

# Strategic Behavioral Communication (SBC) for HIV and AIDS A Framework

FAMILY HEALTH INTERNATIONAL  
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**STRATEGIC  
BEHAVIORAL  
COMMUNICATION  
(SBC)  
for HIV and AIDS**

**A Framework**

**September 2005**

This strategy document was prepared by the SBC Unit of FHI's Institute for HIV/AIDS in consultation with many valued colleagues within and outside of the organization.

## ACRONYMS

AIDSCAP .....	AIDS Control and Prevention Project
ART.....	antiretroviral therapy
ARV .....	antiretroviral
BCI.....	behavior change interventions
CM .....	community mobilization
ECR.....	expanded and comprehensive response
FHI .....	Family Health International
HBC .....	home-based care
IPC .....	interpersonal communication
FSW .....	female sex worker
M&E .....	monitoring and evaluation
OI .....	opportunistic infection
OVC .....	orphans and vulnerable children
PLHA .....	person/people living with HIV/AIDS
PMTCT .....	prevention of mother-to-child transmission
SBC .....	strategic behavioral communication
SM.....	social mobilization
STI.....	sexually transmitted infection
TB .....	tuberculosis
CT .....	counseling and testing
VCT.....	voluntary counseling and testing

# **GLOSSARY OF TERMS**

## **ADVOCACY**

Advocacy is an organized effort to change governmental, public or organizational policies; to redefine norms and procedures; and/or to support protocols for the ultimate benefit of groups such as people living with HIV/AIDS (PLHA), female sex workers (FSW), orphans and vulnerable children (OVC) and populations affected by existing legislation, norms and procedures. Advocacy includes getting important people to speak up, drawing attention to important issues, defending new ideas or policies before those needing to hear about them and directing decision makers toward solutions. Effective advocacy contributes to the creation of an enabling environment for cumulative change of policies, norms and regulations affecting the behavior of individuals and communities.

## **COMMUNITY MOBILIZATION**

Community mobilization (CM) brings together community members, leaders and institutions at various levels to work together to identify and solve problems. It can enhance the ability and commitment of communities to respond to the HIV epidemic. CM is characterized by respect for a community and its needs and by facilitating collective action through a participatory process.

CM helps communities collectively identify and agree on the priority of a specific problem. It helps communities reflect on the problem and identify root causes and options for change. It identifies social groups and maps existing formal structures or networks; builds trust with the community by providing something to meet perceived needs; develops forums around social networks to engage in dialogue with the community; exposes members to new ideas; ensures that they take the lead in problem-solving and encouraging innovative solutions.

CM helps community members explore the relevance of HIV/AIDS programming to their lives. Communication practitioners catalyze this process, providing new information where needed and possibly establishing forums for discussion. The result should be “community-owned,” sustainable solutions to problems that have been prioritized by a range of community members.

CM can result in establishing support groups, user-friendly services or forums for ongoing discussion about HIV/AIDS issues. The community may, over time, establish a range of activities it feels are needed to increase the community’s ability to prevent HIV or mitigate the impact of AIDS. SBC can support CM by enhancing the many communication components of a CM strategy. SBC and other program implementers can play an important role as facilitators of the CM process. A key distinguishing factor that separates CM from SBC is that CM often sets up structures such as formal networks, advisory boards and/or committees whose function may include, but may not be limited to, HIV/AIDS issues. Such formal structures can decide to seek support for HIV and AIDS-related issues where necessary.

## **HIV/AIDS PROGRAM**

HIV/AIDS program refers to overall program areas (strategic behavioral communication, voluntary counseling and testing, care and treatment, monitoring and evaluation, orphans and vulnerable children, antiretroviral therapy, etc.) that are designed together to achieve a large impact on HIV/AIDS goals: reducing incidences, preventing new infections and developing patterns of behavior in program recipients.

## **PRIMARY BENEFICIARY POPULATION**

The primary beneficiary population is the main group for whom and with whom strategic behavioral communication (SBC) messages, materials and activities are defined and designed. It is the people whose awareness, levels of knowledge and skills, attitudes and behaviors are addressed by SBC in HIV/AIDS programs.

## **PROGRAM AREAS**

In HIV/AIDS programs, the program areas or components are: voluntary counseling and testing, orphans and vulnerable children, prevention of mother-to-child transmission, strategic behavior communication, home-based care, and monitoring and evaluation.

## **SECONDARY BENEFICIARY POPULATION**

The secondary beneficiary population is a group who has a significant influence over the awareness, knowledge, skills, attitudes and behaviors of a primary beneficiary population.

## **SOCIAL MARKETING**

Social marketing is the obtaining and selling high-quality, low-cost products (such as condoms or antiretroviral drugs) while focusing on the social value of these products when they are made widely available to low income populations who would otherwise not have access to them. Social marketing is a key strategy for supporting specific behavioral goals, especially when specific products are required for the implementation of programs.

A social marketing strategy attempts to understand and account for all of the aspects involved in marketing the product. It concentrates on the product's advantages over its competitors, packaging standards, storage requirements, delivery system and delivery points, sales structure, revolving inventory, market and profit margins.

## **SOCIAL MOBILIZATION**

Social mobilization (SM) is a process that brings together various segments of society (social groups, political and religious leaders, organizations, etc.) to change social norms and provide sustainable, multi-faceted solutions to broad social problems. Where CM tends to focus on local communities, SM addresses change at the national or societal level. SM often involves high-level political action and is thus particularly effective when it includes strong advocacy for policy change. For HIV/AIDS programs, SM often involves creating an enabling environment to reinforce other behavioral objectives. Channels and activities for SM may include mass media to promote reduction of stigma and discrimination against PLHA, advocacy with policymakers to increase their commitment to speaking out on HIV/AIDS-related issues, and activities that promote broad social dialogue about HIV/AIDS issues, such as talk shows on national television and radio.

## **STAKEHOLDERS**

Stakeholders are people who have an interest in, who stand to benefit from or may be affected by the outcome of a program. Stakeholders may be other key people, including:

**Decision makers:** People who make the final choices, usually at the political or administrative level

**Gatekeepers:** People with the authority to permit something to happen

**Influentials and/or opinion leaders:** People who can influence the behavior and/or opinions of large numbers of people

**Policy makers:** People in charge of making official policy

We should involve stakeholders and other key people from the start and throughout the entire life of our programs. Program managers and donors in a given country or context can identify who are the most important stakeholders and other key people to include.

### **STRATEGIC BEHAVIORAL COMMUNICATION**

Strategic behavioral communication (SBC) is an interactive process with individuals and communities to develop tailored communication strategies, messages and approaches using a mix of communication channels and interventions to promote healthier behaviors and support individual, community and societal behavior change. SBC supports FHI's entire continuum of HIV/AIDS prevention, care, treatment and support interventions with strategic communication. It lends communication expertise to advocacy, social and community mobilization, and other interventions to deliver consistent messages through multi-layered approaches and channels for maximum effectiveness.

### **STRATEGIC BEHAVIORAL COMMUNICATION (SBC) ACTIVITIES**

Within an intervention such as community mobilization, multiple SBC activities are designed and implemented to achieve the strategy. For example, within a mass media intervention, SBC activities might include a launch, an open house event and a survey.

### **STRATEGIC BEHAVIORAL COMMUNICATION (SBC) INTERVENTIONS**

SBC interventions include peer education, counseling, support groups, mass media, traditional media, community mobilization and advocacy, among others.

### **STRATEGIC BEHAVIORAL COMMUNICATION (SBC) STRATEGY**

An SBC strategy is found within the SBC program area and refers to the various avenues and overall design of the communication intervention. That strategy may call for a variety of interventions. SBC is a program area, but it must have a strategy to make it effective.

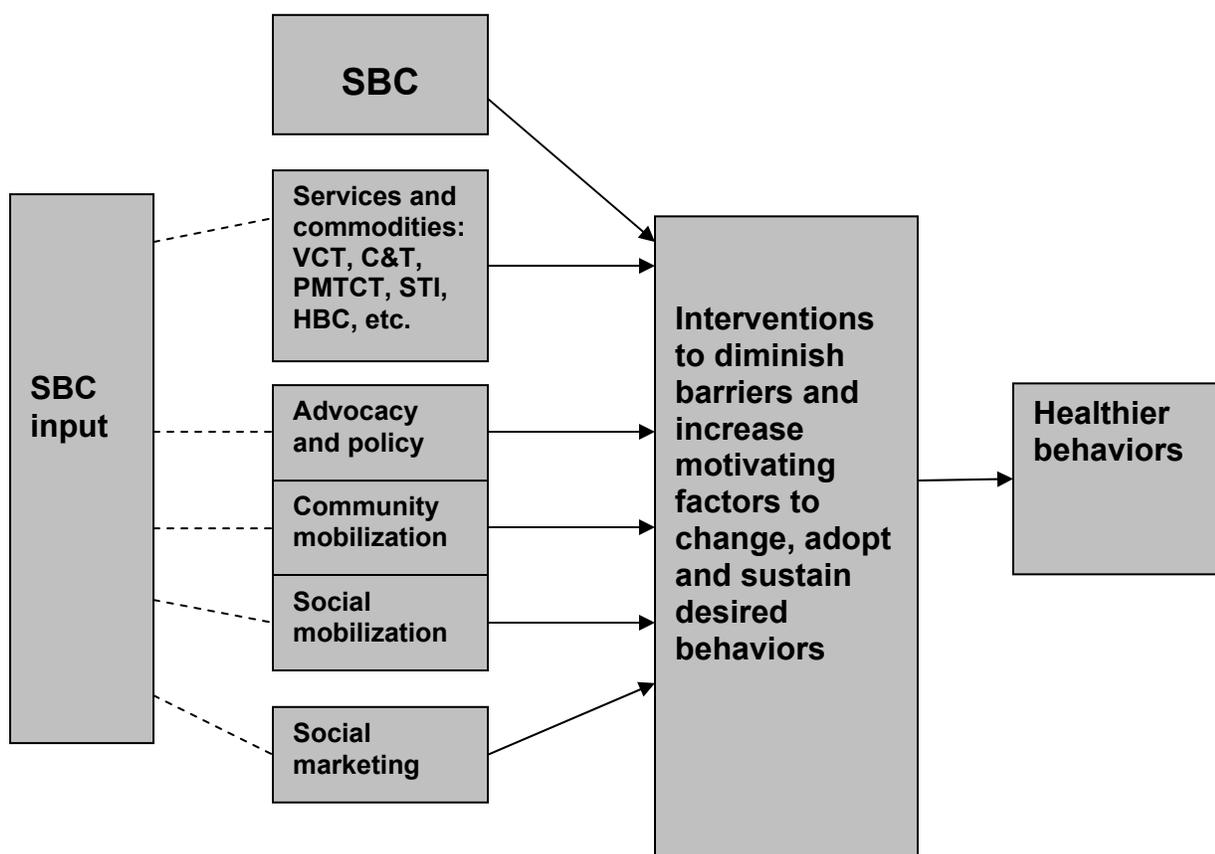
## Introduction

The purpose of this paper is to introduce strategic behavioral communication (SBC), a term that will replace behavior change communication (BCC), which previously described all communication-related components of FHI's HIV/AIDS interventions. This paper also provides an in-depth description of the functions of SBC in the context of HIV/AIDS programming, SBC's guiding principles and process, and the benefits it can offer across different programmatic areas.

## What is SBC?

Strategic behavioral communication (SBC) is an interactive process with individuals and communities to develop tailored communication strategies, messages and approaches using a mix of communication channels and interventions to promote healthier behaviors and support individual, community and societal behavior change. SBC supports the entire continuum of FHI's HIV/AIDS prevention, treatment, care and support interventions with strategic communication. It lends communication expertise to advocacy, social and community mobilization, and other interventions to deliver consistent messages through multi-layered approaches and channels for maximum effectiveness. SBC helps integrate strategic communications into the entire range of FHI's activities by building linkages to all critical program areas, thus making communication a core capacity and technical competency of the organization.

The chart below illustrates the place of SBC in comprehensive prevention, care, treatment and mitigation programs:



## Why Change the Name?

Communication-related interventions have been a part of FHI's key program components since the beginning of its AIDS Control and Prevention (AIDSCAP) Project in 1992. What became known as behavior change communication (BCC) grew into an essential part of comprehensive programs that aimed to help members of beneficiary populations increase their knowledge of HIV and AIDS, change their attitudes and beliefs, modify their perception of risks and build their skills in adopting and maintaining healthy behaviors. The term "BCC" has been widely recognized in the field and is associated with communication programs that pursue specific communication objectives in support of overall program goals.

Behavior change interventions (BCI) came to be recognized as another approach to promoting behavior change and sustaining positive behaviors through strategically planned activities that are tailored to the needs of specific groups and create a supportive environment for individual and collective change. BCI implementers have stressed that, like BCC, BCI works in combination with services and commodities and through interventions such as advocacy, community mobilization and social mobilization. BCI places a greater emphasis than BCC on seeking to transform the social conditions in which behavior change takes place by creating an enabling environment through social mobilization approaches.

At the time behavior change communication was taking its place in HIV/AIDS programming, the term "BCC" became associated largely with the prevention-oriented programs that constituted the bulk of HIV interventions in the early years.

Over time, science developed products that improved the lives of many PLHA, and HIV/AIDS interventions changed to reflect these developments. Communication programs also adapted to the changing landscape, expanding their expertise in risk reduction, care, treatment and support interventions. These interventions addressed such diverse areas as nutritional needs, preventing HIV transmission to partners, altering lifestyles to avoid opportunistic infections and adopting new healthy behaviors. However, the planners of care, treatment and support programs often did not incorporate BCC, partly due to the perception of BCC as primarily a prevention strategy. The name change underscores the fact that SBC encompasses all relevant programmatic areas, not just prevention, by providing expertise for their communication-related component.

In addition, many in the field of HIV and communication began to question the effectiveness of approaches focused on inducing individual change and based on the assumption that change results from individuals making rational decisions. The name change emphasizes the constant changes in people's lives and the interaction of people and their environment that results in additional vulnerabilities.

Programmatically, the new term emphasizes that population-wide shifts are needed to have a sustainable effect on the epidemic. SBC is the driving force for population-based initiatives and community mobilization that challenge social norms and promote structural interventions that go beyond a person-by-person approach to have a large-scale public health impact.

While BCC and BCI approaches have proven successful at promoting such behavior changes as the use of condoms and reduction in partners, "behavior change" does not capture behaviors like adherence to treatment regimens or abstinence because these represent maintenance or slight

modification of existing behaviors rather than clear-cut behavior change. In some countries, the term “behavior change” has developed a negative connotation associated with imposed or “top-down” approaches rather than strategies developed with full participation of primary beneficiaries, stakeholders and other community members. The new term emphasizes SBC’s focus on behavioral goals that are not necessarily classifiable as “behavior change.” SBC’s broader scope includes influencing many different types of behaviors and removes the implication that these influences are imposed from outside a community or society.

FHI has examined these and other issues through extensive dialogue between BCC staff at FHI headquarters, BCC and BCI personnel in the field and senior managers worldwide. After the exchange of viewpoints, consensus was reached on the following positions:

1. Although BCC has been widely used in prevention-oriented interventions, **the process FHI uses to design and implement its behavior communication programs is fully applicable to other programmatic areas**, including HIV/AIDS care, treatment and support interventions. SBC adds value to and should be used in every programmatic area, including VCT, OVC, HBC, prevention, antiretroviral therapy (ART) and treatment of opportunistic infections (OIs) and tuberculosis (TB). Planners should involve SBC practitioners in the design and implementation phases of programs to see how SBC can support overall program objectives.
2. While BCI embraces the variety of interventions FHI uses to influence behaviors (including advocacy, CM and SM), SBC emphasizes and clarifies the role of communication in these interventions. SBC articulates clearly how communication can benefit and strengthen interventions that include more than just communication, such as advocacy, community mobilization, social marketing, etc. Whereas BCC and BCI refer to behavior change, SBC may be more broadly accepted given it avoids the “baggage” of the term “behavior change” (associated with prevention-only, top-down approaches).

SBC has many methodological similarities that overlap with advocacy, community mobilization and social mobilization. While these strategies do not belong entirely to the communication arena and require more than communication expertise from their implementers, they do depend on participatory communication approaches and need many communication-related strategies and tools to reach their goals. Therefore, practitioners responsible for planning and implementing advocacy and community/social mobilization strategies can benefit from collaborating with SBC professionals. SBC approaches are designed to move service providers and beneficiary populations closer to the desired behaviors, which increases the likelihood that the intervention will be able to meet its programmatic goals.

## **What Can SBC Do For FHI’s Programs?**

FHI believes that SBC should be an integral component of a comprehensive HIV/AIDS prevention, care, treatment and support program. Well-planned and executed SBC components, when integrated with overall programming efforts, can help achieve program goals by bringing about the changes in knowledge, attitudes and skills that intended audiences need to adopt or maintain healthy behaviors. Whatever the goals, SBC can help program planners achieve them by providing the communication-related content to move beneficiary audiences closer to the intended behavior. Below is a list of the contributions SBC can make to different program areas targeting different population segments:

- Increase knowledge of HIV prevention and transmission modes among beneficiary populations to reduce risky behaviors
- Influence the adoption of positive health behaviors (such as abstinence, faithfulness and condom use) by members of the beneficiary populations
- Reduce stigma and discrimination among health workers to improve care and treatment services for PLHA
- Create demand for VCT services to help the community fully utilize available resources
- Stimulate community dialogue on developing an appropriate response to OVC issues
- Train healthcare outreach and home-based care workers to better provide information on OIs, drug side effects, good nutrition and exercise during home visits to PLHA and ART patients
- Work with mass media to stimulate more press coverage of HIV/AIDS-related issues
- Invite audiences to change social norms to allow for more open discussion of sexuality between parents and children to help delay the onset of sexual activity
- Improve PLHA's skills to help them adhere to ART and seek medical help as needed
- Help change policy makers' attitudes and influence them to increase budget allocations for HIV/AIDS programs

The list above is provided only for illustration purposes. SBC contributions will vary depending on the overall program goals, behavioral and SBC objectives, and intended populations. What remains constant is SBC's ability to help the intended audiences of all HIV and AIDS programs in the prevention-to-care continuum adopt new or maintain existing behaviors.

## **SBC Guiding Principles**

FHI plans and implements its SBC interventions in the context of the expanded and comprehensive response (ECR), which aims to deliver a comprehensive range of interventions to reduce HIV transmission and the impact of the disease on the population. FHI's SBC approach emphasizes comprehensive coverage and embraces the following guiding principles:

1. SBC should be **integrated with program goals and interventions** from the very beginning of program design. This ensures that SBC activities have **the necessary linkages with the other elements of the program**, including services and commodities.
2. SBC approaches, messages, channels and activities must be applied across all program interventions in a unified, consistent fashion. This means the communication messages and activities used in different areas of the program must be consistent and speak to the intended populations with the same voice to preserve the identity of the program. SBC activities are most effective when they are delivered through a mix of channels to reinforce the same key messages. For instance, the program can **incorporate several different but interrelated versions of the same key messages** in such diverse interventions (within the same program) as promoting VCT services within a community, counseling in PMTCT, educating in-school youth about HIV transmission and prevention, stimulating dialogue with policy makers and working with PLHA to increase their motivation to adhere to treatment regimen.

3. When applied in this manner, SBC becomes the glue that holds all program elements together by **ensuring a consistent and authentic look and feel to all interventions within a program**. SBC activities also have the strongest impact when they are delivered through a mix of channels in a manner that reinforces the same key messages by using the relative strengths of each channel. As HIV/AIDS interventions scale up and diversify their services, this principle becomes even more important for the maximum program impact.
4. For SBC interventions to succeed, FHI believes **beneficiary populations, relevant stakeholders and PLHA** must take part in all phases of SBC development and much of implementation. Involving intended audiences and stakeholders throughout the program design, implementation, monitoring and evaluation builds local capacity and ensures local ownership and sustainability of the program beyond the initial phase.

SBC shares several other guiding principles with FHI's technical programmatic areas. Because SBC plans and implements its interventions in the context of comprehensive programming and in full integration with other program components, it shares the following principles with other elements of HIV/AIDS programming:

- **Adapted locally:** Interventions should not be designed from the outside or a centrally funded office, but rather at the local site. Interventions have to be tailored to the needs of the local population and audiences involved. For instance, strategy design workshops are conducted with the participation of key community representatives and stakeholders to ensure that the activities, messages and channels respond to community knowledge and culturally sensitive to the community beliefs.
- **Beneficiary focused/driven:** The beneficiaries define the needs, perceptions, attitudes, beliefs and obstacles that the intervention must address. These must be identified through initial data collection, previous research and new formative research.
- **Evidence based:** Interventions are designed using all available data from baseline surveys, formative research, epidemiological data, demographic and health surveys, and any well-documented, successful intervention done locally or elsewhere.
- **Results based:** Interventions must be designed to produce results that can be observed, documented and presented as concrete outputs. Monitoring and evaluation systems aid in demonstrating results.
- **Quality assurance/quality improvement:** Interventions must meet the quality standards that are accepted in the field. Interventions must also address qualitative improvement.
- **Sustainability:** The interventions should contribute to the development of systems that can be sustained over time by building capacity, formalizing informal groups, developing managerial skills, financial systems and supervisory mechanisms.
- **Responsiveness:** Implementation design should take into account the changes occurring in the field and make the necessary adjustments so that it captures the best of what the change imposes.

- **Creating partnerships:** FHI cannot confront the epidemic alone and works with all organizations that can contribute to program goals.

## Why “Strategic” Behavioral Communication?

In the context of SBC, “strategic” means the following:

- Strategic communication programs must be structured to achieve carefully selected and appropriate communication objectives through the right combination of well-timed program interventions. This means that all activities, tactics and tools are selected for their ability to move the program closer to its pre-determined results.
- Strategic communication elements should be integrated into all program areas (such as prevention, counseling and testing, care and treatment, etc.) so they can be coordinated through strong linkages to ensure consistency of messages across the entire prevention and care continuum. This will provide a unifying “look and feel” of all the themes, messages and graphic elements.
- Effective strategic communication is built on the foundation of well-chosen and designed program elements, including: accurately segmented and researched beneficiary populations; well-researched and identified barriers to change; motivating factors and key benefit statements related to the desired behaviors; appropriately chosen channels, messages and activities; monitoring and evaluation indicators; and other communication-specific elements.
- Strategic communication programs are designed to fit in the context of the bigger picture within a given country or region to ensure sustainability.

## Why Strategic “Behavioral” Communication?

The unique benefit of FHI’s approach to communication in HIV/AIDS prevention, care and treatment programs is its emphasis on and understanding of behavior. By involving SBC practitioners in the beginning of the program design, planners can get the most value from SBC’s ability to analyze behavior and identify behavioral factors that the program needs to take into account and manage.

The behavioral component is present in almost all HIV/AIDS interventions within the prevention to care and treatment continuum. The program goals usually focus on some aspect of intended audiences’ behavior—changing behavior (condom use during transactional sex, use of STI/HIV testing services), maintaining new behaviors (adherence to ART regimen), sustaining existing behaviors (staying abstinent), or modifying behavior (reduction of casual sex partners.)

Program success is usually dependent on how widely and how successfully the intended beneficiary populations can embrace the desired behavior, regardless of whether it represents a direct change, a slight modification or maintenance of existing behavior. This is where SBC can be of most value by designing and implementing communication strategies that highlight the benefits of the desired behavior or explain the risks of not adopting the behavior.

A number of theories address behavior change by exploring potential motivating factors and barriers influencing individuals. Some theories investigate specific factors that trigger/hinder behavior change, while others put more emphasis on the stages of behavior change.

Some models focus on the individual and posit that the key to behavioral change lies in one’s perception of risks and benefits, or in the increase of motivations and reduction of barriers associated with certain behaviors (Health Belief Model, AIDS Risk Reduction Model and Theory of Reasoned Action). There are those that place more importance on the social and environmental forces that may constrain people from or motivate them to adopt new behaviors, emphasizing enabling and reinforcing factors rather than individual’s abilities to cope and manage the new behaviors. For instance, the Social Ecology model posits that behavior and environment have a fully reciprocal cause-effect relationship. Others still explore the stages of behavior change that typically range from awareness to concern, motivation, action, trial and adoption of new behavior. Theories help program planners prioritize the personal and environmental factors they will consider during assessments and planning. Understanding the interaction between personal and environmental factors helps design SBC activities that clearly address both.

The value of behavior theories for SBC effectiveness is twofold. First, identifying the stage of behavior change the individual is in gives SBC program planners an opportunity to tailor approaches to the information needs of that specific stage of the priority population. It also allows program planners to set realistic goals with respect to how much change is feasible. Second, understanding the intended audiences’ behaviors (through formative assessments) with respect to internal and external motivating factors and barriers makes it possible to design SBC interventions that boost motivating factors and diminish barriers.

The following table presents some examples of internal and external motivating factors and constraints to behavior change:

<b>Sample</b>	<b>Motivating Factors</b>	<b>Barriers</b>
<b>External</b>	<ul style="list-style-type: none"> <li>• Peer and family support</li> <li>• Enabling environment</li> <li>• Positive opinion leaders</li> <li>• Positive policies/laws</li> <li>• Support groups</li> </ul>	<ul style="list-style-type: none"> <li>• Stigma and discrimination</li> <li>• Lack of services and commodities</li> <li>• Lack of supportive policies and/or donor restrictions</li> <li>• Cultural and gender norms</li> </ul>
<b>Internal</b>	<ul style="list-style-type: none"> <li>• Perceived self-efficacy</li> <li>• Perception of individual risk</li> <li>• Concern for own health</li> <li>• Familial ties</li> </ul>	<ul style="list-style-type: none"> <li>• Lack of life skills (such as negotiating condom use)</li> <li>• Fear of violence</li> <li>• Gender role expectations</li> <li>• Low self-esteem and/or low self-efficacy</li> <li>• Lack of HIV and STI risk awareness</li> </ul>

Once the motivating factors and barriers have been clearly identified, this information can be used to design an appropriate SBC intervention. The following provides an example of this analysis\*:

<b>Program Goal:</b>	Reduce AIDS morbidity
<b>Current Behavior:</b>	Low uptake of antiretroviral (ARV) drugs, high dropout rate once on ARV drugs and low adherence to ARV drugs
<b>Desired Behavior:</b>	ARV patients adhere to treatment regimens
<b>Behavior Change Goal:</b>	Increase the number of HIV-positive individuals starting and maintaining adherence to ARV drugs
<b>SBC Goal:</b>	Increase awareness and knowledge of the benefits of ART and its availability; increase motivation to adhere to the treatment
<b>Barrier to change:</b>	Lack of awareness about treatment efficacy and availability, exaggerated fear of side effects and lack of self-efficacy in overcoming them, stigmatizing attitudes of health providers and family members, lack of peer support, perceived improvement, complexity of treatment, desire for secrecy, etc.
<b>Motivating factor:</b>	Desire to live and stay healthy
<b>Key benefit:</b>	Adhering to treatment can allow people to lead a normal life and be there for their families
<b>Sample SBC Activities:</b>	<ul style="list-style-type: none"> <li>• Patient education on basic ARV drugs facts, including efficacy and availability of and importance of adhering to treatment</li> <li>• Patient education on expected side effects and their management</li> <li>• Training primary healthcare provider on how to work with the patient to develop strategies to maximize ARV drugs adherence</li> <li>• Training health providers on reducing stigma and discrimination</li> <li>• Communication input to advocacy interventions targeting policy makers to make ARV therapy available and affordable</li> <li>• Communication input to community mobilization interventions targeting family members to reduce stigma</li> <li>• Mass media campaigns to reduce stigma against PLHA and stimulate community dialogue</li> <li>• Outreach to PLHA support groups to boost peer support</li> </ul>

\* Please note that the chart is audience-specific (in this case, the audience is new ART patients.) This does not imply that other audiences (such as policy makers, etc.) do not need to be involved to increase the number of people on ART. Similar charts can be developed for all audiences involved in reaching a goal.

## **SBC's Relationship with Community Mobilization, Social Mobilization, Advocacy and Social Marketing**

Facilitating behavior change requires that the barriers to behavior change are modified or diminished before new, healthier behaviors are tried and possibly adopted. Many well known strategies address some of the behavioral determinants that play a role in individual behaviors and that are outside of the individual's control. Some of these have been used in the past by FHI: strategic behavioral communication (counseling and interpersonal communication, mass media, traditional/small media, etc.), advocacy, community mobilization, social mobilization and social marketing. Each of these strategies approaches behaviors in a different manner, at a different level and with a different methodology, but in each of them SBC plays a distinct role. This is why SBC practitioners are often asked to participate in community/social mobilization, advocacy and social marketing activities. Although community/social mobilization, advocacy and social marketing all represent individual disciplines with their own methodologies and approaches, communication runs very prominently through their planning, design and implementation.

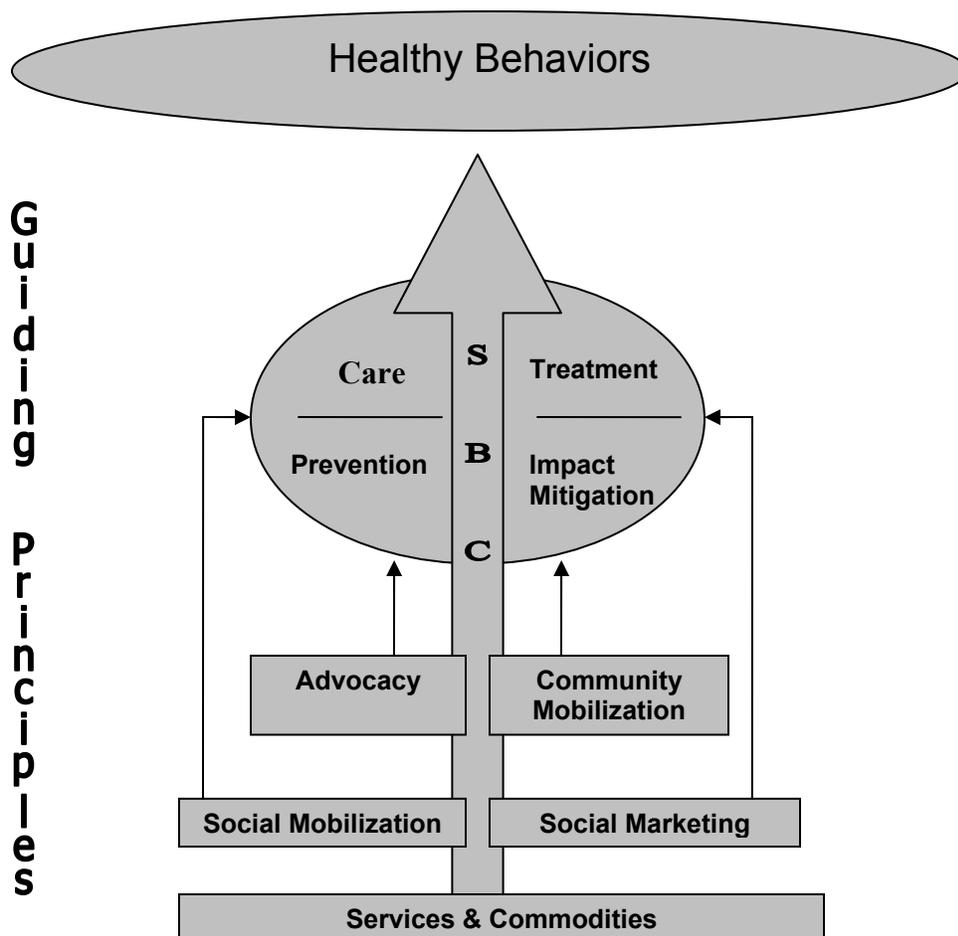
Advocacy typically aims to work with national or local policy makers to change the laws and regulations to create a more enabling environment for HIV/AIDS prevention, treatment, care and support interventions. SBC can contribute to advocacy in a variety of ways, such as by carrying out formative assessments of the beneficiary populations to identify barriers and motivations to desired behaviors, helping present the findings of formative assessments to policy makers in a compelling way that diminishes barriers and motivates policymakers to make the changes, and by effectively disseminating new policies to the beneficiary populations once the change has been made. Advocacy planners need other types of expertise in addition to SBC, such as policy analysis and development of draft laws, but SBC approaches and strategies are critical for the success of advocacy projects.

Social marketing focuses on marketing commodities and services to the beneficiary population. SBC can contribute to the social marketing goals by conducting surveys and assessments of knowledge, attitudes and behaviors; by collaborating with social marketers to develop a marketing and communication strategy that packages the product as a solution to the beneficiary populations' barriers; by developing, pre-testing and producing supporting materials that conform to the strategy; by working with mass media; and by ensuring that all social marketing communication activities have solid linkages with the overall SBC strategy and program plan.

SBC's focus on participatory approaches and behavior analysis can assist social and community mobilization efforts by carrying out formative assessments exploring social norms and underlying behavioral motivations and barriers, facilitating peer-driven interventions, promoting community events, and developing communication strategies and tactics to promote desired solutions.

It is critically important that the planners of social mobilization, community mobilization, advocacy and social marketing work in close collaboration with SBC practitioners and seek their input early in the program design phase. SBC practitioners provide strategic communication expertise that ensures interventions speak to their beneficiary populations with one voice and carry consistent messages across different channels to maximize effectiveness.

The following chart illustrates the cross-cutting nature of SBC inputs into all programmatic areas and contributions to healthier behaviors:



## How Should SBC Interventions Be Developed?

FHI has developed a step-by-step approach to assist programs in developing comprehensive SBC strategies:

### Step 1. Establish program goals; conduct situational assessments and baseline studies

Program goals should be based on available epidemiological and behavioral data and are often based on the results of situational assessments. Although program goals are typically established outside of SBC, the SBC practitioners should be aware of the program goals so that they can develop SBC objectives, indicators and monitoring and evaluation plans to support program goals. This step and all others should be implemented in collaboration with stakeholders and other key people. Program managers and donors can most likely identify key people. They can also include people responsible for community mobilization, social mobilization, care, treatment, support and other programmatic areas.

## **Step 2. Involve stakeholders and other key people**

Stakeholders and other key people (such as decision makers, gatekeepers, “influentials” and opinion leaders) are people who have an interest in, who stand to benefit from or may be affected by the outcome of a program. For communication interventions to take root and make a difference, community members must perceive a public health program as their own. Stakeholder involvement through *all stages* of a program from design to implementation facilitates community ownership and gives the program its best chance of success.

## **Step 3. Identify beneficiary populations**

The most effective SBC interventions have well-defined beneficiary populations. These are usually selected based on many factors, including epidemiological information, donor mandate, budget and schedule. Building a program around a specific beneficiary population gives SBC practitioners an opportunity to focus on the behavioral and communication needs of this group for maximum impact.

## **Step 4. Conduct formative assessment**

SBC programs need to be based on detailed, in-depth information about beneficiary populations. Formative assessment results help to ensure that SBC strategies accurately address the needs and concerns of beneficiary populations as well as environmental constraints in order to effectively motivate people to modify, change or sustain behaviors.

## **Step 5. Segment beneficiary populations**

SBC strategy is more effective when it is focused on addressing the needs of the specific groups of people with similar characteristics. To improve effectiveness further, beneficiary populations can often be segmented on the basis of these characteristics.

## **Step 6. Define behavioral and communication objectives**

Behavioral and communication objectives should be stated in terms of the needs identified through formative assessments and based on the change in knowledge, attitudes, skills or policy environment that should result from activities. It is important to remember that most behavior influence is incremental over a long period of time, so SBC objectives should reflect and support behavior change that is realistically achievable in a set time frame.

Distinguishing between behavioral objectives and communication objectives is also critically important. While behavioral objectives refer to specific behavioral changes or sustained positive behaviors, communication objectives refer to changes in levels of awareness, knowledge, concern, motivation and/or intention. These are important steps that usually precede behavior change or successfully sustained positive behaviors. Since people usually need services and commodities combined with communication to change or sustain positive behaviors, communication objectives are important because they help to determine the desired effect of communication on beneficiary populations. Both behavioral and communication objectives should be specific, measurable, appropriate, realistic and time-bound (SMART). The chart below illustrates the relationship between behavioral and communication objectives.

<b>Behavior objectives</b>	<b>Communication objectives</b>
Increase condom use	<ul style="list-style-type: none"> <li>• Increase truckers' motivation to use condoms by 25%* within six months.</li> <li>• Increase out-of-school youth's perception of risk of unprotected sex by 20%* within one year.</li> <li>• Improve female sex workers' confidence negotiating condom use in by 30%* within one year.</li> </ul>
Delay the onset of sexual activity	<ul style="list-style-type: none"> <li>• Increase in-school youth's (age 11 to 16) perception of abstinence as a positive lifestyle by 40%* within two years.</li> <li>• Build high school girls' negotiating skills to refuse to engage in sex by 25%* within one year.</li> </ul>
Increase adherence to ARV drug use	<ul style="list-style-type: none"> <li>• Increase a given community's knowledge of ART facts, availability and side effect management by 40%* within one year.</li> <li>• Increase PLHA's perception of self-efficacy to remain on treatment by 25%* within six months.</li> </ul>
Increase the use of VCT services	<ul style="list-style-type: none"> <li>• Increase youth's motivation to learn HIV status by 25%* within two years.</li> <li>• Reduce stigma associated with use of VCT services; reduce the number of community members who believe only people who practice risky behavior use HIV testing services by 25%* within one year.</li> </ul>

\*Compared to baseline

### **Step 7. Design SBC strategy and monitoring and evaluation plan**

A good SBC strategy clearly segments beneficiary populations and includes their profiles, communication objectives, indicators, barriers and motivating factors to change, a key benefit statement, themes and messages, a combination of interventions and channels, and links to services and commodities. An SBC strategy should also include a monitoring and evaluation (M&E) plan based on the behavioral and communication objectives.

### **Step 8. Prepare to develop SBC activities, materials and monitoring tools**

After designing a SBC strategy, the next step is to prepare everything required to implement the strategy. This may include developing training curricula, training of trainers materials and monitoring tools, and selecting the most appropriate communication channels for any stand-alone SBC interventions. SBC staff will also need to collaborate closely with people in other program areas on other interventions. Developing communication-specific inputs into other programmatic areas may also be required. Above all, SBC practitioners need to develop and maintain solid linkages with managers of programs providing services and commodities, particularly if the SBC strategy seeks to create demand for these services and commodities.

### **Step 9. Pre-test**

Pre-testing is essential to confirm the effectiveness of SBC messages, materials, monitoring tools and training curricula. It gauges a beneficiary population's reaction to and understanding of messages, images and behavior change information before materials are finalized and activities are implemented to scale.

### **Step 10. Implement and monitor**

After the preparation phase, the program is implemented and the strategic SBC plan is put into action. The behavioral and communication objectives are translated into work or implementation plans that consist of activities and timelines and define who is responsible for them. Monitoring is intricately tied to the planning and implementation process as its data helps measure program performance in terms of progress, reach and quality. Monitoring is different from program evaluation in that it uses different methods, requires different expertise and is typically carried out by staff not involved in day-to-day program management. Monitoring typically focuses on periodic accountability and ongoing program management.

### **Step 11. Evaluate SBC Strategy**

Evaluation helps determine if the SBC strategy has accomplished its goals and objectives. SBC strategies should be evaluated as part of the overall HIV/AIDS program and preferably in reference to a baseline. As both behavior and structural/environmental change are usually a long-term processes and are influenced by other programs and factors, establishing a direct causal link between SBC interventions and behavior change and other outcomes can be difficult. However, well-defined indicators based on behavioral and communication objectives (such as changes in knowledge, attitude or skills) can aid in determining the amount of behavioral or environmental change that may be attributable to the SBC strategy. Often these indicators can be evaluated by repeating some of the in-depth formative research with members of the beneficiary audience or through special studies that help identify factors influencing project outcomes.

### **Step 12. Analyze feedback and redesign**

SBC monitoring and evaluation results are used to give feedback on the progress of SBC implementation and the effect it is having. M&E communicates the successes and challenges of the project to key stakeholders to give them an opportunity to revise the program and to help programmers make evidence-based decisions.

## **What Can SBC Do for Specific Program Areas?**

We have explained why SBC can and should be an integral part of all HIV/AIDS prevention, care, treatment, advocacy and community/social mobilization programs. The sections below detail how SBC can contribute to specific program interventions, including C&T, STI, OVC, PMTCT, ART/OI/TB and HBC services. They are included for the benefit of planners and implementers of these specific program areas to demonstrate the value SBC can add.

### ***How Strategic Behavioral Communication (SBC) Can Strengthen Counseling and Testing Services***

SBC is vital to helping voluntary counseling and testing clients make informed decisions about avoiding HIV infection and re-infection and preventing transmitting HIV to others. Counseling and testing is an umbrella term that encompasses all HIV testing avenues, including voluntary counseling and testing (VCT), diagnostic testing, the services that providers give their patients when making HIV-testing recommendations, and additional counseling to help people disclose their HIV status, protect their partners or plan to reduce risk. Testing sites can be stand-alone sites in a community setting or integrated into a comprehensive service site such as a hospital or clinic. The two types of sites have shared and unique communication issues.

In both stand-alone and integrated sites, SBC must be designed based on the needs of the community and the particular service site. Ideally, a multi-tiered SBC intervention approach will be implemented to enable the VCT site to have the greatest impact on the population. For example, only a small percentage of those with HIV know their serostatus or perceive benefits to knowing their status. SBC can help create an enabling environment so that people in the community want to know their serostatus. Of those who do get tested, many do not return for their results. SBC can help the providers and counselors communicate the benefits of staying or returning for test results.

Communication issues specific to integrated testing sites include:

- Managing the community's and patients' pre-encounter expectations of what will take place at the comprehensive care site. Healthcare workers may make routine HIV testing recommendations to every patient; therefore, it is important that patients understand the benefits of this approach and are not reluctant to visit a hospital/clinic for fear of being tested, especially against their will.
- Communicating and clarifying to the community and patients that all HIV-testing services are confidential and require consent, and that counseling is provided to those who want testing. In an integrated site, confidentiality, consent and counseling need to be clarified for patients so they feel control over whether or not they are tested.
- Dispelling misconceptions about the new forms of counseling and testing during the post-encounter. It is important that suggesting HIV-testing to each patient is not misunderstood or misinterpreted. In addition, there may be cultural beliefs (such as beliefs surrounding the drawing, handling and disposing of blood) that could develop into myths. The benefits of routine HIV-testing recommendations and the patient's individual rights to get tested need to be clarified during the post-encounter.

Counseling and testing is essential to mitigate the impact of the HIV epidemic, and SBC is an important link both within and outside of the testing center. SBC can help ensure that testing centers, whether integrated or stand alone, meet their objectives in the most effective manner.

**SBC for counseling and testing (CT) can:**

- Promote and raise awareness of counseling and testing within the community
- Support advocacy directed at national and local politicians and stakeholders regarding policies, guidelines and standard operating procedures for counseling and testing
- Support and facilitate community mobilization to create additional services, strengthen existing services and provide the CT centers with necessary linkages and support networks
- Provide a supportive environment to community members to motivate them to get tested, stay or return for their test results and make healthier decisions in the future
- Contribute communication-related inputs to ensure that the CT experience is positive for all clients so that the center builds a reputation of respect, trust and safety

**Channels and activities:**

- Implement a strong mass media program to promote CT, reduce HIV stigma and discrimination, and reduce gender stereotypes within the community to enable more women and men to get tested.
- Ensure that CT sites are acceptable to marginalized communities. Carefully prepare communication workers to make effective referrals and perform follow-up.
- Work with peer educators and outreach workers to stimulate dialogue among families and community groups about sensitive topics such as sexuality, peer and community norms, fears, taboos, and motivations and barriers to testing, returning for test results, knowing your status, sharing the result and living positively with test results.
- Design a SBC strategy that includes messages and materials for religious leaders to help them tell their congregations about the benefits of counseling and testing.
- Develop interactive materials such as videos to help counselors and health workers explain to clients the implications of getting tested for HIV, the window period, what to expect when getting tested, how to cope with a possible positive result and how to change their riskier behaviors.
- Develop checklists and reminder cards to help providers remember what to cover during sessions and how to help clients ask questions and be a part of their own care.
- Design and produce posters, brochures, leaflets, videos and other materials to provide useful information in the clinical setting. Clients can read these materials in the waiting room, discuss them with a provider and take them home for future reference.

### **Possible SBC tactics to help drive the process:**

- Organize and facilitate stakeholder meetings to gather support for the CT center and identify other programs that can support the needs of CT clients.
- In consultation with CT programmers, develop and disseminate media packages to national and local newspapers and other news sources to promote CT.
- Implement a formative assessment of the community and CT center to identify communication strengths, weaknesses and gaps.
- In collaboration with CT programmers, organize and facilitate an SBC strategy workshop with community members, stakeholders and beneficiary populations. The workshop will be used to develop a communication strategy based on the results of the formative assessment. Workshop outcomes will include an SBC theme, messages, channels and materials.
- Train healthcare providers on effective communication approaches to use in their interactions with clients.
- Train peer educators and outreach workers on effective communication approaches to stimulate discussion and learning about HIV, AIDS, CT and other relevant issues.

### ***How Strategic Behavioral Communication Can Strengthen Prevention of Mother-to-Child Transmission (PMTCT)***

SBC can support positive behaviors and promote changes in behavior, knowledge and attitudes for prevention of mother-to-child transmission interventions at the clinic, family, community and policy levels. SBC for PMTCT should be part of a comprehensive framework based on the four PMTCT goals set by the international community:

- Prevention of primary HIV infection
- Prevention of unintended pregnancies among HIV-positive women, and promotion of optimal pregnancy spacing intervals among women who want to become pregnant
- Prevention of HIV transmission from women to their infants
- Provision of treatment, care and support to HIV-positive women, their infants and their families.

SBC practitioners should work with the following four important thematic considerations when developing SBC strategies for PMTCT: 1) PMTCT is not just about mothers—it's about parents, partners, families and communities as well, 2) PMTCT interventions can be effectively linked with existing maternal, child and family survival approaches to make them more easily accepted by communities, 3) a “family-centered” model is important for promoting family support to women receiving PMTCT services and 4) reducing stigma and discrimination, especially at the provider/clinic level, is crucial to increasing uptake of PMTCT services.

Specific objectives for SBC in the context of PMTCT interventions and international PMTCT goals include:

### **Prevention of primary HIV infection**

- Promote community understanding and acceptance of PMTCT services.
- Promote HIV prevention and access to prevention services, particularly among girls and women. Include emphasis on abstinence and be faithful approaches among girls/young women.
- Promote HIV counseling and testing, especially in pregnant women.

### **Prevention of unintended pregnancies among women infected with HIV and guidance for those who want to become pregnant regardless of their HIV status**

- Promote awareness, knowledge and use of family planning services.
- Make available information regarding the benefits to mothers, babies and older siblings of spacing pregnancies at optimal intervals.

### **Prevention of HIV transmission from women to their infants**

- Promote informed decision making for all pregnant women, especially HIV-positive pregnant women, so they can make the best choices to preserve their health and that of their infants. Increase knowledge among pregnant and postpartum women about PMTCT services, including the benefits of antenatal care, HIV testing, antiretroviral therapies, good breastfeeding and alternative infant feeding practices, family planning, disclosing one's HIV status and delivering at a health facility under the care of a skilled birth attendant.
- Help women negotiate realistic behaviors that best suit their situations. Support PMTCT providers and staff to offer quality PMTCT counseling and education.
- Promote disclosure by PMTCT clients/women where safe and appropriate. When it will lead to clear benefits, women should be encouraged to disclose their HIV-positive status to:
  - Health care workers for care and support
  - Families, friends, co-workers, employers and communities for emotional support
  - Partners to prevent further transmission
  - The general public to “put a human face” on the epidemic (education, advocacy, reduction of stigma and discrimination, etc.)
- Promote community understanding and acceptance of PMTCT services.
- Promote reduction of stigma and discrimination against PLHA, particularly women at PMTCT centers.
- Promote access and referrals to related services, including antenatal care, labor and delivery, postpartum, family planning and PLHA support services, including succession planning.

- Support improved policy environment for PMTCT services, including PMTCT protocols for healthcare providers, infant feeding, drug therapies and family planning.

**Provision of treatment, care and support to women infected with HIV, their infants and their families**

- Promote involvement of partners and families to support disclosure of HIV status; support testing, infant feeding and family planning choices.
- Promote access to and use of maternal and child health services including antenatal, labor and delivery, postpartum and family planning services, and referrals for HIV care and support services.

**Channels and activities to achieve above objectives:**

- Comprehensive SBC strategies that are integrated at all levels, including at clinic, community and policy levels
- Strategies to increase demand for quality PMTCT services, including use of mass media, logo creation and promotion, etc.
- Materials to support client-provider interaction. Materials should address PMTCT issues for HIV-positive and -negative pregnant women before, during and after delivery
- Training materials to strengthen outreach workers' and peer educators' capacity to promote understanding and acceptance of PMTCT services at the community level
- Mass media to promote reduction of stigma and discrimination against PLHA, especially PMTCT clients
- Training for healthcare workers to improve their communication skills in the context of client-provider interaction, counseling, etc.
- Materials (posters, brochures, videos, etc.) to increase acceptance and understanding of PMTCT services in clinic waiting rooms and for PMTCT clients to take home to their families
- Materials such as referral guides to increase access to PMTCT services
- Inclusion of PLHA and potential PMTCT clients in every aspect of SBC development and implementation process

## ***How Strategic Behavioral Communication Can Strengthen Sexually Transmitted Infection (STI) Services***

That people with sexually transmitted infections are at increased risk of HIV transmission is well documented. This makes timely detection and treatment of STIs an important HIV prevention strategy.

Even when HIV infection is not a consideration, prevention and treatment of STIs are important since STIs can cause infertility in males and females, ectopic pregnancies, pregnancy loss, and congenital abnormalities and other diseases in infants.

SBC has a long been used in STI treatment and prevention interventions and can help:

### **Increase STI prevention**

- Identify the barriers and motivating factors driving risky behaviors such as unprotected sex with someone who may have an STI. These may include existing beliefs, cultural traditions, lack of knowledge, perceived lack of opportunities to protect oneself, etc.
- Identify motivating factors that may encourage members of beneficiary populations to adopt preventive behaviors to avoid contracting an STI.
- Identify barriers and motivations for seeking treatment and improving uptake.
- Promote safer behaviors such as abstinence, mutual fidelity, reduction of partners, and correct and consistent condom use.
- Package the benefits of preventive behaviors for the beneficiary populations in an appealing and convincing way that resonates with their belief system.
- Providing accurate and correct information on STI transmission to minimize myths.
- Develop easy and compelling explanations of asymptomatic STIs and the long-term effects of untreated STIs.
- Develop effective methods of explaining and promoting regular checkups for sex workers.
- Identify gaps in the beneficiary population's verbal, negotiation and other skills needed to adopt the desired behaviors (such as communicating to partners without damaging the relationship, the need to test for and treat STIs and the need to use protection to avoid re-infection).

### **Increase STI treatment-seeking behavior**

- Educate audiences at risk of infection about the major symptoms of STIs so that they can identify symptoms in themselves and in potential partners. This will encourage people to seek immediate treatment, to use protection and to refer their partners for services.
- Develop messages for PLHA on the importance of preventing STIs to avoid further weakening of the immune system and to keep from infecting others with HIV.

**Channels and activities:**

- Formative assessment findings can be used to develop healthcare provider trainings to improve client/provider communication during STI testing and treatment, and to develop the necessary materials (flipcharts, cue cards and posters) to support the client/provider interaction.
- Participatory formative assessments can help identify materials and signage that can be used at STI clinics to avoid stigmatizing clients and to secure confidentiality. Materials can include posters, leaflets, brochures and cards displayed in waiting rooms and doctor's offices and available for clients to take home.
- Interpersonal communication, such as word-of-mouth referrals and peer education efforts supported by the necessary materials, can also be used.

**Promote adherence to STI treatment regimen**

- Through formative assessment, identify and analyze the internal and external barriers to completing STI treatment, including misconceptions about how treatment works.
- Design SBC interventions to manage barriers to treatment and enhance the self-confidence required to seek, accept and complete STI treatment.

**Channels and activities:**

- Interpersonal communication: Peer education, support groups and counseling
- Clinic site: Take-home materials addressing the importance of treatment adherence, especially for multiple-dose medication
- For family members of those at risk of STIs: Materials that address the need for family support and the negotiation skills needed to encourage partners to seek testing and treatment
- Clinic site and home visits: Materials and interpersonal communications (IPC) addressing PLHA's specific needs for preventing, detecting and treating STIs

***How Strategic Behavioral Communication Can Improve Antiretroviral Therapy (ART) Services***

SBC can provide important support to antiretroviral therapy services and clients. SBC can strengthen the quality of client/provider interactions and support clients' adherence to ART. SBC can support access to ART and related services by strengthening referral networks and can create a supportive environment for ART at the family, community and policy levels. SBC practitioners develop and implement SBC strategies for ART in close collaboration with providers, administrators, target populations, PLHA and other stakeholders to ensure that ART services respond effectively to local needs.

**Specific SBC objectives for ART services include:**

- Improve adherence to treatment regimens so that clients receive the full benefits of treatment and avoid developing drug-resistant strains of HIV.

- Increase awareness that antiretroviral drugs have made HIV a chronic condition. SBC strategies can address the challenges faced by ART clients, such as maintaining awareness of correct dosages and combating becoming tired of adhering to a life-long drug regimen.
- Include PLHA in every aspect of developing SBC strategies for ART services.
- Promote clients' participation in their own care and life choices.
- Help clients understand and cope with drug side effects.
- Create an enabling environment for ART clients at the family and community levels to ensure ART adherence, promote reduction of stigma and discrimination, and dispel myths, fears and misconceptions about ART and AIDS.
- Increase understanding of and demand for ART services as needed, while remembering that antiretrovirals are not appropriate at all stages of illness.
- Promote partner, family and community discussion of ART services.
- Promote referrals to related services.
- Promote improved legislation and commitment to ART at the policy level.
- Promote early detection and treatment of OIs as supportive of healthy attitudes and behaviors among potential ART clients.

### **Channels and activities:**

SBC programs deliver the best results when they are comprehensive and employ a mix of channels to ensure that beneficiary populations are exposed to consistent messages in multiple settings. Specific channels and activities for supporting ART and creating an enabling environment for clients include:

- Materials to support client/provider interactions at the clinic level (cue cards, wall charts and flipcharts such as Kenya's *Provider Guide to Communicating with Your Patients about ART*)
- Materials (print, video, etc.) to increase client understanding of ART in clinic waiting rooms
- Activities that engage PLHA groups, FBOs, youth groups and other community groups in supporting ART services and PLHA in general
- Promotion of food access for ART clients
- Promotion of increased ART knowledge in schools and universities (one-third of African PLHA are 15 to 24 years old)
- Take-home materials (leaflets and brochures) for newly diagnosed patients AND their partners/families that explain ART and its benefits, nutrition, OIs, side effects, the need for exercise and rest, prevention of re-infection, emotional well-being and treatment adherence
- Training guides and interpersonal materials to strengthen support groups for PLHA and their families
- Community outreach and peer education by nongovernmental and faith-based organizations, and materials to support these interventions

- Provider in-service and pre-service training curricula
- Referral guides to improve access to ART and related services, including PMTCT, VCT and STI services
- Workplace programs that include ART or provide referrals to ART services
- Manager's guide to working with employees who are HIV-positive and on ART
- Talking points and messages addressing stigma and discrimination for support groups for families of ART patients

### ***How Strategic Behavioral Communication Can Strengthen Tuberculosis (TB) and Opportunistic Infection (OI) Services***

SBC is vital to opportunistic infection (OI) and tuberculosis (TB) services. SBC can stimulate learning, awareness and communication between the provider and patient that leads to compassionate care, health-seeking behavior and adherence to drugs. SBC can help both providers and PLHA prevent, recognize and treat OIs and TB. Preventing OIs and TB and seeking appropriate treatment for them greatly impacts a PLHA's quality of life, and SBC can help in this process.

SBC can help providers communicate in a clear, compassionate and concise manner to effectively relay OI and TB prevention and treatment adherence information to their patients. SBC can also help providers give non-stigmatizing care. SBC also can help providers work together with their patients to design OI and TB treatment strategies that the patients can adhere to.

A unique communication issue for OI and TB services is that most clients do not know their HIV status; therefore, communication interventions need to clarify the facts about OIs and TB without further stigmatizing HIV-positive people. A simple recommendation to see their primary care provider if they experience particular symptoms could help PLHA seek and adhere to OI and TB treatment. This health seeking behavior may motivate people to find out their HIV status. SBC can help communities, caregivers, stakeholders, providers and PLHA understand the many issues surrounding opportunistic infections.

#### **Why is tuberculosis a unique opportunistic infection?**

Tuberculosis, a primary opportunistic infection, has its own unique communication issues not only due to the number of PLHA who are infected with TB, but also because of its severity. Tuberculosis can be deadly to PLHA. If the disease is not treated properly, patients can become drug resistant and difficult to treat. In addition, tuberculosis is highly contagious, so having PLHA seek treatment is both an individual and public health concern. Because these characteristics separate TB from other OIs, SBC usually presents, discusses and designs materials focused on TB alone. Singling out TB issues makes them clearer to the intended audiences.

#### **SBC for opportunistic infections can:**

- Promote and raise awareness of OI and TB prevention, symptoms and treatment within the community and with homecare providers in a sensitive manner.

- Provide guidelines for healthcare providers on how to communicate information and appropriate treatments strategies to patients.
- Identify communication opportunities in the clinical setting.
- Advocate to national and local politicians and stakeholders on supporting policies, guidelines and standard operating procedures for OI and TB treatment.
- Mobilize communities to create additional services and/or strengthen existing services to link and support OI and TB service networks.
- Provide a supportive environment to community members to motivate them to seek and adhere to OI and TB treatment.
- Work to improve client/provider interactions to help make clinical experience positive so that the community respects, trusts and promotes services to others.
- Enhance PLHA's understanding of OI and TB issues to empower them to be actively involved in their care.

### **Channels and activities:**

- Implement a strong mass media intervention that promotes early health seeking behavior, OI and TB treatment, and treatment adherence.
- Have peer educators and outreach workers visit families and community groups to stimulate dialogue about what OIs and TB are, common symptoms, the importance of seeing a doctor, appropriate treatment, adherence to treatment and empowering patients to ask questions about their diagnosis and care.
- Communicate to PLHA the importance of healthy living (diet, moderate exercise, sleep, avoiding smoking and alcohol, hygiene, clean water, cleanliness when preparing food, animal care, and safe sex) to preventing OIs and TB. This can be done through interpersonal communication channels such as peer education and patient/provider interactions.
- Develop interactive materials, such as videos, to help providers explain diagnosis, treatment and care strategies to patients in a stigma-free, uncomplicated manner.
- Develop checklists and reminder cards to help providers cover and clarify potentially complicated treatments with their patients.
- Facilitate interactive sessions inside and outside of the clinic or hospital using role plays, demonstrations and guest speakers to raise awareness, knowledge, health seeking behavior and treatment adherence.
- Design and produce posters, brochures, leaflets, videos, etc. to provide useful information in the clinical setting. These materials can be read in the waiting room, discussed with a provider and taken home for future reference.

### **Possible SBC tactics to help drive the process:**

- Organize and facilitate stakeholder meetings to gather support for OI clinics and to identify other programs that can support client needs.

- Develop and disseminate media packages promoting OI clinics to national and local newspapers and other news sources.
- Implement a formative assessment of the community and the OI clinic to identify communication strengths, weaknesses and gaps.
- Organize and facilitate a SBC strategy workshop with community members, stakeholders and beneficiary populations to develop a communication strategy based on formative assessment results.
- Train healthcare providers on effective communication approaches to use in their client interactions.
- Work with clinic staff on how they can facilitate patient learning.
- Train peer educators and outreach workers on effective communication approaches to stimulate discussion and learning about OIs, including prevention, health seeking behavior and appropriate treatment.

### ***How Strategic Behavioral Communication Can Strengthen Home-Based Care (HBC) Services***

Home-based care is an essential component of FHI's comprehensive care and support strategy. Effective HBC programs rely on communities and individuals adopting new attitudes and behaviors towards PLHA and people affected by HIV/AIDS and the provision of quality care, treatment and support services in the home environment. Strategic behavioral communication (SBC) is an integral component of HBC programs.

When incorporated into HBC programs, SBC can help accomplish the following key goals:

#### *1) Empower PLHA to demand and access essential services, including HBC*

SBC interventions can help PLHA demand their rights. Strengthening PLHA support groups (through capacity development workshops, treatment education training, materials development, etc.) and providing information and linkages to other services (e.g. ART, OIs, palliative care, HBC, etc.) helps PLHA and their families demand and access quality services.

#### *2) Increase support for and promotion of sustainable HBC programs among policy makers and stakeholders*

Sensitizing and mobilizing ministries of health, governments and partners to articulate and promote policy guidelines and minimum standards of care for HBC programs is crucial to HBC sustainability. SBC interventions and programs tailored to policy makers and stakeholders can help increase awareness of the benefits of and basic needs for HBC services.

Illustrative examples of SBC interventions include:

- Conduct formative assessments of the beneficiary populations to identify barriers to and motivation for adopting desired behaviors, and help present these findings to policy makers in a convincing way.

- Developing handbooks, training curricula, posters and brochures for policy-makers to sensitize and motivate them to make changes.
- Conduct sensitization and training workshops for policymakers to address HBC and help them mainstream it into other policies and programs.
- Disseminate new policies to beneficiary populations once a policy change has been made.

All of these interventions will be carried out in close collaboration with HBC experts.

### *3) Reduce stigma and discrimination against PLHA and people affected by HIV/AIDS*

Combating stigma and discrimination against PLHA and their families at household, community, institutional and national levels is essential for the sustainability of HBC and for positive living within communities.

Targeted SBC interventions and programs can help reduce myths and misconceptions about HIV/AIDS and increase support for PLHA rights. Examples include anti-stigma campaigns and demand creation for palliative care.

Involving PLHA in all phases of program development and giving them active roles (as managers, technical staff, counselors, etc.) in the implementation of interventions is also essential to the battle against stigma and discrimination.

### *4) Support creation of an enabling environment for HBC*

SBC can help create an enabling environment for HBC services and strengthen partnerships with support organizations and care programs to ensure a continuum of medical, psychological, social and legal care and support for PLHA and their families. SBC can help achieve these goals through interventions and channels that educate people about HIV/AIDS and other illnesses prevalent in their communities.

Examples of interventions include:

- Community-based activities (e.g. anti-stigma campaigns, community events, debates, theater) to create awareness and mobilize communities to care for and support PLHA and their families
- Multi-disciplinary and/or combined technical approaches that include technical experts from several areas and building capacity of PLHA support groups

### *5) Support and build capacity of caregivers*

The home-based caregivers of PLHA and people affected by HIV/AIDS are usually women and, increasingly, young people and children. Most are expected to provide full nursing care for bed-bound, often terminally ill people, adherence support for people on ART or TB treatment and management of clinical situations in the home. At best caregivers have received a few weeks of training; the luckiest receive some supervision from a professional. Caregivers are also expected to be volunteers and to provide substantial amounts of care over a sustained period of time without any

assistance. A few may receive some token support, usually basic essential supplies such as gloves, cotton and gauze, but they receive no real incentive to sustain their support behaviors.

HBC programs need to provide ongoing and extensive training on caring for ill family members and friends, on self-care for well and ill clients, and, mostly importantly, on self-care for caregivers. Mass awareness-raising campaigns on providing caregivers with salaries, materials, professional and clinical supervision, and relief or respite mechanisms are also needed.

SBC can help facilitate caregiver training sessions conducted by HBC clinicians and trainers by providing training materials to educate caregivers, PLHA and their families in basic treatment and care of PLHA in the home setting, and by strengthening the communication skills of trainees. Developing pictorial or low-literate support materials in local languages is also important given that caregivers are often illiterate or semi-literate.

### **Possible SBC tactics to help drive the process:**

- Hold individual, group or community interpersonal sessions at schools, community gatherings, faith-based meetings, community celebrations, the marketplace, the workplace or anywhere community members are present to increase awareness of HIV/AIDS and support of PLHA. These sessions will be carried out by SBC practitioners in collaboration with skilled and trained counselors or nurses and other community health workers.
- Use community-based activities (anti-stigma campaigns, community events, debates, theater, etc.) to mobilize communities to care for and support PLHA and people affected by HIV/AIDS.
- Hold combined training sessions with HBC clinical experts and SBC specialists for all members of the HBC team/care-givers.
- Use mass media to educate the public about HIV/AIDS stigma and discrimination, home care and how to support ill people and families at home. It can also be used to highlight the problems of children affected by and infected with HIV.
- Provide communication support to advocacy interventions such as developing briefs and information kits for policymakers.
- Develop contextualized tools and materials that support or complement training and education activities and that provide guidance on topics in the prevention, care and support continuum (such as drug adherence, HIV prevention for patients and family members, condom promotion and distribution, referrals to CT for family members and to PMTCT services for pregnant women, STI management and universal precautions in the home).

### ***How Strategic Behavioral Communication Can Strengthen Programs for Orphans and Vulnerable Children (OVC)***

SBC can support the maintenance of positive behaviors and promote behavior change within the extensive range of strategies that fall under programs for orphans and vulnerable children. SBC can be particularly useful to OVC programs by bringing behavioral analysis to the development of strategies, activities, messages and materials that best suit specific populations. These populations can include children themselves, as well as various secondary populations on whom children rely, such as parents, caregivers, teachers and community leaders. Policy makers and the media can also

be considered for dissemination of certain key messages given the large scale of orphaning in some countries.

**SBC Guiding principles for OVC include:**

- Inserting the SBC strategy at the beginning of program planning is the best approach to developing SBC for OVC programs.
- SBC should never use terms like “AIDS orphans” that contribute to stigmatizing children. In addition to singling out children, this term contributes to the myth that the majority of children orphaned by AIDS are HIV-positive.
- The term “OVC” is a programming acronym and should not be used in communication products. Preferred terms include the full “orphans and other vulnerable children” or simply saying “children” whenever possible. “Vulnerable children,” “most vulnerable children” and “children affected by HIV and AIDS” may also be appropriate depending on the context.
- OVC programs are based on the premise that families and communities are already doing much to support OVC. They are the “first line of response” to the epidemic and should be supported to do more. SBC strategies and messages should support family- and community-driven responses to OVC needs.
- SBC for OVC should address how gender differences impact children.

**SBC strategies for children affected by HIV/AIDS:**

- Promote support for children and their families before children are orphaned. Children are affected by HIV and AIDS from the time a parent tests positive or falls ill. Involve families in programs that support disclosure between parent and child and promote preventive health care.
- Promote material support for all vulnerable children. Children should not be singled out for material support. Providing support to one child within a family is unrealistic as resources are generally shared. Providing resources only to children affected by AIDS within a vulnerable community causes further resentment and stigma against AIDS-affected children.
- Promote children’s basic rights. Children’s basic human rights are defined by the Convention on the Rights of the Child and include the right to schooling, shelter and health care. Children affected by HIV/AIDS may be denied these basic rights for financial reasons or due to discriminatory practices like denying HIV-positive children schooling. Depending on local gaps, strategies can communicate the need to remove barriers to accessing essential services such as universal primary education.
- Promote permanency planning. Because research shows that institutional settings negatively impact a child’s development, every effort should be made to place orphaned children in families rather than institutions.
- Promote increased child protection. Protection against child abuse, including sexual abuse and exploitation, is a key tenet of the President’s Emergency Plan for AIDS Relief and contributes to prevention and mitigation goals. Orphaned children may be at higher risk for sexual exploitation. Strategies can communicate where to find child protection services as well as how to identify and refer possible instances of abuse.

### **SBC strategies for children living with HIV and AIDS:**

- Promote reduction of stigma and discrimination against children living with HIV. They are not a risk to other children and should be welcomed at school and in other public places.
- Promote children's rights to access to the most effective medicines available. With appropriate treatment, children with HIV can live into adulthood.

### **Channels and activities:**

- A rich body of materials have been developed to support interpersonal approaches and community mobilization in OVC programs. SBC practitioners should collaborate with OVC practitioners to integrate existing materials with other approaches (mass media, for example) as appropriate.
- Strategies and materials to encourage care for children
- Information about basic services, nutrition, ART services, adherence to ART and other medications, immunizations, tuition waivers, legal assistance, food programs, etc.
- Communication support to advocacy and social mobilization interventions
- Background materials and information kits for policymakers and mass media to promote universal primary education or to remove barriers to getting birth certificates
- Strategies and materials to educate specific audiences (teachers, faith-based leaders and the business community) about how they can help support families and OVC

### **Conclusion**

SBC is the communication component of any behavior change strategy designed to promote, stimulate and support specific behavior modification, change or maintenance. Developing strategic behavioral communication interventions is an interactive process with individuals, communities and stakeholders working to create structured activities and tailored messages using a variety of communication channels.

The SBC framework is based on the following tenets:

- FHI's interventions are aimed at preventing the spread of HIV, providing treatment as appropriate, and helping mitigate impact on PLHA and OVC.
- Most interventions have a behavioral component that SBC can support.
- The behavioral component contributes to understanding why people behave the way they do.
- Behaviors are shaped by internal and external determinants.
- Addressing these determinants and diminishing their impact increases the likelihood that behaviors will be modified and healthier behaviors will be adopted and sustained.
- The strategies most commonly used by FHI are SBC, advocacy, community mobilization, social marketing (through other partners) and social mobilization. The different strategies address behavioral determinants at various levels and have both shared and unique objectives.
- Each strategy has its own implementation methodology.
- SBC plays a distinct role in current HIV prevention, care, treatment and support programs (CT, PMTCT, ART, STI, TB and OI, HBC and OVC ).





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