Module 1 Unit 4

This is a **OPTIONAL READING.**

McKee, N., Becker-Benton, A., and Bockh, E. (2014). Social and Behavior Change Communication. In K.G. Wilkins, T. Tufte and R. Obregon (Eds.). The Handbook of Development Communication and Social Change. Hoboken, NJ: John Wiley & Sons. pp. 278-297 [19].

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Social and Behavior Change Communication

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This chapter documents the experience of the Communication for Change (C-Change) project[1] in developing and rolling out a holistic and comprehensive socioecological approach to social and behavior change communication (SBCC) within the context of a donor-funded program with short term goals. The project documentation and statistics are derived from C-Change records and other experiences.[2]

One of C-Change's mandates was to combine principles of social change and behavior change communication (BCC) and operationalize them for capacity strengthening (CS) of NGOs, ministries, and USAID missions for work across development sectors. While BCC has its origins in the dominant medical model of public health and often uses communication to persuade individuals to adopt healthier behaviors and lifestyles (Green and Tones 2010), social change communication is influenced by the social sciences' focus on social determinants or enablers of change. According to social change communication principles, SBCC should be empowering and horizontal; encourage communities to be agents of their own change; promote dialogue, debate, and negotiation (as compared to information and persuasion techniques); emphasize the process of interactions, shared knowledge, and collective action (rather than a sender–receiver model); and focus – beyond but to include individual behaviors – on social norm change, policies, and culture to unfold sustainable change in communities and among individuals (Figueroa *et al.* 2002).

While some of these principles were recently integrated into more sophisticated BCC strategies and products, C-Change's gap analysis showed individual behavior change continued to be the default and final goal of most communication efforts. In fact, various BCC concepts and strategies acknowledge the importance of

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social determinants of change but underestimate how shaped, sanctioned, and ingrained individual actions are within the fabric of community norms and governing structures.

Triggered by the lack of sustained progress in changing individual risk behaviors in HIV transmission there has been a shift in how many researchers and programmers think about human behaviors.[3] As noted by Glass and McAtee, "the study of health behavior in isolation from the broader social and environmental context is incomplete, and has contributed to disappointing results from experiments in behavior change" (2006: 1664). Without ignoring the science of individual change measurement, this includes a gradual move away from the strict medical model, which tends to view risk as responsibility of the individual, toward emphasis on sustainable, social, and structural change (Green and Tones 2010).

This change has long been demanded by development and social change communication practitioners, and health promotion planners (FAO 2011; Servaes 2008). The principles and values of recent health promotion approaches, for example, provide guidance for the practice of SBCC: they include a socioecological perspective on health and development; taking into account the social, cultural, and economic determinants of change; a respect for cultural diversity and sensitivity; a dedication to social justice and sustainable development; and a participatory approach to engaging intended audiences in identifying needs, setting priorities, and planning, implementing, and evaluating practical and feasible health and development solutions using effective communication to address those needs (Fertman and Allensworth 2010).

Beginning in 2009 and based on the above thinking, the C-Change project developed a framework for SBCC and a comprehensive CS toolkit, including a set of six training modules for SBCC as part of a comprehensive capacity building strategy. These C-Modules were given open source website status and have been downloaded in part or in whole over 25,000 times by various users worldwide, at the time of writing. In addition, in late 2010 the C-Modules were adapted for online courses in SBCC on Ohio University's website platform. With support from C-Change, SBCC courses were also established in the University of the Witwatersrand, South Africa; Del Valle University, Guatemala; Tirana University, Albania; and two universities in Nigeria, University of Calabar and Cross River State University of Technology.

Theoretical Basis of the C-Change Framework

C-Change's SBCC framework uses a socioecological model for change (see Figure 17.3 later in this chapter). This model views social and behavior change as a product of multiple, overlapping levels of influence as well as political and environmental factors (Sallis, Owen, and Fisher 2008). By using this larger ecological perspective to understand change processes, theories and models from

Table 17.1 Change: process and targets

Level of change	*Change process*	*Targets of change*
Individual	Psychological	Personal behaviors
Interpersonal	Psychosocial	How the person interacts with his or her social network
Community/social	Sociocultural	Dominant norms at community and societal levels

Source: Adapted from McKee *et al.* (2000).

various disciplines come into play. Theories and models address human behaviors on one of three possible levels of change: individual, interpersonal, or community/social. The change process and the targets of change (Table 17.1) show which related discipline best describes these levels: psychology, sociology, anthropology, political science, and media studies, to just name a few.

By looking at theories and models, practitioners can begin to understand or further reinforce "what, why, and how health problems should be addressed" (Glanz, Rimer, and Su 2005). Theories and models are essential for program planning because they identify and make clear the assumptions behind the development of interventions and strategies. They can help to formulate communication objectives for programs and determine how to measure them, as well as clarify the reasons why programs succeed or fail (McKee *et al.* 2000).

As noted earlier, over the years, there has been a shift in thinking about human behavior. In addition, theories developed for application in industrialized countries have seldom been sufficient in trying to understand and predict behavior and social change in developing countries. While cognitive behavioral models may be able to explain the links between intention and behavior, particularly at an intrapersonal level, they are less able to account for interpersonal and contextual factors related to the complexity of sexual behavior, such as the experience of youth and disparities in social, cultural, and economic realities in sub-Saharan Africa (Michielsen *et al.* 2012).

More recently, many of the dominant theories are viewed as "out of context" since they are embedded in very different psychological and social dynamics. Development communication practitioners now acknowledge four key facts about human behavior:

1. People give meaning to information based on the context in which they live.
2. Culture and networks influence people's behavior.
3. People can't always control the issues that determine their behavior.
4. People's decisions about health and well-being compete with other priorities.

Below are some selected theories for each level of change that go beyond the usually mentioned theories and that can help practitioners start thinking about how theory can assist their communication work (C-Change 2012).

Individual level

While not a new model, the "health belief model" helps to find out why audience's perceptions are not in favor of change (e.g., buying and using an insecticide-treated mosquito bed net) in the search for tipping points for change. According to the model, beliefs about certain issues can be predictors of behaviors (Glanz, Rimer, and Su 2005). The model explores:

- perceptions about the possibility of acquiring a health problem (such as malaria);
- perceptions about the risk or vulnerability to the disease (e.g., perceptions about the severity of malaria);
- perceptions about the effectiveness of taking preventive action (e.g., the use of nets);
- perceptions about barriers or costs associated with taking action (e.g., the cost of buying nets);
- perceptions of one's ability to use it (e.g., self-efficacy to use the net regularly).

Interpersonal level: Theory of gender and power

In any society, members face constraints and barriers, many of which are gender specific (Connel 1987). Understanding the relationship between power and gender is crucial for planning interventions to address issues of gender-related inequality and to identify barriers. 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, any communication intervention/activity design should consider how gender and power relations may affect participation (do women have time or need permission to attend?) and 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?).

Community/social level: Culture-centered and positive deviance approaches

A major concept included in the culture-centered approach is the idea that traditional cultural beliefs do not need to be perceived as barriers to social change. Instead, they can be viewed as assets and resources to be harnessed in change efforts. Along similar lines, the "positive deviance approach" begins with the idea that the solution to existing challenges most likely already exists within the community. In other words, in any given community, there are often individuals and/or families that deviate from the norm in a positive way. For example, if a village has a 95% malnutrition rate for children under the age of five, a Positive Deviance Approach would begin with the 5% that are *not* malnourished and

attempt to identify promising practices that can be used by the entire community. However, if an individual or family (positive deviant) has access to additional resources (like extra farm land) then that solution is not applicable to the community – only practices that can be replicated by *all* in the community are selected and incorporated into programs. In the positive deviance approach, the deviating community members are the experts and it is they (not an external expert) who are called upon to share their successful practices with other community members.

The socioecological model has synthesized the concepts of the above and other models and theories in the "cross-cutting" factors as seen in Figure 17.1. It demonstrates how different theories and models contributed to and were synthesized into each ring of this model. The intention of demonstrating the potential connection with so many theories is largely educational rather than research based. This is because no single theory has proven sufficient to explain

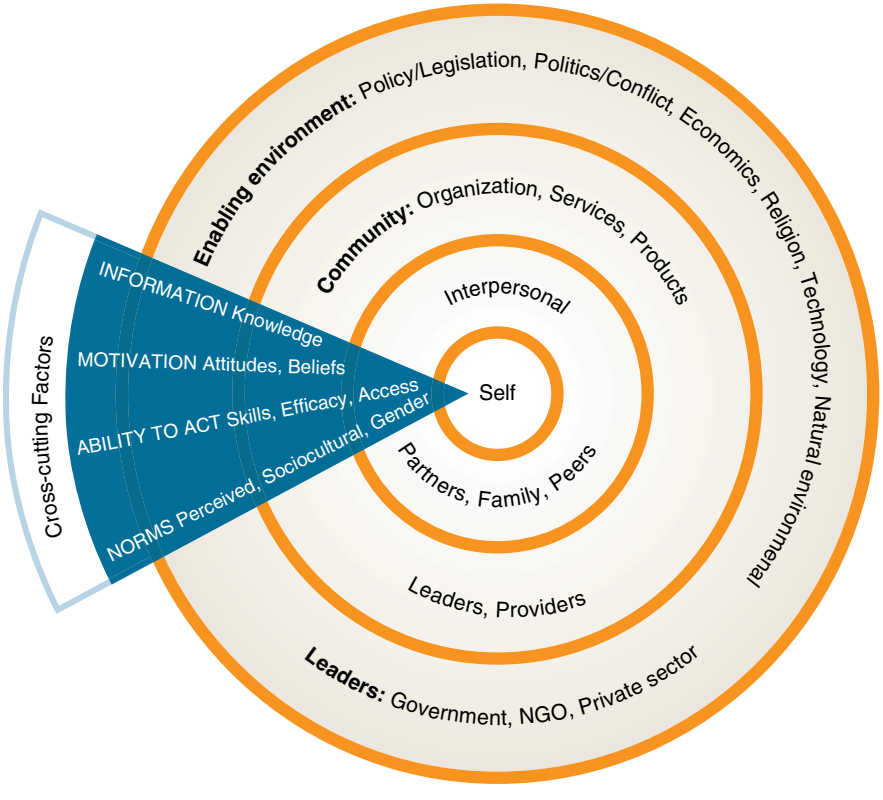

Figure 17.1 Socioecological model for change.
Source: Adapted from McKee, Manoncourt, Chin, and Carnegie (2000). C-Change Project, 2011.

human behavior change or social change in development contexts. C-Change has had experience in exposing training participants to these concepts and helping them to back up their own "theory of change" thinking with critical questions related to relevant theories and models for particular applications.

SBCC Framework: Three Characteristics

According to C-Change's framework, SBCC comprises the systematic application of interactive, theory-based, and research-driven communication processes and strategies to address *tipping points* for change at the individual, community, and social levels. Instead of individual behavior change as a default, the SBCC framework requires a socioecological analysis to find *tipping points* at various levels. A *tipping point* in this sense refers to the dynamics of social change, where small, sometimes unpredictable changes rapidly accelerate change and may become permanent change. They can be naturally occurring events or something which is determined or researched and planned such as "political will" by senior leadership that provides the final push to "tip over" barriers to change. *Tipping points* may entail processes that build momentum to a point where change gains strength and becomes unstoppable.

While addressing individual behavior can achieve individual empowerment, and may address perceptions of the behavior of others (perceived social norms), SBCC involves processes of looking at a problem from multiple sides by analyzing individual, societal, and environmental factors to identify and address barriers to change. These are often found in social norms embedded in policy, legislation, cultural identity, and group behaviors and pressures. Addressing them is anticipated to lead to more sustainable change.

The three characteristics of SBCC are described below.

1. SBCC is a process

It is an interactive, researched, planned, strategic process with the aim to change social conditions and individual behaviors. C-Change's model follows well-known steps in applied communication (see Figure 17.2). Many communication planning models have been developed over the past 30 or more years. C-Planning is derived from many of these, as referenced below. However, it should be noted that within the first step, "Understanding the Situation," the creators of the model emphasize more than formative research on knowledge, attitudes, and practices but more attention to barriers and facilitators of change as well as their indirect and underlying causes. It also includes looking at key players at the community, service providers, district and higher levels, including national or international. Hence, as

Figure 17.2 C-Planning: principles, competencies, and planning tools.
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. C-Change Project, 2011.

indicated in Figure 17.2, there is a strong relationship between step one of C-Planning and the socioecological model.

The second substantial difference in C-Planning is the attention on "Focusing and Designing" (step 2) and "Creating" (step 3). While many frameworks include communication strategy formats requesting individual behavioral objectives, they tend to do so without requesting sufficient analysis. An immediate focus on behavior change tends to be prescribed from budgetary or bureaucratic considerations rather than on evidence and true involvement of audiences in having a say in what is needed to induce positive change.

2. SBCC uses a socioecological model for change

A socioecological approach to understanding the situation is essential to arrive at barriers and opportunities for social and behavior change, as well as to design strategies that will accelerate change in the long run. C-Change's socioecological model (see Figure 17.3) is derived from earlier writing on participatory methods for behavior change (McKee *et al.*, 2000).

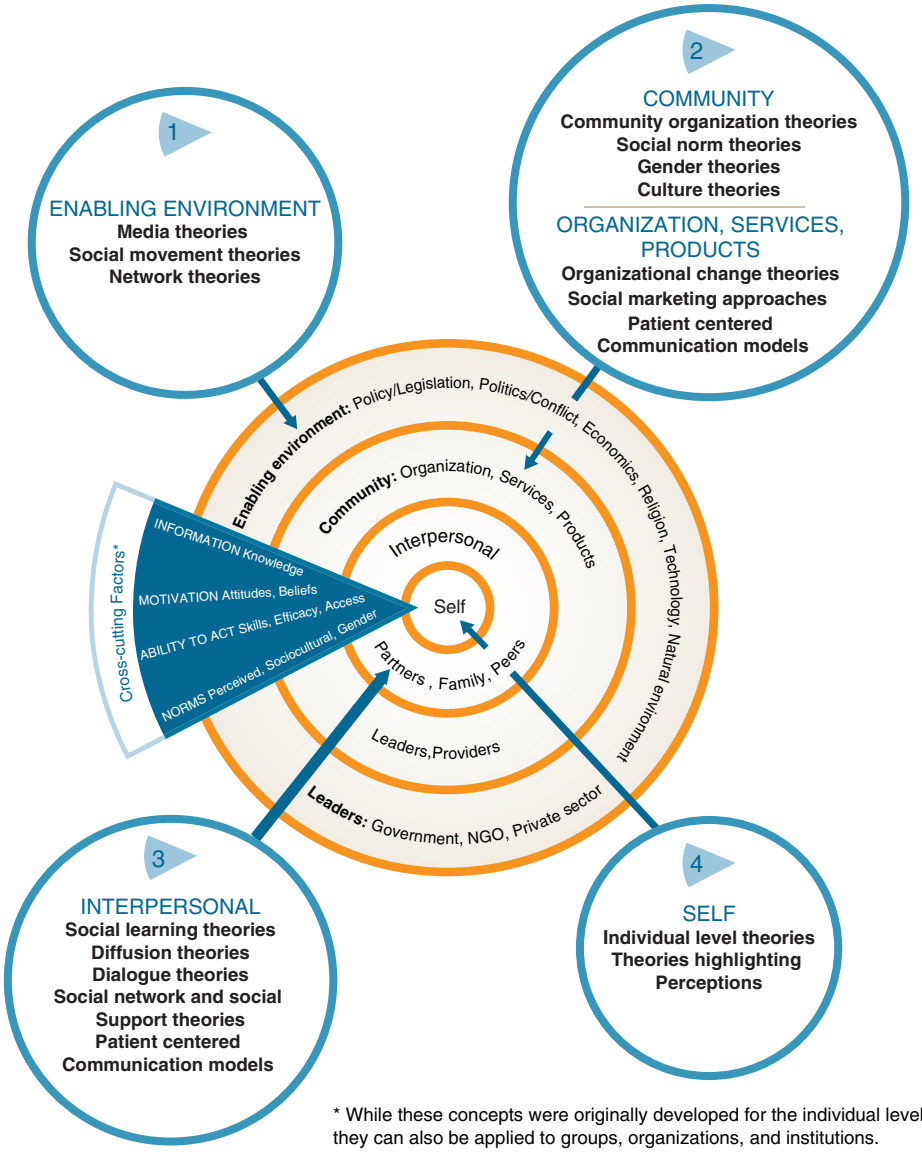

Figure 17.3 Theoretical base for the socioecological model.
Source: Adapted from McKee, Manoncourt, Chin, and Carnegie (2000). C-Change Project, 2011.

This model, used in both analysis and planning, applies core concepts central to most ecological models, such as environmental determinants, community capacity, and the relationship between individuals and their social context (Richard, Gauvin, and Rain 2011). In addition, it offers a practical way to analyze barriers and opportunities, sources of influence, and potential audiences, partners,

and allies from national to community, family, and individual levels based on a variety of SBCC theories and models.

Models and theories are essential in guiding SBCC, providing methods for studying and addressing development issues. C-Change's socioecological model for change is based on existing theories, models, and approaches from several disciplines, including political science, sociology, psychology, and communication. Through a synthesis of the information included in these theories and approaches, the socioecological model proposes several levels of influence to find effective tipping points for change. The model has two parts:

1. *Levels of analysis*, the rings of the model represent both domains of influence as well as the people involved in each level. The innermost ring represents the individual most affected by the issue (self) and moves outwards to direct influences on the individual (two inner rings). Both the interpersonal and community rings shape community and gender norms, access to and demand for community resources, and existing services. Indirect influencers make up the outer enabling environment.
2. *Cross-cutting factors* in the triangle influence each of the actors and structures in the rings. These include the larger categories of Information, Motivation, Ability to Act, and Norms. By affecting these cross-cutting factors SBCC interventions may be able to generate change. They may act in isolation or in combination.
    - People need information that is timely, accessible, and relevant. For most people, information is not enough to prompt change.
    - People require motivation, which is often determined by their attitudes, beliefs, or perceptions of the benefits, risks, or seriousness of the issues that programs are trying to change. Practitioners should also look at the actual skills, self-efficacy (or collective efficacy), and access of the actors as motivation may not be enough. For instance, few women and girls in the countries hardest hit by HIV and AIDS have the power to negotiate the time and conditions for having sex, including condom use, or they may lack the funds to buy condoms. Note that: (1) skills include psychosocial life skills;[4] (2) self-efficacy is concerned with the confidence of individuals and groups (collective efficacy[5]) in their own skills to affect change; and (3) access includes financial, geographical, or transport issues that affect access to services and ability to buy products.
    - Finally, norms have considerable influence on behaviors and vice versa (Mollen, Rimal and Lapinski 2010). Norms reflect the values of the group and/or society at large and social expectations about behavior. Practitioners distinguish perceived norms (those that an individual believes others are holding), sociocultural norms (those that the community as a whole follows) and gender norms (views of expected behaviors of males and females).

SBCC operates through three key strategies

The ecological approach requires that SBCC works through *three key strategies*: advocacy for policy change and resource mobilization; social mobilization (including community mobilization) for involvement of a broader coalition and capacity strengthening of partners and allies from the international to the community level; and BCC, using interpersonal, group approaches, mass media, and new information technologies for specific behavior and social norm changes. These three strategies, essential for sustained behavior and social change, are visualized in Figure 17.4.

Definitions of these key strategies are helpful for full understanding of SBCC. Very often, projects only focus on BCC, attempting to change individual behaviors without addressing, for example, the demand for more accessible and friendly service delivery through advocacy. It is not essential or even realistic that any one project or entity leads all three strategies as they can engage partner and allies who are already doing it. However, SBCC should always be linked to services or to products that people can access. If these are not in place, SBCC efforts remain toothless, and communication activities may not have significant impact.

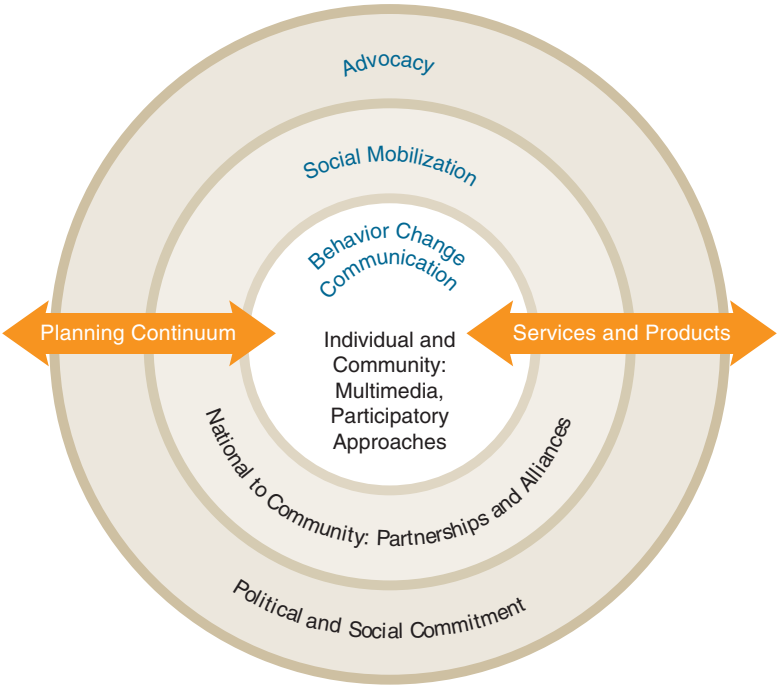

Figure 17.4 Three key strategies of social behavior change communication.
Source: Adapted from McKee (1992). C-Change Project, 2011.

Both advocacy and mobilization strategies tend to use communication techniques to reach their goals. Practitioners do not always apply strategic communication principles to this type of work, which could make interventions more effective. For example, techniques used under social and community mobilization include publicity, public discussions, dissemination of information using mass and community media, and training/coordination of stakeholders.

While social mobilization may often take place at a national level among civil society organizations, donors, and parts of government to build coalitions for certain issues, community mobilization can do the same at a community level with similar techniques. Practitioners can begin with any one of the three strategies (represented by the left arrow in Figure 17.4), depending on such factors as:

- the problem being addressed;
- the policies in place to deal with it;
- the organization(s) and resources already engaged in addressing the problem.

For example, if leadership isn't ready for advocacy on a certain issue, a program might concentrate instead on building a critical mass of a social network or coalition that can put pressure on leadership through a well-defined social mobilization strategy. Or, if resources allow, consideration could be given to working with the community on a broad-scale BCC effort linked with a mass media intervention to set the public agenda. This could eventually affect leaders' perspectives and engage them and others in a social movement.

In South Africa throughout the 1990s, for example, there was very little recognition of the impact HIV had on the country or the rights of people living with HIV and AIDS to care and treatment. In fact, there was a lack of political will and this caused government inaction well into the new century. Concerted advocacy by the South African Treatment Action Campaign (TAC) was one of the factors that changed the situation. After gaining assurances from the government on treatment provision, TAC utilized social mobilization strategies to pressure the government to follow through on its promises (see www.tac.org.za).

Experiences in Applying SBCC Approaches

While there are various multilevel interventions using individual and interpersonal strategies (Richard, Garwin, and Raine 2011) there are few well-documented examples of full-scale SBCC approaches. This is largely because few SBCC projects are funded by donors. Donors usually request competing agencies to achieve specific measurable results, including individual behavior changes within limited time frames such as three to a maximum of five years. Development project models are usually built on the time it takes to complete infrastructure projects,

not the achievement of social change. Where there is an attempt to measure social change it is usually equated with changes in perceived social norms or changes of individual attitudinal or behavior change often based on medical model thinking. Under such short time frames, sustainable social change is seldom considered since accountability remains within the time limits of the specific project. Most recently, efforts under AIDS prevention and treatment started using the term "structural interventions" to address determinants of new infections. These include cultural, demographic, economic, educational, legal political and social issues. It remains to be seen if their evaluation methods will measure those effects within a social change framework (AIDS Star 1 2011).

However, as mentioned above, the intention of the SBCC approach is not usually to put the onus on any one project to work on all fronts at the same time. It is recognized that few projects have a mandate to carry out advocacy, social mobilization, and targeted BCC. Instead, the intention is that different social forces join together to engender change, using their resources in different ways. Or, it may be that an initiative begins with advocacy, moves to social and community mobilization and then begins to design and implement specific, focused BCC approaches according to needed. A strong example of the need for an SBCC approach to HIV prevention in Africa is grounded in research. Through extensive formative research in South Africa and Namibia, C-Change has found that many existing communication initiatives are not connecting with adult women who remain very vulnerable to HIV infection (Parker and Connolly 2011; Parker 2012).

C-Change has devised a strategy to help organizations address some of the deficiencies in approaches to adult HIV prevention in Africa noted in the above formative research example from South Africa and Namibia. This is the Community Conversation Toolkit (CCT), a set of tools that are now being used by 31 organizations in Lesotho, Malawi, Namibia, Nigeria, Swaziland, Zambia, and Zimbabwe. The Toolkit directly addresses the above studies call for the "development and expansion of horizontal systems of response that are led on the ground and incorporate contextually relevant solutions." In Box 17.1, there is a summary of the main features and achievements of this initiative.

Moving from Africa to South Asia, it is worth noting that one of the first SBCC initiatives, which started in the early 1990s is still being used in health and development programs. This is the Meena Communication Initiative of UNICEF (McKee and Shahzadi 2008) for the development and empowerment of South Asian girls. It includes a set of tools originally developed for Bangladesh, India, the Maldives, Nepal, Sri Lanka, and Pakistan. Since it was launched in 1992, Meena has also spread to Afghanistan, Central Asia, and has been adapted for use in Vietnam, Indonesia, and the South Pacific island nation of Kiribati.

The original three-pronged strategy of Meena: advocacy, social mobilization and BCC, was derived from experience in the Expanded Program on Immunization (EPI) and other child health and development programs in Bangladesh (McKee 1992). It is interesting to note, therefore, that this tradition of communication continues in that country.

Box 17.1 C-Change's Community Conversation Toolkit

Background

C-Change's Community Conversation Toolkit (CCT) mobilizes adults in southern Africa to engage with their HIV risks – including concurrency, alcohol abuse, gender-based violence, and harmful cultural practices – and take action toward prevention. Geared toward adults over age 20 with lower literacy skills, the regional toolkit includes six interactive materials grouped around a simple community mobilization process. This process is supported by steps to facilitate community-driven dialogues to trigger culturally and locally specific individual and group actions that respond to the epidemic.

The CCT was developed in rural South Africa, using the participatory "Action Media" methodology. It was later adapted and field tested in local languages in seven African countries, in collaboration with Soul City partners. A total of 41 NGOs are using the CCT in southern Africa.

In order to evaluate the CCT, C-Change worked with four community-based organizations (CBOs) of the Southern African AIDS Trust engaged in HIV prevention in Malawi and Zambia. They used the CCT with 23 community groups with whom they were working. Peer educators were trained to prompt dialogues that fostered reflection, problem solving, and action at individual and group levels.

Evaluation

Over 80 dialogues with four partners were monitored and interviews and focus group discussions held with implementing partners, peer educators, participants, and other stakeholders. Based on a model that addresses change processes in a particular context through identifying cultural scripts, the evaluations assessed whether CCT activities resonated with individuals and groups, helped them to internalize their HIV risk, led to individual or community actions, and fostered a new understanding of how to respond to the epidemic.

Results

Results include an increase in individual acknowledgment of HIV risk, stronger links to support services, more advocacy by local leaders, and more partner communication on concurrency. Dialogues resulted in specific actions – such as tested couples encouraging other couples to get tested and use condoms, and police services being called upon to enforce laws against rape.

Facilitators and participants voiced strong appreciation of the CCT's interactive components because they prompt thinking, reflection, and problem solving and engage audiences affected by "AIDS fatigue."

Lessons learned

- Participatory development and testing led to relevant and valued communication tools.
- The interactive, game-like approach promoted dialogue.
- The CCT is most effective with ongoing training in facilitation, observation, and note-taking.
- The established relationships between CBOs and community stakeholders fostered group actions and follow-up.
- While dialogues and specific actions prompted are grounded in a given community and culture, the application of the CCT can be taken to scale in any country and community.

Overall, the CCT demonstrates that communication tools can generate individual, interpersonal, and social change actions to address HIV risk, such as in sexual relationships and with risk embedded in harmful traditional practices. Moreover, participants supported changes they discussed beyond the dialogues, and implementing organizations worked to secure funding for continued implementation. These evaluation results validate the need for non-traditional communication approaches that spur home-grown solutions, focus on relationships, and foster critical group thinking.

Conclusions on the Evaluation of SBCC Approaches

At this point, the key models and concepts of the C-Change's SBCC framework are incorporated into at least 75 government programs in Africa, as well as Guatemala, Jamaica, and The Bahamas. Additionally, worldwide, at least 3,405 government and non-governmental personnel have been successfully trained in SBCC.

Evaluations of multilevel interventions following an ecological approach have increased domestically (Richard, Gauvin, and Raine 2010). At their best, they require monitoring community and social processes involved in the development, implementation and evaluation of interventions, their unintended effects and interactions with local culture. Overall results of recent meta-analyses of communication programs at the international level show that the likelihood of success is substantially increased by the application of multilevel interventions. The availability of and access to key services and products continue to be crucial in persuading individuals motivated by media messages to act on them. Likewise, supporting policies provide additional motivation for change, while policy enforcement can discourage unhealthy or unsafe behaviors. Media advocacy campaigns

that frame public health issues in the news and entertainment media also represent a promising complementary strategy to conventional media campaigns (Wakefield, Loken, and Hornik 2010).

The request for more impact evaluations – often from public health professionals trained in the medical model in which the "gold standard" is the randomized control trial (RCT) – has proven problematic. This is because the goal of all SBCC activities is to have synergistic effects of their interventions and messages across the many types of strategies and channels used. Applying the RCT model to prove communication effects has been unproductive, especially when the measurements simply focus on exposure of messages between treatment and control groups (Hornik 2002). Hornik recommends instead a number of approaches (e.g., natural experiments, time-series designs, and other quasi-experimental approaches) that have been used in other research domains where it remains unpractical and unethical to have a true control group (US Department of Health and Human Services, n.d.).

Conclusion on the Sustainability of SBCC Approaches

As indicated in the above examples, C-Change's socioecological model recognizes, in its outer ring, the importance of the "enabling environment" for both going to scale and sustainability. The extent to which the overall environment will enable change depends on: (1) policy and legislative support, (2) political support or conflict on the issues involved, (3) economic support, (4) religious institutional support, (5) technology and infrastructural support, and (6) natural environmental factors usually beyond the complete control of one country or geographic area.

SBCC approaches and their evaluation should be designed in a collaborative style to ensure that communication programs are not limited in length to the life of a particular project and evaluations are able to measure change over time; this requires a change in the typical modus operandi. Of course, programs should not last longer than they are needed. However, many of the challenges of health and development programs will take decades to solve because many of the populations involved are also facing huge economic and environmental challenges.

More recently, donors in the US have recognized that intersectoral collaboration and coordination is needed in order to provide effective and sustainable programs. The Global Health Initiative and Feed the Future represent concerted efforts to release programming from limitations of stove piped funding and related dominant approaches. However, as long as funding structures and measurements of success have not changed these programs face rather big inherent challenges.

The advocacy and social mobilization strategies of SBCC are aimed at ensuring sustainability through host government "buy-in" and support. It is obvious that some interventions, such as exclusive breastfeeding, may be more popular with politicians and partners than others, such as ensuring safer sex among key affected populations to prevent the spread of HIV. More popular and less controversial programs will, no doubt, receive organizational support and resources. But are there other specific and common elements that can be considered for the sustainability of SBCC programs? Below are some factors:

- *Effectiveness* If there is no baseline, midline, and endline evaluation evidence of the effects of the program it is unlikely to be sustained. In addition to behavior change, permanent social norm change should be a major goal of the program.
- *Affordability* What is the cost of continuation? Who will pay? For instance, is the intervention relying on separately paid staff or is it integrated into existing structures? (O'Loughlin *et al.* 1998). Does the intervention require expensive equipment and resources? Are funds available to subsidize new startups?
- *Attractiveness* Are the interventions entertaining and attractive to the audiences and also appealing to various implementing organizations?
- *Leadership* Is there a champion (or champions) to speak and work for the continuation of needed elements of the program? To what degree is leadership support perceived? (O'Loughlin *et al.* 1998)
- *Communication and facilitation* Did the lead organizations take an open, facilitating approach to program development and implementation, bringing in the suggestions of partners and communities?
- *Ownership* Is there agreement by various institutions on issues such as, the importance given to the problem being addressed? How wide is the ownership of the program? Is it a program belonging to one department or entity only or are there multiple stakeholders? To what degree were communities involved in design, implementation and evaluation? (Wisener and Jarvis-Selinger 2012).
- *Technology and infrastructure* How easily do the structural requirements fit into the organizational capacity and structure of long-term agencies? Is there compatibility with the existing interventions and approaches? (Scheirer and Dearing 2011; Bossert 1990)
- *Flexibility* To what degree are the program's approaches and materials adapted to various community settings?
- *Capacity strengthening* Can we ensure that appropriate knowledge and skills, as well as the abilities to act are firmly embedded within key staff, such as health providers and other field workers, and their supervisors?
- *Timing* How can we ensure good timing of implementing sustainability strategies to reduce uncertainty in whether and how much the intervention will be sustained? (Johnson *et al.* 2004; Pluye, Potvin, and Denis 2004).

These factors are not comprehensive but they can guide us in the further development, implementation and evaluation of SBCC programs. The authors' main concern here is that we provide the beginnings of practical guidelines to more comprehensive and long-lasting programs that have a chance to have a positive impact on individual behaviors and social norms, as well as social change. Our hope is that this chapter illustrates a practical approach for program managers on how they can move towards this goal.

Moving Forward

Moving forward we still need to address challenges that the discipline of program communication has known for a while. Here are some ideas for discussion:

- As we continue to address complex social and behavioral challenges, our approaches have to be able to capture this complexity, break it down, and collaborate with each other to address crucial elements rather than to limit our reach or "dumb it down." Having tried the latter now for decades, it has not shown the desired results!
- Brain surgery is not done by working with a handbook and neither is social and behavior change communication. Communication programming needs to have quality control in measurable terms in order to show short- and long-term results. There is a certain agreement on the basic quality criteria (C-Change SBCC Capacity Assessment Tools, for instance), which needs to be broadened and discussions continued.
- For the same reason, it remains crucial to continue building capacity at the academic levels as with donors, government, the NGO and private sectors. Capacity needs to be established and institutionalized to achieve effective and state-of-the-art communication programming and its measurement. Capacity strengthening indicators for SBCC do exist at this point but consensus has to be created here as well.
- Continued exchange between academia, donors, and programmers on the ground needs to continue to challenge valued assumptions with evidence.
- Evidence cannot only be defined by the still dominant medical model in public health in order to further the discussion on communication impact. Other disciplines have demonstrated research and evaluation methods that hold as much value (for example, complexity science frameworks).
- And, lastly, the concepts of SBCC, health promotion, health or development communication, BCC, and social marketing all have certain strengths for certain audiences, situations, and geographies. There is no need to compete with each other for the "one and only" model.

Notes

1 C-Change, funded by the United States Agency of International Development (USAID), was led by FHI 360 and in partnership with Ohio University, Care, Internews, Soul City, Centre for Media Studies, and New Concept Information Systems from 2007 to 2012.

2 The opinions expressed below are those of the authors only, and do not represent the opinions of FHI 360 or USAID.

3 See, for example, the conclusion of Susan Kippax (2012): "Effective prevention entails developing community capacity and requires that public health addresses people not only as individuals but also as connected members of groups, networks, and collectives who interact (talk, negotiate, have sex, use drugs, and so on) together."

4 For example: problem-solving skills; decision-making ability; negotiation skills; critical and creative thinking; interpersonal communication skills; and other relationship skills, such as empathy.

5 Collective efficacy is defined as "social cohesion among neighbors combined with their willingness to intervene on behalf of the common good" of a neighborhood or community (Sampson, Raudenbush, and Earls 1997). "Building the community capacity to act for the common good is essential for health and development" (Goodman *et al*., 1998).

References

AIDS Star 1 (2011). Structural interventions: An overview of structural approaches to HIV prevention, www.aidstar-one.com/focus_areas/prevention/pkb/structural_interventions/overview_structural_approaches_hiv_prevention (accessed October 4, 2012).

Bossert, T.J. (1990). Can they get along without us? Sustainability of donor-supported health projects in Central America and Africa. *Social Science & Medicine*, 30: 1015–1023. DOI: 10.1016/0277-9536(90)90148-L.

C-Change (2012). *C-Modules: A Learning Package for Social and Behavior Change Communication (SBCC)*. Washington, DC: C-Change/FHI 360.

Connell, R.W. (1987). *Gender and Power: Society, the Person, and Sexual Politics*. Cambridge: Polity Press in association with Blackwell.

FAO (2011) Communication for development: Meeting today's agriculture and rural development challenges. UN Food and Agriculture Organization background paper, www.fao.org/fileadmin/user_upload/oek/oekr/pdf/_FINAL_ExpertConsultation-BackgroundPaper.pdf (accessed October 4, 2012).

Fertman, C. and Allensworth, D. (eds) (2010). *Health Promotion Programs: From Theory to Practice*. San Francisco: Jossey-Bass.

Figueroa, M.E., Kincaid, D.L., Rani, M., and Lewis, G. (2002). Communication for social change: An integrated model for measuring the process and its outcomes. Communication for Social Change Working Paper Series. New York: Rockefeller Foundation and Johns Hopkins University Center for Communication Program.

Glanz, K., Rimer, B., and Su, S.M. (2005). *Theory at a Glance: A Guide for Health Promotion Practice*. 2nd edn. Washington, DC: United States National Cancer Institute.

Glass, T. and McAtee, M. (2006). Behavioral science at the crossroads in public health: Extending horizons, envisioning the future. *Social Science & Medicine*, 62: 1650–1671. DOI: 10.1016/j.socscimed.2005.08.044.

Goodman, R.M., Speers, M.A., Mcleroy, K., Fawcett, S., Kegler, M., Parker, E., Smith, S.R., Sterling, T.D., and Wallerstein, N. (1998). Identifying and defining the dimensions of community capacity to provide a basis for measurement. *Health Education and Behavior*, 25: 258–278.

Green, J. and Tones, K. (2010). *Health Promotion. Planning and Strategies*, 2nd edn. London: Sage.

Hornik, R. (ed.) (2002). *Public Health Communication: Evidence for Behavior Change*. Mahwah, NJ: Lawrence Erlbaum Associates.

Johnson, K., Hays, C., Center, H., and Daley, C. (2004). Building capacity and sustainable prevention innovations: A sustainability planning model. *Evaluation and Program Planning*, 27: 135–149. DOI: 10.1016/j.evalprogplan.2004.01.002.

Kippax, S. (2012). Effective HIV prevention: The indispensable role of social science. *Journal of the International AIDS Society*, 15: 17357. DOI: 10.7448/IAS.15.2.17357

Martin, L., Sanghvi, T., Haque, R., and Baker, J. (2012). *Social Mobilization Strategy for IYCF in BRAC Program Areas*. Washington, DC: FHI 360.

McKee, N. (1992). *Social Mobilization and Social Marketing in Developing Communities: Lessons for Communicators*. Penang: Southbound.

McKee, N., Manoncourt, E., Yoon, C., and Carnegie, R. (eds) (2000). *Involving People, Evolving Behavior*. New York: UNICEF; Penang: Southbound.

McKee, N. and Shahzadi, N. (2008). Meena Communication Initiative takes on new challenges: Psychosocial care in tsunami and tidal wave aftermath. *Journal of Communication for Development and Social Change, A Global Journal*, 2(2): 71–93.

Michielsen, K., Chersich, M. *et al.* (2012). Nothing as practical as a good theory? The theoretical basis of HIV prevention interventions for young people in sub-Saharan Africa: A systematic review. *AIDS Research and Treatment, article ID 345327*. DOI: 10.1155/2012/345327.

Mollen, S., Rimal, R., and Lapinski, M. (2010). What is normative in health communication research on norms? A review and recommendation for future scholarship. *Health Communication*, 25(6): 544–547. DOI: 10.1080/10410236.2010.496704.

O'Loughlin, J., Renaud, L. *et al.* (1998). Correlates of the sustainability of community-based heart health promotion interventions. *Preventive Medicine*, 27(5): 702–712. DOI: 10.1006/pmed.1998.0348.

Parker, W. (2012). *Prevention in Action: A Social Mobilization Model*. Cape Town: Project Concern International.

Parker, W. and Connolly, C. (2011). *Break the Chain, Namibia: Final Evaluation Report*. Windhoek: UNICEF.

Pluye, P., Potvin, L., and Denis, J. (2004). Making public health programs last: conceptualizing sustainability. *Evaluation and Program Planning*, 27: 121–133. DOI: 10.1016/j.evalprogplan.2004.01.001.

Richard, L., Gauvin, L., and Raine, K. (2011). Ecological models revisited: Their uses and evolution in health promotion over two decades. *Annual Review of Public Health*, 32: 307–326. DOI: 10.1146/annurev-publhealth-031210-101141.

Sallis J., Owen, N., and Fisher, E. (2008). Ecological models of health behavior. In K. Glanz, B.K. Rimer, and K. Viswanath (eds) *Health Behavior and Health Education: Theory, Research, and Practice*, 4th edn. San Francisco: Jossey-Bass, pp. 464–485.

Sampson, R., Raudenbush, S., and Earls, F. (1997). Neighborhoods and violent crime: A multilevel study of collective efficacy. *Science*, 277(5328): 918–924.

Scheirer, M. and Dearing, J. (2011). An agenda for research on the sustainability of public health programs. *American Journal of Public Health*, 101: 2059–2067. DOI: 10.2105/AJPH.2011.300193.

Servaes, J. (2008). *Communication for Development and Social Change*. Paris: UNESCO.

US Department of Health and Human Services. (n.d.). Communicating health: Priorities and strategies for progress: Objective 11–3. Research and Evaluation of Health Communication Programs, http://odphp.osophs.dhhs.gov/projects/healthcomm/objective3.htm (accessed October 10, 2012).

Wakefield, M., Loken, B., and Hornik, R. (2010). Use of mass media campaigns to change health behavior. *The Lancet*, 376(9748): 1261–1271. DOI: 10.1016/S0140-6736(10)60809-4.

Wisener, K. and Jarvis-Selinger, S. (2012). Sustaining community based health education programs. abstract for global health. Canadian Conference on Medical Education, Banff, Canada.