ADVANCING **INTEGRATED SOCIAL AND BEHAVIOR CHANGE** PROGRAMMING

THIS RESEARCH AND LEARNING AGENDA HIGHLIGHTS:

- The importance of integrated social and behavior change (SBC) programming for improving behavioral and health outcomes.
- Gaps in existing evidence on integrated SBC programming.
- The priority research and learning questions and the consensus-driven process used to derive them.
- The roles of key stakeholders for putting the research and learning agenda into action.

In recent years, social and behavior change (SBC) programming has experienced a notable shift away from a vertical approach focusing on one health or development topic to integrated approaches concerning multiple health or development issues or outcomes under the same program.[1] Integrated SBC programs aim to address factors such as knowledge, attitudes, and norms pertaining to multiple health areas or development sectors in a coordinated and intentional way that influence multiple health outcomes (see Box). They have the potential to reduce duplication, lower costs, avoid missed opportunities, provide the right services and information to the right clients at the right time, and achieve better success.[2] Such integration is already happening across many health areas/sectors, yet the evidence base to support this is limited.

While integrated SBC programming can be complex, some clear examples highlight the potential of these approaches. For instance, combined implementation of nutrition and water, sanitation, and hygiene SBC interventions have had a stronger impact on reducing stunting among children under age 2 than each intervention alone.[3] In Ghana, the GoodLife Campaign is an integrated umbrella SBC approach that promotes a range of positive health behaviors (such as maternal and child health, and malaria prevention and treatment) through multimedia channels. The campaign has reached a broad base and achieved substantial impact across health areas. For instance, sales of zinc tablets increased 280 percent after the GoodLife media campaign, and 80 percent of women exposed to GoodLife slept under bed nets to guard against mosquitoes that transmit malaria.[4] Most of the existing documentation around integration, however, focuses on service delivery or comprehensive interventions.[5]

Research must still answer key questions related to integrated SBC programming, such as "What works in a particular context or target audience?," "How can it work best?," "How much does it cost?," "Is it cost-effective?," and "How can it be replicated, scaled, and sustained locally?" The current

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evidence to answer these and other questions about SBC integration, however, is limited and uneven in scope.[6] For instance, a recent literature review of interventions that integrate global health and other key development sectors found more evidence on integration across select health areas such as family planning and HIV, and limited evidence on newer or more innovative integration of other health and development sector approaches such as agriculture and nutrition or democracy and governance and health.[7] The review also called for greater rigor in the evaluations of integrated programs. A review of integrated SBC studies found that it was difficult to assess the level of integration in some of the studies, and that most programs targeted pregnant women or new mothers with little information on other target audiences or potential unintended consequences of integrated SBC interventions.[8]

BOX. What Do We Mean by "Integrated SBC Programs"?

Integrated SBC refers to programming that addresses behaviors concerning multiple health areas or development sectors in a coordinated and intentional way. Typically, integrated SBC programming involves developing a single, coherent SBC strategy, which may group behaviors that are:

- Practiced by the same audience or people in the same life-stage.
- Influenced by the same social norms or individual-level factors.
- Preceded by the same gateway behavior.
- Pertain to co-occurring health or development conditions.

Integrated SBC programs typically follow one or more implementation models:

- *Add-on:* A new program integrates additional health or development topics into an existing vertical SBC program.
- *Phased Implementation:* A program phases in health topics and/or behaviors gradually over a period of time.
- *Umbrella Brand:* A program develops an overarching brand encompassing all the included health topics.

Some examples of integrated SBC program activities are:

- Integrated one-on-one counseling between a client and provider that addresses reproductive health, exercise, and nutrition.
- An after-school program for secondary-school students that ties together economic empowerment and sexual and reproductive health.
- An entertainment-education TV serial drama that interweaves storylines on malaria prevention, voluntary medical male circumcision, concurrent sexual partnerships, family planning, and prevention of mother-to-child transmission of HIV.

Source: Integrated SBCC Implementation Kit, accessed at https://sbccimplementationkits.org/integrated-sbcc-programs/design/ approaches/.

A RESEARCH AND LEARNING AGENDA TO FILL EVIDENCE GAPS

To help address these important evidence gaps, Breakthrough RESEARCH worked in partnership with a range of SBC experts to generate a research and learning agenda that includes a core set of consensus-driven, prioritized implementation science questions. Implementation science research is particularly well-suited to the challenges of SBC because it assesses interventions taking place in real-world contexts and factors in various social, structural, economic, and political realities from multiple perspectives. Implementation science research also examines both the process of implementation and the results of implementation. It has an explicit focus on how to introduce potential solutions into a health system or promote large-scale use and sustainability.[9]

An Iterative, Consensus-Driven Process To Develop The Agenda

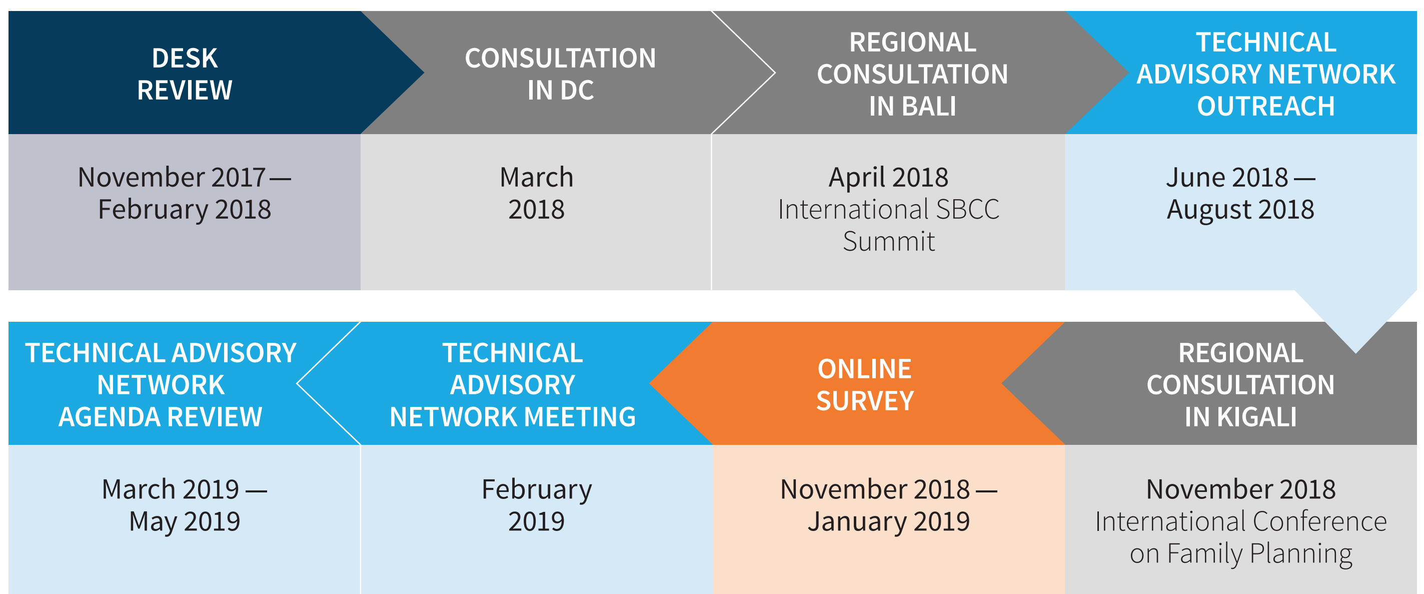
This research and learning agenda builds on longstanding investments to improve SBC. It is designed to prompt the generation of knowledge that can help focus the global SBC community, development partners, and donors on the most important questions related to the effectiveness and efficiency of integrated SBC programs.

The process of developing this research and learning agenda for integrated SBC was multipronged, iterative, and consensus-driven, involving 181 SBC experts (see Figure 1). We carried out the following key steps during the process:

- Conducted a **desk review of SBC literature** to identify cross-cutting knowledge gaps in research for SBC programming. We compiled and reviewed 160 documents from the peer-reviewed and programmatic literature published between 2012 and 2018, from across lower- and middle-income countries and a range of health topics. The literature review highlighted common gaps in knowledge across health areas and two programmatic themes in need of particular investigation: integrated SBC and provider behavior change (PBC).
- Held **a consultation in Washington, DC,** with a group of 31 SBC experts. We gathered their input and generated cross-cutting questions around the gaps identified in the desk review. The experts confirmed the need for greater attention and research on integrated SBC programming.
- Engaged 55 SBC experts who were attending the **International Social and Behavior Change Communication Summit in Bali, Indonesia,** to help us generate and frame research and learning questions around integrated SBC.
- Established a **network of technical experts** and conducted key informant interviews with a select group of SBC experts to weigh in on our process and provide feedback on the questions generated thus far.
- Held a **regional consultation at the International Conference on Family Planning in Kigali** with 34 family planning and reproductive health practitioners and researchers. At that meeting, program implementers and researchers engaged in a rich dialogue around data and design issues to best generate the evidence that we need related to integrated SBC.
- Conducted an **online survey** through which more than 70 respondents reviewed and prioritized the research question ideas for integrated SBC. They also had the opportunity to submit additional priority questions.
- Convened a **technical advisory network** of 20 recognized technical experts in integrated SBC research and programming to review the questions prioritized and generated via the survey and select priority questions for the design, implementation, and evaluation of integrated SBC programming.
- Gathered **final input** from technical advisory network members on the research and learning agenda, confirming the accuracy and phrasing of the priority research questions.

The priority research and learning agenda questions noted below reflect the contributions of participants involved in this process.

FIGURE 1. Timeline of Key Steps in the Agenda Setting Process



RESEARCH AND LEARNING AGENDA QUESTIONS

The consensus-driven approach resulted in a set of research and learning agenda questions that are intended to have broad applicability at global, regional, and local levels, and across health and development sectors. They are meant to be adapted and refined to suit specific programmatic and geographic contexts. Some of the proposed questions can be integrated into programs' existing monitoring and evaluation systems, while other questions will require stand-alone research studies that incorporate appropriate comparisons and account for relevant influential factors.

Implementing in an Enabling Environment

- What are the conditions (for instance, political and donor support, timing, capacity, coordination with/by government, and resources for implementation) that enable or hinder design for appropriate and feasible implementation of integrated SBC programming?
- What are the conditions that enable effective adaptation and sustainability of integrated SBC programs?

Intervention Content and Programmatic Model

- Are there particular behaviors or combinations of behaviors for which integrated SBC programming appears particularly effective?
- What is the best way to deliver integrated SBC programs to target audiences, keeping in mind overburdening of messages/interventions?
  - How can different technical areas be most effectively sequenced or layered in an integrated SBC program (such as adding complementary family planning counseling to an integrated HIV mass media campaign)?
  - What level of exposure to health area-specific content is needed to change priority behaviors or norms in the context of integrated SBC programming?
- What dose or type of outreach, mobilization, and engagement of target audiences is needed for integrated SBC programs compared to vertical SBC programming?
- What is the best way to ensure that programs are engaging the most influential secondary audiences in integrated SBC programming?

Effectiveness of Integrated SBC Programming (Relative to Vertical SBC Programming)

- When a norm (or other determinant) influences multiple behaviors, how and to what extent does addressing it yield desired change for multiple behaviors?
- Under which conditions (such as social structures or health systems structures) is integrated SBC programming more effective than vertical SBC programming?
- What are the potential unintended (positive and negative) consequences at the individual, household, community, and health-systems level for integrated SBC programming compared to vertical SBC programming?
- How and to what extent do differences in the integration program model (for instance, umbrella brand with nested vertical components, phased introduction of content, add-on) impact outcomes among different audiences? Which integration program models are most effective and what models still need to be explored (such as multisectoral integration of family planning and economic growth) with specific audiences?
- How can we utilize more participatory approaches to improve the design, monitoring, and evaluation of integrated SBC programming?

Cost Effectiveness

- Do integrated SBC programs incur additional costs?
- What models exist that have created cost savings in integrated SBC programming? What were the key elements of success in creating cost savings?
- Is integrated SBC programming more cost-effective than vertical SBC programming, and for which health and development outcomes?

PUTTING THE RESEARCH AND LEARNING AGENDA INTO PRACTICE

To advance this research and learning agenda, concerted and coordinated action is needed from a range of stakeholders, including donors, SBC and service delivery organizations, governments and policymakers, and research institutions and universities (see Figure 2). By promoting and taking up this agenda, current and future investments can be maximized to achieve the best possible health and development outcomes.

FIGURE 2. Key Stakeholders and Actions for Putting the Agenda Into Practice

DONORS

- Use the agenda to fund stand-alone or programmatically embedded research.
- Coordinate and align investments across donors.

SBC & SERVICE DELIVERY ORGANIZATIONS

- Update routine monitoring and evaluation systems to capture key information within existing programs and activities to help answer priority questions from the agenda.
- Use emerging research/program evidence to course correct program approaches.

GOVERNMENTS & POLICYMAKERS

- Promote implementation science research agendas to answer key questions about integrated SBC programs.
- Use emerging research/program evidence to influence strategies and update relevant policies.

RESEARCH INSTITUTIONS & UNIVERSITIES

- Develop and share innovative research designs and measurement tools and generate evidence on the priority questions from the agenda.
- Team up with program implementers to help answers questions within existing programs.

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