail requesting support, or asking people to take simple action, which can be passed on by recipients to reach large audiences.
- Design a pro-forma letter to newspapers that can be tailored to and used by supporters in different regions.
- Prepare a celebrity audio of video file where well selected celebrities each are reading a short appeal which could then be issued on social media (YouTube), radio stations or used at public events.
- Collect video statements from supporters instead of collecting signatures to show public support for an issue. (I Can Change It Guide!).
- Seek partnerships with newspapers, journalists or radio and documentary film-makers.
- Develop radio and video spots, newsletters and support leaflets to inform audiences about steps that can be taken to reduce risk and arrange for talk shows to pick up the issues. .
- Mobilize listeners to call in during radio or TV talk shows addressing your issues.
- Organize a flash mob or other visible ways to mobilize a crowd to show support for an issue such as sit-ins, sleep-ins and other forms of non-violent protest

Social Mobilization Corner: Mobilization Activities and Tips

Social mobilization strategies (Cohen , Chavez, and Chehimi 2010).

- Ensure there is an appropriate leader to bring together people of different perspectives and vested interests.
- Develop approaches to reach out to people directly and invite them to get involved by showing them that it is in their interest to be involved.
- Research what type of channels might be effective in mobilizing supporters.
- Sustain public support for the initiative by retaining partners for the long haul and integrating them into the team.
- Once a coalition in the broad sense is successful in attaining its goal, framing the victory on a group's terms can help consolidate public support and build a base for future initiatives

Community Mobilization Strategies (adapted from USAID/ACCESS 2009)

- Orient the community to make them aware of the mobilization effort, hold a series of one-on-one meetings before a general community meeting.
- Solicit community leaders to reach further out to their communities about issue to be promoted.
- Share information on the importance of the issue by reaching out to various community groups through awareness raising events and encouraging the local media to publicize about the importance of the issue.
- Assemble a community team for taking ownership of the initiative and by designing roles and responsibilities.

Social Mobilization Corner: Special Focus on Mobilizing Communities with New Media and Communication Technologies (adapted from Mercy Corps n.d.):

New media and mobile technologies can be dynamic and offer low cost opportunities to exchange information and receive feedback from a wide range of groups to support mobilization efforts. A strategy to mobilize communities using new media is through mobile phones. For example program cans send text messages (SMS) to various audiences to mobilize and gain support. Another example is online through social network platforms that offer space for members to manage content and connect with other individuals with similar interests. These different social network platforms include blogging platforms to express thoughts; social bookmarking to share web-based resources to various groups; some video or photo sharing sites (vimeo, slideshare etc.) for posting multi-media content, and finally voice over internet protocol for users to make free user to user phone calls via the internet.

WORKSHEET: Activity, Channel, and Material Mix

Think creatively about how to support strategies through a variety of activities or interventions. Which channels and materials will support them? As the table below suggests, the possibilities are endless. It is not important to determine whether a particular channel or material fits neatly into one of the categories shown. It is the way the materials are planned to be used as part of an activity that determines what effect they will have. For example, a flier that is posted on the walls at a student orientation could be used by a counselor to trigger personalized conversations about HIV prevention. This worksheet and others that follow will help you to prioritize activities, channels, and materials, based on their relative advantages and on audience preferences and lifestyles.

Tips

- Use a combination of channels that are linked and mutually supportive. For example, use mass media to highlight effective community dialogue.
- Build in repetition of messages throughout various media and create opportunities for audience members to ask questions or state what they think of the activities (feedback loop).
- Make sure that all activities are recognizable as originating from the strategic design and tied together by a logo.
- Invest wisely for sufficient repetition. Make sure that activities are disseminated as many times as possible, but avoid audience fatigue.
- Make sure a workshop that trains trainers lasts longer than three days and participants apply learning before they train others.
- Don't automatically choose a peer education programs. They are often seen as a quick and inexpensive way. Experience has shown that volunteers need to be continuously trained, motivated, and supervised to be effective.
- Remember, less is more—that is to say, quality pays off in communication. It is better to do one thing well than to have many different activities that people don't remember because they were poorly implemented.

Channel Types	Examples of Activities and Supporting Materials	Your Activities and Supporting Materials
Interpersonal Peer education; client–provider communication; counseling; telephone hotlines	• Series of site visits with leaders and politicians • Coalition-building meetings • Peer education for ART adherence	
Community-based Community dialogues; rallies; stop- and go-drama; risk mapping; community radio	• Rallies in front of the parliament • Community dialogues • Radio or road shows with a game show for couples about FP	
Mass and Social Media Radio and TV spots; chat rooms; celebrity testimonies; serial dramas; game shows; newspaper articles; posters; brochures; websites; Facebook; blogs; YouTube videos; SMS; podcasts	• Email and letter campaign to the Minister of Health • Newspaper call for new civil society network partners • Radio soap opera with call-in program and brochures • Facebook page where youth pose anonymous questions on MCMs and receive answers from physicians • Blog for urban men and women on social norms on multiple concurrent partnerships	

WORKSHEET: Deciding on the Right Channel and Material Mix

Channel Types	Examples	Potential Benefits	Cost and Effort Estimates
Interpersonal	One-to-one communication, such as provider-to-client, peer-to-peer, and partner-to-partner exchanges; social networks; training and skills-building activities in small groups	• Tailored communication • Interactive • Able to unpack complex information • Provides personalized assistance • Can build behavioral skills • Increases self-efficacy • Can increase intentions to act	Though interpersonal communication activities are not expensive, they are not one-off investments. They need to be continuously supported by supervision and incentives to keep up the quality of the intervention.
Community-Based	Bulletin boards; community meetings and parent–teacher meetings; church and mosque notice boards; posters; drama groups, cultural events; community radio	• Can stimulate community dialogue • Can motivate collective solutions • Provides social support • Can increase intentions to act • Provides feedback to broader community	Community-based activities do not have to be expensive, especially if the project has community ownership and taps into existing resources and strengths. However, ensure they are well planned and possibly linked with mass media to implement them at an effective scale.
Mass and Social Media	Television; radio; newspapers; billboards; transit advertising; web sites; Facebook; blogs; YouTube; videos; SMS; podcasts	• Extensive reach • Efficient and consistent repetition of message • Have potential to mobilize youth effectively (social media)	Mass media are expensive, but their wide reach often makes the cost per person minimal. Social media also involve a minimal cost per person reached, but access issues must be considered.

Factors that influence the choice of communication channels

- *Complexity of the issue:* Although IPC is the most appropriate and effective communication for many situations, it is also the most labor- and cost-intensive communication channel.
- *Sensitivity of the issue:* Highly sensitive issues may not lend themselves to the use of mass media.
- *Literacy:* Low literacy levels rule out print materials with extensive text.
- *Desired reach:* Programs aiming at national or regional coverage often use mass media.
- *Prevailing social norms:* Countries differ greatly in their openness and willingness to address sexual issues. Many countries have constraints at airing condom messages.
- *Media habits and preferences of intended audiences:* Formative research needs to give answers to the question of access and habits to tailor programming to preferred listening times, favorites stations, programs, and media ownership.
- *Cost:* The cost of the many available communication channels and their combination vary by type and also by country. It is clearly a determining factor for strategy.

(McKee, Bertrand, and Becker-Benton 2004)

EXAMPLE: Channel and Material Selection

This is an example of a channel selection tool for a workplace audience segment. An appropriate channel and material mix for activities is selected by considering when (timing) and where (location) the audience can be effectively reached. The worksheet on page 38 can be used to create a similar tool.

Time of Day	Location	Channel	Final Decisions
Audience: Urban and rural sex workers in Jamaica			
Early morning	Commuting to work by bus	Billboards; peer educators at traffic cross points; tapes or CDs played in mini taxis	
Mid-morning	Office tea break	Workplace activities for those that have other jobs	
Mid-day	Lunch across the street	Posters; flyers at cafés; peer educators	
Early afternoon	In office	Email, blogs	
Late afternoon	Tea break	Distribution of materials through people who serve coffee and tea in the workplace.	
Early evening	Commuting home	Billboards; peer educators at traffic cross points; mini taxi tapes	
Dinner	At home	Radio, television, newspapers	
Special events	Church	Job aids for religious leaders	
Seasonal events	Holidays; back to village	Billboards; peer educators at traffic cross points; mini taxi tapes; print	

Adapted from O'Sullivan, Yonkler, Morgan, and Merritt (2003)

WORKSHEET: Channel and Material Selection

Directions

- Focus on one audience segment at a time and.
- map out *their* typical day in the two left-hand columns
- Decide on the best time and/or location to reach *this audience segment.*
- Choose one or more interventions, channels, or materials that best suit *this audience segment's* lifestyle and preferences. Make sure the channels lend themselves to the key content that will be conveyed through the channels. Try to find more audience data (e.g., http://www.audiencescapes.org/) to back up assumptions and choices.

Time of Day	Location	Channel	Final Decisions
Audience: _____			

Adapted from O'Sullivan, Yonkler, Morgan, and Merritt (2003)

EXAMPLE: Environment of Change—An Example of Mutually Reinforcing Activities, Channels, and Materials

Here's an imagined but realistic description of how a certain channel mix might be experienced by an audience member (National Cancer Institute 2008).

A woman watches a local TV health reporter's feature about a new focus on prevention of HIV in unborn babies as part of the National AIDS Campaign. She also hears a radio spot on the same topic. She knows from a confidential talk that her pregnant sister tried calling the AIDS Hotline, but hung up as soon as someone answered. The sister is still thinking about getting tested.

The woman encourages her pregnant sister to finally call the hotline. Based on the call with a friendly hotline counselor, her pregnant sister goes to a physician who has been trained in HIV testing. The physician does pre-HIV test counseling with her using a nice flipchart and encourages her to get tested with her partner. He gives her some strategies and a handout about how to overcome her partner's resistance to getting tested.

The physician has become more sensitive to the issue of couples testing because of a recent national VCT Day campaign, some recommendations from the National AIDS Program, and a collection of articles on a website geared towards health professionals.

With the help of the handout, her sister, and encouragement of a family friend, the pregnant woman convinces her partner to go for couples testing. She is ready to adhere to the medical advice because all of the sources around her—media, family, and service providers—are telling her that she should.

The pregnant woman then talks about her positive experience with another pregnant friend. The friend follows her recommendation to call the AIDS Hotline.

Reflection Questions

- ✧ What part of the program worked well? What was essential for success?
- ✧ How does this relate to the three key strategies of SBCC?

Our ideas

This program is effective, but not because of one single activity or specific intervention. It is successful because several programs collaborated to address prevention of mother-to-child transmission (PMTCT) at the same time and as part of a coordinated national program. A systematic SBCC strategy made sure that the program is reaching all involved audiences with an effective mix of media and interpersonal channels that repeat similar messages. What else makes this approach effective?

- It addresses the individual (the pregnant woman) about HIV testing through multiple channels and people in her life.
- It addresses the peers, family, and community (older sister), providing them with information and resources to support the pregnant woman.
- It addresses the service providers (the physician) and services (hotline and PMTCT services) to support the pregnant woman.

WORKSHEET: Scenario to Create an Environment of Change

Directions: A good way to check progress is to imagine a scenario at some point in the future when your strategic approach, position, and channel mix reach your chosen audiences. Describe here what the scenario might look like, sound like, and feel like for a particular audience.

WORKSHEET: Draft List of Activities with Matching Channels and Materials, by Audience

Now it's time to match the ideas for activities with appropriate channels and supporting materials.

Directions: Once potential communication channels have been selected, the next step is to prioritize resources in the development of a manageable set of materials and activities.

1. Summarize your key activities or interventions by audience.
2. Refer to your worksheets on channel mix and materials (pages 40-41) and make a final selection of channels and materials to support your key activities, based on audience preferences and your budget. Remember, channels and materials should not be considered separately from the overall program design. Instead, they should be integrated with other program activities and service delivery.
3. Name the key content for each audience through each channel.

Audience Segment	**Key activity chosen, by audience**	**Final channel selected** (interpersonal, community-based, or mass or social media)	**Materials to support activities**	**Key content to communicate through each channel**
Example: urban and rural sex workers in Jamaica	Peer education	Interpersonal: one-on-one street work with peer educators and group activities	Peer educator's handbook in pocket size as job aid	HIV-prevention tips, safety, rights, responsibilities

Module 2, Session 7: Draft Implementation Plan

All decisions made up to this point now feed into the implementation plan. Such a plan answers each of the following questions all in one place.

- Who will do the work? (staffing)
- What's a realistic timeline? (time)
- How much will all this cost? (budget)
- What are the expected roles and responsibilities of partners and allies? (partnering)

See Step 4 for more implementation tips and lessons.

It is worthwhile to pause and take time to address these practical considerations. Otherwise, resources can be wasted moving in directions that are not a feasible part of the overall plan in the end.

It is important to think about what activities will be conducted and which materials will be developed to meet the program's communication objectives. More detail on the implementation plan is provided in Step 4. However, it is important to think about what activities will be conducted so that materials to support them will be created (Step 3). No material should be developed as a stand-alone; all need to be supported by and integrated into program activities. As the Albania example on page 48 shows, all activities and matching channels and materials are integrated and support each other.

ALBANIA EXAMPLE: Draft Implementation Plan

This draft plan will become a detailed workplan in Step 4. It is only an example of C-Change Albania's draft implementation plan. An overview of C-Change's family planning program in Albania is in Module 0, session 1, page 3, and session 4, page 16.

List of Activities	Implementers (including Partners)	Resources	Timeline
Communication Objective: By the end of the program, there will be increased support for the use of modern contraceptive methods (MCMs) in a greater number of family planning corners and private counseling rooms at university clinics.			
Identify Technical Advisory Group members	C-Change		Jan 2009
Communication Objectives: By the end of the program, there will be: • an increase in the number of university students who have learned about MCMs and the benefits of their use • an increase in the use of MCMs among women and men ages 18–35, from 20 percent in 2005 to 30 percent by 2010 • an increase in the number of young women who discuss MCMs with their partners • a decrease in fear and misconceptions about MCM use among women of reproductive age and men ages 18–35 from 84 percent in 2002 to 47 percent by 2010			
Activity 1: Develop, launch, and sustain integrated BCC mass media campaign			
Pretest communication materials	C-Change; SRC&IT (sub-contractor)		Jan–Feb 2009
Develop and produce final communication materials	C-Change; New Moment (creative firm)		Mar 2009
Develop and implement program launch	C-Change; New Moment		Mar 2009
Implement public relations activities after launch of campaign	C-Change		
Monitor advertising campaign on mass media	C-Change		
Activity 2: FP/MCM peer education program			
Train peer educator trainers	C-Change; UNFPA; two local consultants		Mid-Feb 2009
Orient peer educators	C-Change; peer educator trainers		Mar 2009
Conduct peer education session	C-Change		Mar 2009
Communication Objective: By the end of the program, there will be an increase in the number of editors of prominent print products in Albania who consider FP and reproductive health to be topics worth reporting under various sections (e.g., politics, health, sports, and culture).			
Select media organization or consultant to work with journalists	C-Change		Early Mar 2009
Develop advocacy and media relations plans	C-Change with 10 select journalists		Mid-Mar 2009
Develop and implement the Champion Journalists Initiative	C-Change; C-Change media consultant and a media co-trainer; expert journalist on ethical reporting; obstetrics and gynecology specialists		Mar 2009 (2.5 days)
Produce media relations materials	C-Change with 10 select journalists		Mar 2009

WORKSHEET: Draft Implementation Plan

Directions: Start to think about how communication objectives will be achieved (the activities) and the barriers to change they will address. Also think about possible supporting materials (with what), and how the activity and material fits into the communication strategy. Please note this draft plan will become a detailed workplan in Step 4.

List of Activities	Implementers (including partners)	Resources	Timeline
Communication Objective #1:			
Activity:			
Activity:			
Communication Objective #2:			
Activity:			
Activity:			
Activity:			
Communication Objective #3:			
Activity:			
Activity:			

Module 2, Session 8: Draft Monitoring and Evaluation (M&E) Plan and Baseline Indicators

Most practitioners know that decisions about how to evaluate their programs should be made early in the process (as illustrated in the C-Planning graphic on page 51). Nonetheless, such decisions often get put off or given to others to consider. This session allows key decisions to be made now, which will enable effective M&E later on.

A full description of M&E is in Step 5. (Session 2 of Module 5 is titled, "What Is Monitoring? What Is Evaluation?"). In brief, ***evaluation is data collection at discrete points in time to investigate program effectiveness systematically.*** For SBCC practitioners, evaluation can answer the following questions, among others:

- What kind of change happened among the people or communities reached by our efforts?
- Were these changes meaningful for our program?
- How close did we get to our projected targets?
- Were there different outcomes for men versus women?

Evaluation is invaluable for practitioners. Without it, they can only guess what worked, what didn't work, and what could have worked better.

Evaluation requires the measurement of change over time. The best approach to measuring change is to have a good solid baseline: data collected early in the process with the population or audience chosen that accurately represent the situation ***before*** the program began. The same data will be collected over time for comparison. Session 5 of Module 5 provides an overview of various evaluation designs that use baseline data, with or without comparison groups.

Several key decisions need to be made prior to collecting baseline data. The first of these can be made now, using the worksheet "Users and Uses of M&E Data" on page 52. All other decisions build upon this—including on naming indicators, selecting methods and tools, planning how to analyze the data, and sharing findings. Module 5 has guidance for each of these decisions.

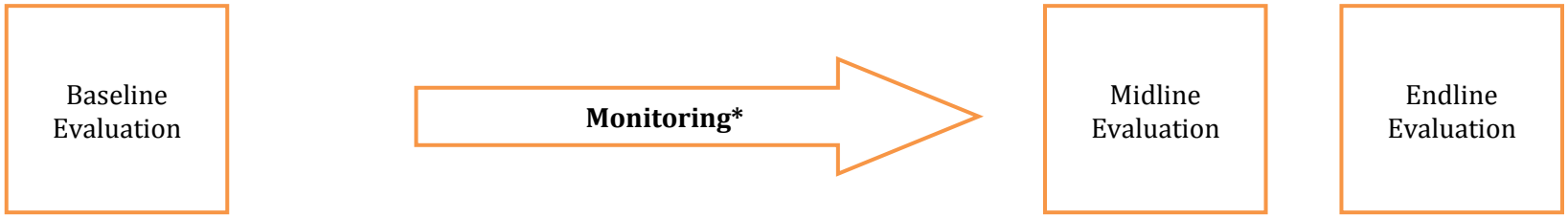
GRAPHIC: Where M&E Fits into SBCC

This graphic shows that setting the M&E for a program means the early drafting of a plan and collection of baseline data. The baseline data are used for comparison with outcome data in Step 5. Thinking through the approach to M&E in early stages of the planning process contributes to identifying and allocating sufficient funds for M&E activities and their inclusion in project timelines and staffing plans.

SOURCE: Adapted from: Health Communication Partnership, CCP at JHU (2003) the P-Process; McKee et al (2000) the ACADA Model; Parker, Dalrymple, and Durden (1998) the Integrated Strategy Wheel; Roberts et al (1995) the Tool Box for Building Health Communication Capacity; and National Cancer Institute (1989) Health Communication Program Cycle.

WORKSHEET: Users and Uses of M&E Data

Directions: As you start to think about your draft evaluation plan and baseline indicators, first think about ***who will use the data*** and ***how it will be used.*** You will come back to this worksheet and your M&E plan in Module 5, but it is worthwhile to start thinking about it now.



Baseline Evaluation	Monitoring	Mid- and Endline Evaluation
If you plan to collect baseline data…	*If you plan to monitor your program…*	*If you plan to evaluate your program….*
Who will use the baseline data and how?	Who will use data about program processes and how? Who will use data about program quality and how?	Who will use outcome data and how? What kind of baseline or group comparison will you need in order to satisfy the users of your outcome data?

**PEPFAR funding requires process and quality monitoring.

Module 2, Session 9: Refining the Communication Strategy

Throughout Step 2, different components of the communication strategy have been drafted. Now it is time to review and refine it. Keep in mind that it is the bridge between the formative research and situation analysis in Step 1, the creation of activities and supporting materials in Step 3, and implementation in Step 4. It is important to review and refine the communication strategy to ensure that it guides implementers.

Practitioners who familiarize themselves with the "Table of Potential Application of Theories, Models, and Approaches" on page 54 can make sure they have chosen the most appropriate theory (or combination of theories) to back up the strategic approach selected at the end of Step 1, based on assumptions formulated in the theory of change.

Module 2, Appendix 1: Table of Potential Application of Theories, Models, and Approaches

1. Enabling Environment Level

What: Policy/legislation, politics/conflict, economic systems and its state, technology, natural environment, and institutions
Who: Government, business, faith and movement leaders, and media professionals
Strategies: Advocacy and social mobilization

Possible Tipping Points for Change: Political will, resource allocation, policy change, organizational/institutional development, national consensus/strategy, social movement pressure, and shaping media agenda

Theories/ Models/ Approaches	Critical Questions	Possible Application

1.1 Media Theories
 	
Key Concepts
• *Agenda setting* (McCombs and Shaw 1972; Glanz, Rimer, and Viswanath 2008)
• *Agenda dynamics*—media agenda, public agenda, and policy agenda (Dearing and Rogers 1996)
• *Media advocacy* (Wallack et al. 1993)
• *Framing* (Goffman 1974; Iyengar 1991)
Persuasion (Perloff 2003)
	• How can the media influence public opinion?
	• How can the media contribute to changes in the enabling environment?
	• Would increased media coverage of the issue help to change perception about its importance among policy-makers and the public?
	• How would increased media coverage affect policy discussion?
	• How can media coverage of an issue be expanded and changed?
	• Does it make a difference how the media frames the issue?
	• How should media decision-makers (e.g., reporters, editors, publishers) be engaged to promote changes?
		• Understand and affect how the mass media influence public opinion, especially about politics and policymaking.
		• Engage decision-makers in the media—journalists, editors, producers, and policymakers.
		  o Organize training events.
		  o Circulate press releases and project newsletters and reports.
		  o Invite press and policymakers to events.
		  o Organize a yearly prize for excellence in coverage on a given topic.
		• Attempt to increase the amount and type of coverage of a given issue by producing and diffusing high-quality materials and holding newsworthy events.

Theories/ Models/ Approaches	Critical Questions	Possible Application

1.2 Social Movement Theories (Tilly 2004)
Key Concepts
• *Collective action*
• *Coalition building*
• *Policy/legislative change*
 	
Actions: campaigns, movement repertoire, WUNC displays
	• How do social movements contribute to changing the enabling environment around a specific issue?
	• How does a social movement change policy/legislation around the issue? What policy changes might help bring about overall change?
	• Is there an existing social movement supporting change related to the issue? What actions has it used? What are its achievements? If there is no social movement, how can one be developed and sustained?
	• What promotes people's participation around the issue? What collective actions are needed to change the environment?
	• What collective action strategies have been successful in expressing demands and advancing change in the past?
		• Understand how communities and groups self-organize and engage in collective action, or how they resist mobilization efforts.
		• Acquire resources and mobilize people toward affecting structural barriers to change.
		  o Create a base of support, e.g., form recruitment networks to tap potential members.
		  o Generate motivation among members by framing issues.
		  o Promote participation by offering incentives and removing barriers.
		• Maintain commitment by building a collective identity and nurturing interpersonal relationships.
		• Help organize actors to use communication tactics such as *persuasion, facilitation, and bargaining* to promote policy changes.

1.3 Social Network and Social Support Theory (also used at community and interpersonal levels) (McKee, Manoncourt, Yoon, and Carnegie 2000; Glanz, Rimer, and Viswanath 2008) **Key Concepts** • *Structural network characteristics* (reciprocity, intensity, complexity, formality, density, geographic dispersion, directionality) • *Functions of social networks* • *Types of social support*	• How do social networks influence an individual's knowledge, attitudes, and behaviors (KAB) around the issue? • How might social networks support possible changes? • How can social networks be influenced? • What dimensions (knowledge, attitudes, perceptions) of behavior/social change can be promoted through social networks?	• Identify characteristics of the social network (e.g., professional, friendship). • Enhance existing network linkages through skills training of members in providing support. • Enhance existing network linkages through events and activities that can also serve to increase visibility and ownership, such as contests for creating content). For an example see www.scenariosfromafrica.org. • Develop new social network linkages (e.g., to mentors, buddy system, self-help groups).

Theories/ Models/ Approaches	Critical Questions	Possible Application
1.4 Social Capital (Putnam 2000) **Key Concepts** • *Institutions* • *Norms and values* • *Trust* • *"Social" resources* (not financial resources)	• What institutions are adequate platforms to promote change? • How might trust among people promote change? • Where do people gather to discuss common interests? Who do people trust? Who do they rely on to develop links and engage in different activities?	• Find out about the motivation of key stakeholders to foster change with a social capital perspective (e.g., to revise health care) . • Find out what resources and opportunities for change are available and what possible outside motivators can create trust among support networks.
1.5 Ecological Models **Key Concepts** • *Ecological systems* • *Physical and socio-cultural surroundings* • *Direct effects of environment* • *Intrapersonal factors* • *Interpersonal relations* • *Community factors* • *Institutional factors* • *Public policy*	• What factors in the social context influence individual behaviors? Which ones can be positively affected? • What elements and/or components of the social ecology are more likely to influence individuals? • What evidence shows successful changes of various factors and their impact on individual behaviors and decisions? • Must changes to the social context always have an impact on individual behaviors?	• Understanding that the position of an individual within a larger set of systems can influence the design and implementation of interventions and activities. • Ecological systems theory suggests that individual-level interventions should always take other influencing factors into consideration. This type of intervention can often be fruitfully supplemented by interventions promoting change at the level of neighborhood, community, institution, and social/political structure. • For example, an intervention promoting bed net use could include an information campaign addressing misconceptions, supplemented by efforts to improve access to low-cost bed nets by improving local supply chains or requesting government subsidies to provide wider access to the nets,
1.6 Theories of Complexity (Waldrop 1992; Lewin 2000; Morin 2008) **Key Concepts** • *Complex adaptive systems* • *Interacting agents* • *Diversity of agents* • *Self-organization*	• What system components affect individual behavior around the specific issue? • What system elements can be influenced? • What is the most likely point of entry into the system? • How are systems organized and how do they avoid chaos and disorganization?	• From an evaluation standpoint, a complexity perspective requires being creative and flexible, with impact indicators, in light of the unpredictable nature of human behavior and interactions.

Theories/ Models/ Approaches	Critical Questions	Possible Application
1.7 Theories of Change (Kubisch and Auspos 2004) **Key Concepts** • *Outcome map* • *Assumptions* • *Pathway of change/action* • *Logic model* • *Inputs/outputs* • *Intermediate outcomes/impacts* • *Emergent change* • *Transformative change* • *Projectible change*	• What are suitable pathways of actions to promote change? • What changes relating to specific issues are already occurring in a community? • What likely changes may have positive and negative ripple effects? • What secular trends/emergent changes encourage or discourage proposed changes? • What changes have already occurred in a given community that offer insights into local processes of change?	• Develop an outcome map or pathway of actions, outputs, outcomes, and impacts expected, and add to it a list of assumptions about change. (Note that a sound theory of change needs to be based on a theory of how change actually happens.)
1.8 Behavioral Economics (Kahneman 2003; Thaler and Sunstein 2008) **Key Concepts** • *Rational choice* • *Choice architecture*	• How can environments be affected to facilitate desirable behaviors? • What behaviors can be made easier if certain environmental factors are altered (e.g., laws, regulations, presentation, distribution, offerings)? • Are there examples of successful choice architecture in a given community? What lessons can be considered for the design of other choices around desirable changes? • Are choices based on rational thought, self control, or selfishness? Or are choices based on rules-of-thumb, irrationally seeking satisfaction, or spur-of-the-moment decisions? • Is a policy change needed, rather than behavioral appeals? • What incentives and regulations can be put in place and/or promoted to make certain behaviors beneficial or mandatory?	• Find out how real people make choices, drawing on both psychology and economics: Are choices based on rational thought, self control, or selfishness? Or on rules of thumb, irrationally seeking satisfaction, or spur-of-the-moment decision-making? • Analyze the environmental structures in place that affect decision-making. Is a policy change needed instead of behavioral appeals? • Frame and design options in a sensible way to "nudge" and coax decisions along. • Determine what incentives could make the decisions lucrative or mandatory.

2. Community Level (Structures, Organization)

What: Community structures, organization
Who: Leaders
Strategies: Advocacy, community mobilization, BCC

Possible Tipping Points for Change: Community leadership/buy-in; collective-efficacy; network participation, community ownership

Theories/Models/ Approaches	Critical questions	Possible Application
2.1 Community Organization (Glanz, Rimer, and Su 2005) **Key Concepts** • *Empowerment* • *Community capacity to perform critical tasks* • *Participation* • *Self-determination/ relevance*	• What community organizations exist? How are communities organized? • How is power structured around specific issues? • What organizations can be mobilized towards positive change? What organizations may be opposed to change? • What local beliefs and practices are or might be linked to change? • What has been the role of local organizations in local processes of change?	• Allow community members assume greater power, or expand their power from within, to create desired changes. • Identify local beliefs and practices linked to change. • Identify community priorities and key activities. • Organize and build alliances to bring about change. • Include participants in planning and implementing activities.
2.2 Integrated Model of Communication for Social Change (Reardon 2003) **Key Concepts** • *Catalyst/stimulus* • *Community dialogue* • *Collective action*	• Where do people talk about common problems? • How can dialogue about specific issues be promoted? • What are the barriers to dialogue around specific issues? How can they be addressed? • Are there past examples of how local dialogue affects attitudes, opinions, collective action, and/or decisions? What are the lessons that are valuable for future plans?	• Use situation analysis to: o identify a catalyst for change to initiate community dialogue around problems and desired change (e.g., a person, information communication technology, medium). o identify and address assets for and barriers to dialogue and collective action. • Develop action plans through dialogue and facilitate implementation by community members and relevant organizations. • Continue with community dialogue and collective action to address external constraints and support over time.

Theories/Models/ Approaches	Critical questions	Possible Application
2.3 Theory of Social Norms (Jones 1994) **Key Concepts** • *Social norms* • *Collective norms* • *Perceived norms* • *Subjective norms* • *Injunctive norms* • *Descriptive norms* • *Stigma*	• What prevalent social norms encourage or discourage proposed changes? • What alternative norms may be emphasized to promote desired changes (e.g., tobacco cessation can be promoted through appealing to social norms about health, economic savings, consideration for the health of relatives, and so on)? • Are there gaps between collective norms and perceived norms (the difference between what individuals perceive to be dominant norms and actual norms)? • Are proposed changes stigmatized? If so, what beliefs underlie stigma? What social norms can be promoted to counter stigma (e.g., real men take care of women)? • Do people have positive or negative views about proposed changes? What are the bases for such beliefs (e.g., religion, culture, economic incentive, policy)? • What do people believe should be the dominant (subjective) norms around proposed changes/issues? • Have there been recent social norm changes in a given community? If so, what are the explanations? Has generational change anything to do with it? What other insights can be drawn from that experience?	Social norms approaches to change are considered an ecological approach, seeking to influence individuals by having an impact on their social and cultural environments. They have been widely applied using social marketing techniques. • Conduct formative research to better understand structural characteristics of social systems and networks in a given community and barriers or assets to change. For example, to capture collective norms, study a society's media description of a certain issue, policies, and how they are followed, and legal regulations. • Design normative messages using various media and promotion strategies, promoting accurate norms of health and safety. • Promote the inclusion of accurate norms in curricula; create press coverage, support policy development and small group interventions. (For more information, see Linkenbach et al. 2002; Haines, Perkins, Rice, and Barker. 2005).
2.4 Social Convention Theory (Mackie and LeJeune 2009) **Key Concepts** • *Interdependent decision-making* • *Organized diffusion* • *Critical mass* • *Tipping point*	• What social conventions need to be changed? Why do specific conventions persist? • What social networks can be mobilized to promote new conventions? • What social conventions have recently changed in the community? Why? Is there wide public knowledge about those changes?	• Define the social convention to be changed. • Use social networks to promote changing the identified convention and to increase awareness about alternatives. • Change attitudes through community discussion of advantages and disadvantages. • Identify and address the following factors that support

Theories/Models/ Approaches	Critical questions	Possible Application
• Public commitment	• What factors support social convention? Why do people do it? What would happen if people changed conventions? • What might discourage people from practicing the current convention?	the convention: self-enforcing beliefs and social, legal, religious, and moral norms. • Publicize community efforts and successes and mobilize community sanction against returning to the convention.
2.5 Theory of Gender and Power (Connell 1987) **Key Concepts** • *Sexual distribution of labor and power* • *Gender inequality as a social construction* • *Gender approaches: neutral, sensitive, transformative, empowering (Gupta 2000)*	• What gender inequalities exist around the specific issues? Who makes decisions? How are those decisions linked to broad gender power divisions? • What factors maintain gender inequalities around specific issues? What factors discourage women from gaining more power? • How can gender equitable decision-making be promoted? What social norms can be tapped to strengthen women's power? • Are there other areas in a given community where men and women have more equitable relationships? If so, why? • Are there men who don't act like "most men" around specific issue? If so, why?	• Identify gender differences in division of labor and power (e.g., low or no income), division of power (e.g., physical abuse), and social norms and emotional attachments (e.g., desire to conceive). • Use advocacy tools to encourage law and policymakers to work to increase girls' and women's access to education, improve women's access to economic resources, increase women's political participation, and decrease gender-based violence. • Attempt to challenge or put on the public agenda various issues of gender inequality. • The *sexual division of labor* suggests that interventions and activities should be designed with women's obligations (e.g., in the home) and barriers to their participation in mind (including transport, child care, disapproving spouses).

Theories/Models/ Approaches	Critical questions	Possible Application
2.6 Culture-Centered Approach (Airhihenbuwa 1999; Dutta 2007) **Key Concepts** • *Links between culture and structure* • *Multiple and shifting contexts* • *Cultural relevance* • *Local community has agency and expertise* • *Shaming techniques (Ttofi and Farrington 2008)* • *Emotional motivators* • *Community-led commitment to change*	• How do communities think about a given issue in terms of their own culture? • How does local culture affect people's beliefs and practices about the issue? • How do people talk/communicate about the specific issue? What are the preferred modes of communication? • Do people have opportunities to talk about a given issue? If so, where and when? Are there obstacles? • What local/traditional values might promote "good" practices and changes?	• Work within the community to identify problems critical or meaningful to them. • Identify critical issues with the community, using participatory methodologies (e.g., community mapping, participatory appraisal). • Build capacity so community members can identify and articulate challenges and participate in developing solutions. • The culture-centered approach seeks to recover voices that are normally marginalized to change inequalities and the structures producing them. • Encourage, facilitate, and publicly recognize community-wide participation and leadership in social change efforts. • Use symbolic activities in public (e.g., a "walk of shame" and community discussion that draw attention to poor hygiene in a village) to trigger a collective, emotional responses at community level about the norms or behaviors in question (Pattanayak et al 2009).
2.7 The Positive Deviance Approach (Zeitlin et al. 1990; Pascale and Sternin 2005) **Key Concepts** • *Asset-based approach* • *Community ownership of change process* • *Community-based and community-driven design and practice* • *Local expertise and solutions* • *Community capacity* • *Community as agent, resource,*	• Are there people who do not conform to the negative norm? Why do they act in that way? Are there common elements among them? • Is it possible to spread their "unique/deviant" norms across the community? Are there barriers? How can they be addressed? What will it entail to mainstream deviant positive behaviors? • What resources do communities have to promote desirable changes? How can they be mobilized towards positive change? • Who (individuals/groups) may be more inclined or disinclined to promote change? What are the reasons? Will informing about examples of positive deviance persuade people who practice undesirable	It begins with the question, where are the assets and successes, rather than what is the problem or deficit or what needs to be fixed. Most importantly, it is the community who must identify and apply the home-grown solutions, rather than importing best practices that are external to the community. The Positive Deviance Approach of "defining, determining, discovering, and designing" has been used in a wide variety of contexts and geographic locations with promising results, including to: • identify and amplify effective infection-control practices in U.S. hospitals • identify successful strategies for resisting the trafficking of girls in Indonesia

Theories/Models/ Approaches	Critical questions	Possible Application
setting, target (McLeroy et al. 2003)	behaviors?	• discover the practices that help decrease dropout rates for school children in Argentina • locate families who resist the practice of female circumcision in Egypt and design an initiative to share their stories

2. Community Level (Services, Products)

What: Services, products
Who: Service, product, and institutional provider
Strategies: Advocacy, community mobilization, BCC

Possible Tipping Points for Change: Product design, access, availability, quality of services, demand, service integration, provider capacity, client satisfaction

Theories/Models/ Approaches	Critical questions	
2.8 Theory of Organizational Change (Glanz, Rimer, and Viswanath 2008) **Key Concepts** • Organizational *development* • *Organizational policies* • *Structure of programs and services* • *Institutionalization*	• What organizations are responsible or exercise influence over specific issues (e.g., quality of health services)? • What organizational practices and rules affect a given issue (e.g., service provision quality and hours)? • What organizational policies and dynamics negatively affect a given issue? • How is change possible in a specific organization? Is there a previous example of change? If so, how did it happen? Was it gradual or sudden? What parts of the organization are more likely to be changed? • What may motivate organization members to support change? Who has power over change? • How can changes be institutionalized in the organization?	• Perform an organizational diagnosis. • Provide process consultation to inform decision-making. • Involve management and staff in awareness-raising activities. • Help organizations identify stages of change for institutionalization.
2.9 Diffusion of Innovations (Rogers 2003; for a concise and thorough summary, see Robinson 2009) **Key Concepts** • *Social system* • *Communication channels* • *Opinion leaders* • *Relative advantage*	• What attitudes exist toward specific innovations? • Who (individuals, groups) is more likely to adapt the innovation? Who is less likely? Why? • What are the advantages of the given innovation over current practices/uses? • Which opinion leaders strongly support innovations and might be mobilized to provide public support? • Have people already experienced the innovation? If so,	• Identify existing attitudes toward or knowledge of innovation. • Identify opinion leaders in the social system and request or invite collaboration. • Address concerns about the innovation and communicate its benefits (relative advantage). • Provide opportunities to try out the new innovation. • Visualize positive outcomes related to adoption of

Theories/Models/ Approaches	Critical questions	
• *Compatibility with existing values* • *Complexity* • *Triability* • *Observability* • *Re-invention*	what happened? Do people have easy access to try the innovation? • What might be the benefits of adopting the innovation for different groups of people?	the innovation.
2.10 Social Marketing Approach (Andreasen 1995; McKenzie-Mohr 2011). **Key Concepts** • *Four Ps:* product, price, place, promotion • *Community-based social marketing*	• What are the benefits of a given product? • Why would people try, using, and continuing to use a new product? • What is the cost/price for people to access the product? • How can the product be effectively distributed in the population? Where will people access it? • How can the product be promoted? What appeals, format, and content will attract people's attention and reach them most effectively?	• Identify product/action benefits to create incentives or highlight advantages. • Identify perceived cost or barriers to using the product or practice. • Identify and utilize effective distribution and access points. • Investigate format and content preferences to ensure information reaches people effectively.
2.11 Models of Patient-Centered Communication Functions (Reeder 1972; Holman and Lorig 2000; Glanz, Rimer, and Viswanath 2008) **Key Concepts** • *Paternalism* • *Consumerism* • *Physician-patient relationship* • *Health literacy* • *Patient self management* • *Social distance* • *Patient preferences for physician and patient roles* • *The 5 As model (Glasgow, Emont, and Miller 2006)*	• What difference does it make to call patients clients? • What advantages do more assertive patients provide for physicians? • How can physicians encourage patient self-management? • What difference would social distance make to the client-provider relationship? And what difference does a good client-provider relationship make for health outcomes (e.g., adherence to HIV treatment)? • What decisions should be made by the provider and what decisions can a client make?	The 5 As Model can be used to facilitate four steps in client-provider interaction that is patient-centered (Glasgow, Emont, and Miller 2006): • Ask (e.g., about the reasons for coming). • Advise (e.g., about their issues and choices). • Assess (e.g., what other needs they have). • Assist (e.g., in finding suitable solutions). • Arrange for follow up.

3. Interpersonal Level

What: Relationships, interpersonal communication, perceived norms
Who: Partners, family, peers, neighbors
Strategies: Community mobilization, Interpersonal Communication, BCC

Possible Tipping Points for Change: Social norms, perceived norms, self and collective-efficacy, network, participation, ownership

Theories/Models/ Approaches	Critical questions	
3.1 Social Learning Theory/Social Cognitive Theory (Bandura 1977, 1997, 2001, 2004; Glanz, Rimer, and Su 2005) **Key Concepts** • *Environment* • *Behavioral capability* • *Perceived facilitators and barriers to change* • *Self-efficacy* • *Reinforcements* • *Observational learning (modeling)*	• How do people come to know about a given issue? • How do people feel about their ability to practice certain actions? Is self-efficacy high or low? • Who influences people's knowledge, attitudes, and behaviors? • What barriers discourage practicing certain behaviors? • How can specific practices be reinforced/reminded/maintained? • Who are credible role models who perform the targeted behavior? • How can collective-efficacy about specific issues be promoted?	• Attempt to influence the environment (social approval, rewards, or punishment) to enable choice of behaviors. • Promote learning through step-by-step skills training. • Approach behavior change in small steps or changes to ensure success; be specific about the desired change. • Offer credible role models who perform the targeted behavior. • Model collective efficacy, e.g., self-organization of parents' groups to organize and advocate for environmental changes to reduce underage alcohol use by their children. • Promote self-initiated rewards and incentives.
3.2 Diffusion of Innovations (Rogers 2003) **Key Concepts** • *Opinion leaders*	• Who are opinion leaders on specific issues in a community or group? • Why are they trusted and followed? • Have they introduced new behaviors? If so, what happened?	• Identify existing attitudes toward or knowledge of the innovation. • Identify opinion leaders in the social system and request or invite collaboration. • Address concerns about the innovation and communicate its benefits (relative advantage). • Provide opportunities to try out the new innovation. • Visualize positive outcomes related to adoption of innovation.

Theories/Models/ Approaches	Critical questions	
3.3 Theories of Dialogue (Freire 1993; Walton 1998) **Key Concepts** • *Consciousness-raising* • *Connection*	• What might a dialogic communication strategy look like? • What should the role of the expert be in communication for social and behavior change? • What activities and processes can facilitate consciousness-raising and connection?	• To generate "dialogic" communication, community members are considered capable allies who are invited to contribute to change in their own communities.
See also 1.4 Social Network and Social Support Theory, applicable at environmental and community levels (McKee et al. 2000; Glanz, Rimer, and Viswanath 2008)		
See also 2.11 Models of Patient-Centered Communication Functions, applicable at the community level (Reeder 1972; Holman and Lorig 2000)		

4. Individual Level

What: Identity, perception of self, locus of control
Who: Individuals
Strategies: BCC

Possible Tipping Points for Change: Knowledge, beliefs, values, attitudes, perceived risks, self-efficacy, social support/stigma, personal advocacy, life and other skills

Theories/Models/ Approaches	Critical questions	
4.1 Hierarchy of Effects Model (Chaffee and Roser 1986) **Key Concepts** • *Knowledge* • *Attitudes* • *Behaviors*	• What knowledge and attitudes might lead to desirable behaviors? • How do we know that specific behaviors might be changed if specific knowledge and attitudes are changed?	• Investigate audience knowledge, attitudes, and behaviors in surveys and focus groups as formative research prior to designing a campaign, intervention, or activity.
4.2 Theory of Self-determination (Osbaldiston and Sheldon 2002) **Key Concepts** • *External motivation* • *Internal motivation*	• Do people feel that they or others control decisions about specific behaviors? • Do people believe they can change or promote changes? What is the basis for those beliefs? • Do people hold fatalistic beliefs about change? Or do they think that change is possible? • Have people effectively promoted and achieved positive change? If so, which ones?	Requested behavior can be encouraged in three ways: 1) by acknowledging and validating the current perspective of the person, e.g., that condom negotiation may be difficult; 2) by allowing the person as much choice as possible, e.g., the behavior could be tried out first; 3) by ensuring the person is clear about the request and its meaning, especially when choices are limited.
4.3 Theory of Human Motivation (Maslow 1943) **Key Concepts** • *Hierarchy of needs:* physiological • safety, social, esteem, self-actualization	• What are people's perceived priority needs? What are their most urgent needs around specific issues (e.g., health, education)? • Do people perceive that the promoted change is important? • Is it possible to present the promoted change in terms of existing perceived priorities?	Consider whether the basic needs of people are met when planning and designing an intervention. Success may be limited in circumstances or contexts where people are focused on meeting basic needs. • Consideration of the threat of terminal illness (such as lung cancer or AIDS) may not be a priority for those struggling to survive and feed their families.

Theories/Models/ Approaches	Critical questions	
4.4 Stages of Change/ Transtheoretical Model (Proschaska and DiClemente 1986; Glanz, Rimer, and Su 2005; Glanz, Rimer, and Viswanath 2008) **Key Concepts** • *Pre-contemplation* • *Contemplation* • *Preparation* • *Action* • *Maintenance*	• What are the different stages across several groups in a community vis-à-vis proposed changes/issues? • Are there any obvious explanations to understand such differences across groups? Why do they hold different attitudes or are in different stages? • How can stage transition be promoted? • What appeals can be mobilized to promote stage change? • What motivates people to act and maintain behavior change? Can those factors be tapped into to promote changes among peoples in other, previous stages?	• Increase awareness of need for change and personalize information about risks and benefits. • Motivate and encourage the making of specific plans. • Assist with developing concrete action plans; help set gradual goals. • Assist with feedback, problem-solving, social support, and reinforcement. • Assist with coping, reminders, finding alternatives, avoiding slips or relapses.
4.5 Theory of Planned Behavior (Ajzen 1985)[1] **Key Concepts** • *Behavioral intention* • *Attitude* • *Subjective norm* • *Perceived behavioral control (equivalent to self-efficacy)*	• Do individuals want to perform the behavior? How likely are individuals to perform behavior? • Are individuals opposed to the behavior? • Why do some individuals have positive or negative intentions? • Do people feel they can control behaviors? • What might motivate people to have positive attitudes?	Assess if the person is: • Likely to perform the behavior or not. • Has a positive, negative, or neutral attitude toward the behavior. • Thinks that the behavior is viewed positively by those who influence them. • Thinks that it's up to him or her to perform the behavior or not (i.e., has a sense that he or she can control the behavior).
4.6 Health Belief Model (Rosenstock 1974; Glanz, Rimer, and Su 2005; King 1999) **Key Concepts** • *Perceived susceptibility* • *Perceived severity* • *Perceived benefits* • *Perceived barriers* • *Readiness to act* • *Cues to action*	• What populations are at risk? What are their levels of risk? • How can risk perceptions be changed or maintained? • Why do people believe that they at risk? Why do some people believe they are not at risk? • How do risk perceptions match objective risk (the statistical probability of being at risk)? • What perceive barriers and perceived benefits for	• Define what populations are at risk and their levels of risk. • Tailor risk information, based on an individual's characteristics or behaviors. • Help the individual develop an accurate perception of his or her own risk. • Specify the consequences of conditions and recommend actions. • Explain how, where, and when to take action and

[1] The **Theory of Planned Behavior** is a later and more robust version of the **Theory of Reasoned Action** (Fishbein and Ajzen 1975, 1980).

Theories/Models/ Approaches	Critical questions	
• *Self-efficacy*	practicing specific behaviors exist? • What actions can be promoted to reduce risk and risk perception? • Are there groups who seem ready to change/practice new behaviors? • Do people feel they are capable of changing behaviors? • Do people understand how change is possible—what needs to happen?	what the potential positive results will be. • Offer reassurance, incentives, and assistance and correct misinformation. • Provide "how to" information, promote awareness, and employ reminder systems. • Provide training and guidance in performing action. Use progressive goal setting. give verbal reinforcement, and demonstrate desired behavior.

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Additional Readings

These references provide additional information that will assist your work in SBCC. The entire SBCC curriculum, references cited below, and additional resources are available at http://www.c-changeprogram.org/our-approach/capacity-strengthening/sbcc-modules. For more resources and opportunities to strengthen capacity in SBCC, visit C-Change's Capacity Strengthening Online Resource Center at http://www.comminit.com/c-change-orc. Graphics in the *C-Modules* can be accessed online, expanded, and shown to participants on a large poster board or through a PowerPoint presentation.

Background Reading

Topic	Item
SBCC	***Communication for Better Health,* Series J, No. 56.** Discusses how managers of family planning programs can build effective behavior change communication programs.
	A Field Guide to Designing a Health Communication Strategy. Shares a set of steps and tools on how BCC efforts can be developed strategically with participation from all stakeholders. Primary audiences are program managers in developing countries who are responsible for designing and implementing health programs, communication specialists, policymakers, and representatives of funding agencies.
Advocacy and/or Social Mobilization	***How to Mobilize Communities for Health and Social Change: A Field Guide.*** Designed to be used by directors of health programs and managers of community-based programs who are considering using communication mobilization at individual, family, and community levels.
	Engaging Communities in Youth Reproductive Health and HIV Projects: A Guide to Participatory Assessments. Provides guidelines for carrying out participatory assessments with youth and adults in communities and outlines how the tools and methods can be applied.
	An Introduction to Advocacy Training Guide. Introduces the concept of advocacy and provides a framework for developing an advocacy campaign. Designed primarily for use in training sessions, but can also be used as a self-teaching device.
Gender	***Changing the River's Flow Series: Zimbabwean Stories of "Best Practice" in Mitigating the HIV Crisis Through a Cultural and Gender Perspective.*** A collection of best practices from six CBOs in Zimbabwe that implemented innovative strategies and approaches in gender programming through a cultural lens.

Existing Curricula/Training Materials

A Training of Trainer's Facilitation Guide on Strategic Communication and HIV and AIDS. Designed to assist in facilitating a five-day training on the basics of HIV and AIDS strategic communication, HIV and AIDS stigma and discrimination, research, M&E for HIV and AIDS communication programs, utilization of demographic and health surveys for health programming, applied skills in HIV communication and counseling, and community mobilization for health and development.

Designing for Behavior Change. Provides an updated curriculum to *Applying the BEHAVE Framework*. Designed as six-day training to build the capacity of NGO staff to plan, implement, monitor, and evaluate effective behavior change strategies.

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Credits for Graphics

The Second Step of a Planning Process for SBCC—Focusing & Designing (page 3); **Where M&E Fits into SBCC** (page 46)

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