Blueprint *for* More Sustainable Social and Behavior Change Systems

July 2024

FEDERAL MINISTRY OF HEALTH, NIGERIA

HEALTH PROMOTION
...Ensuring health literacy for all

as-sbc
African Society for Social & Behaviour Change

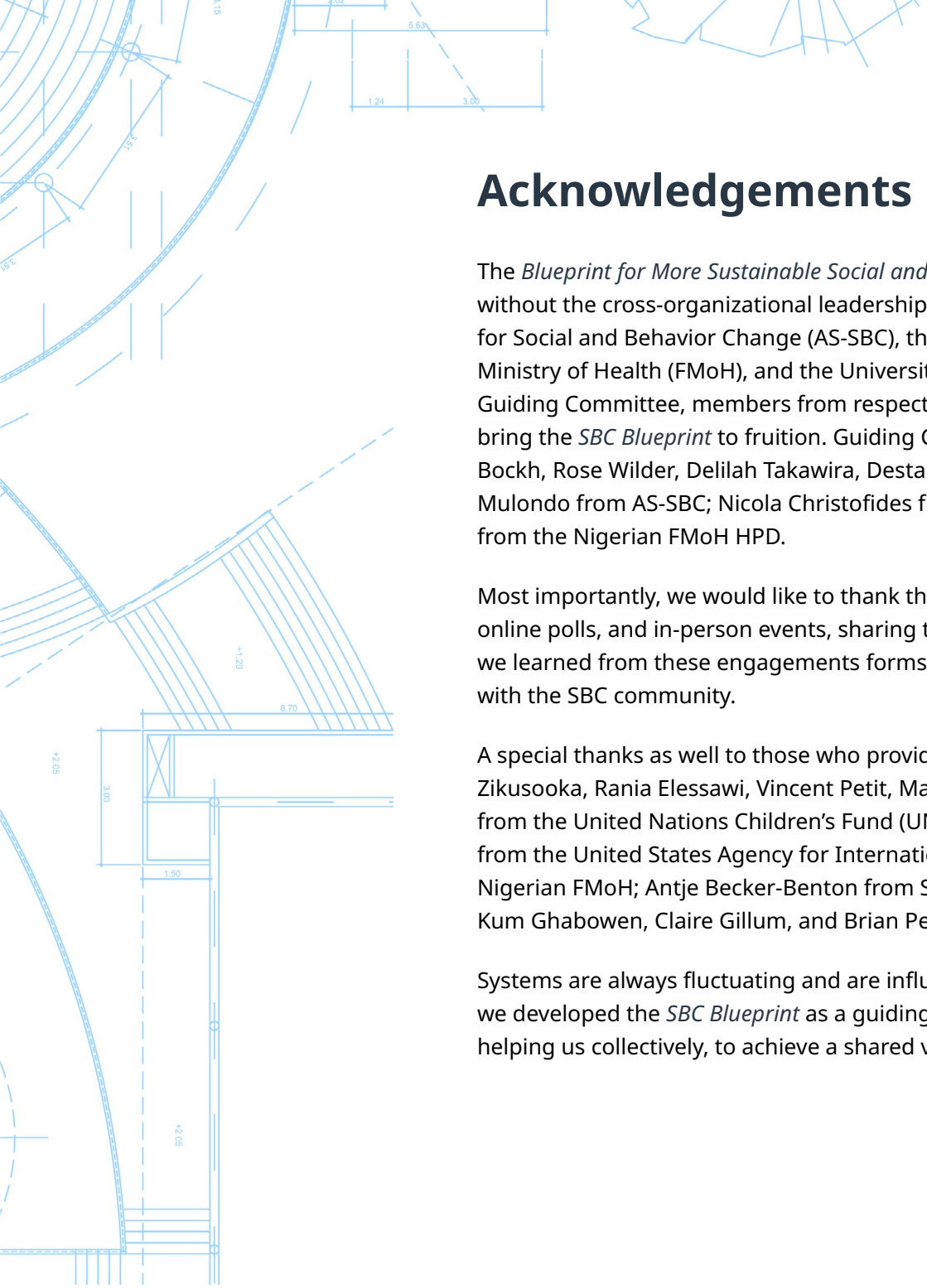
UNIVERSITY OF THE WITWATERSRAND, JOHANNESBURG

fhi360

CONTENTS

ACRONYMS

AS-SBC	African Society for Social and Behavior Change
ASBC	Accelerating Social and Behavior Change
CHW	Community Health Worker
CSO	Civil Society Organization
ECCD	Early Childhood Care Development
FHI 360	Family Health International
FMoH	Federal Ministry of Health
HCD	Human Centered Design
HMIS	Health Management Information System
HPB	Health Promotion Board
HPD	Health Promotion Division
HR	Human Resources
HSS	Health Systems Strengthening
LGBTQI+	Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, and more
M&E	Monitoring and Evaluation
MERL	Monitoring, Evaluation, Research, and Learning
MOH	Ministry of Health
NGO	Non-governmental Organization
PFM	Public Financial Management
SBC	Social and Behavior Change
SBCC	Social and Behavior Change Communication
SDG	Sustainable Development Goals
TWG	Technical Working Group
UN	United Nations
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WHO	World Health Organization
Wits	University of Witwatersrand



Acknowledgements

The *Blueprint for More Sustainable Social and Behavior Change (SBC) Systems* would not have been possible without the cross-organizational leadership and dedication of colleagues from FHI 360, the African Society for Social and Behavior Change (AS-SBC), the Nigeria Health Promotion Division (HPD) of the Federal Ministry of Health (FMoH), and the University of Witwatersrand (Wits) School of Public Health. Forming a Guiding Committee, members from respective organizations worked closely over the last year and a half to bring the *SBC Blueprint* to fruition. Guiding Committee members and authors included Kara Tureski, Emily Bockh, Rose Wilder, Delilah Takawira, Desta Kebede, and Emelia Benyiwaa Ainooson from FHI 360; Kenneth Mulondo from AS-SBC; Nicola Christofides from Wits; and Chinyere Nmu Ogbonna and Bako Aiyegbusi from the Nigerian FMoH HPD.

Most importantly, we would like to thank the SBC community for actively engaging in discussion sessions, online polls, and in-person events, sharing their knowledge and experience from around the world. What we learned from these engagements forms the basis of the *SBC Blueprint*, and we are honored to share it with the SBC community.

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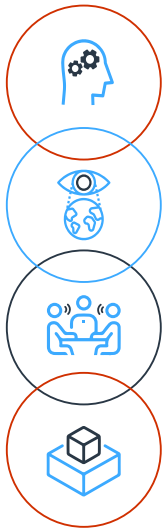
Systems are always fluctuating and are influenced by both internal and external changes; with this in mind, we developed the *SBC Blueprint* as a guiding star, laying out a set of core principles to strive towards, and helping us collectively, to achieve a shared vision of more sustainable SBC systems.

Introduction

Introduction

The *Blueprint for More Sustainable Social and Behavior Change (SBC) Systems*, or the *SBC Blueprint*, is a comprehensive framework and toolkit for individuals and institutions involved in country level SBC programs, as well as those supporting these initiatives. Its primary objectives are to:



1. Challenge the global SBC field to think critically about the systems that govern the oversight, design, implementation, and evaluation of SBC initiatives, aiming for greater quality, impact, and sustainability.
2. Create a shared vision for sustainability within the SBC field at country and global levels by adopting a more holistic approach to SBC that enables systems to address multilevel SBC needs more effectively.
3. Advocate for increased resource allocation, prioritization, and investment in SBC systems, across local-to-global levels, to bolster the resilience and sustainability of health systems.
4. Propose a foundation to guide the achievement of these objectives, fostering dialogue around the tools and skills needed to enable country level actors, donors, and stakeholders within SBC systems to realize institutional and technical capacity improvements.

The *SBC Blueprint* aims to achieve these objectives by delineating the role that different actors can play in SBC systems, and the competencies required for the successful achievement of these roles. We believe this will enable SBC actors to identify national and global SBC systems strengthening priorities.

While the *SBC Blueprint* primarily focuses on capacity and systems strengthening to achieve health-related objectives, it also underscores the interplay and interdependence between SBC systems, sectors, and actors beyond the health domain. Multisectoral collaboration and programming is essential for sustained improvements in health behaviors and supportive social norms, necessitating SBC systems that integrate systems strengthening principles. These systems must drive SBC interventions to address social and structural determinants of healthy behaviors, in addition to individual and interpersonal factors, and to meaningful engage communities, in coordination with other system and sectoral actors.

WHY THE *SBC BLUEPRINT* NOW?

Globally, in the last two decades, we have seen substantial reductions in global maternal and child mortality and declines in infectious diseases, such as HIV, tuberculosis, and malaria. Together with advancements in supply-side services, SBC interventions have undoubtedly played a pivotal role in these successes. Despite these gains, certain health indicators have either plateaued or regressed across different contexts. This has been in part due to the disruptive impacts of COVID-19, conflict, the increasingly evident consequences of climate change, as well as poverty and inequality, lack of social cohesion, violence, poor mental health and addiction, and other emerging public health challenges. Health equity is a pressing concern on a global scale. Even in contexts where indicators show improvements, persistent inequities continue to lead to unequal health access and achievement of health indicators, based on factors such as sex, race, gender, sexuality, religion, disability, political affiliation, and other intersecting factors.

The field of SBC has a critical role to play in addressing these urgent challenges, and the poor health outcomes fueled by them. In many contexts, significant SBC advancements have been made but need to be secured through their institutionalization. It is also apparent that one-off investments in SBC capacity strengthening are insufficient to deliver country-led SBC solutions capable of addressing SBC needs in a sustained way. It is time as a field that we critically look at how initiatives aimed at generating social change and behavior change are designed, implemented, and evaluated, by first better understanding and addressing the complex systems that govern these functions.

The *SBC Blueprint* seeks to initiate this transformation by offering an ambitious and bold approach for future SBC capacity and systems strengthening agendas, building upon prior investments and informed by a global dialogue focused on SBC systems-specific change needs.

Beyond social and behavior change communication (SBCC) and health promotion-only approaches

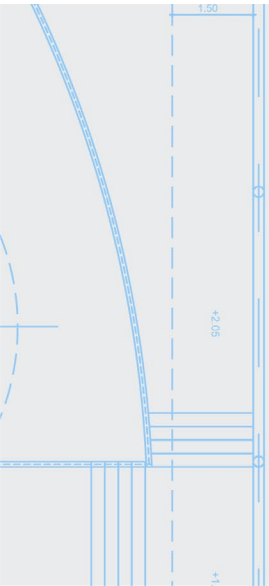
Inherent in the need for systems and capacities able to address complex health-related SBC challenges is the need to embrace a wider perspective and set of strategies to achieve this vision.

What is SBC? SBC is a systematic, evidence-based approach that seeks to improve and sustain changes in behaviors and norms through addressing individual, social, and structural factors, drawing from a range of behavioral sciences. SBC approaches recognize that communication is not always the primary catalyst needed for change and employs a wide range of tactics and strategies to address factors across all levels of the socio-ecological model, as appropriate to need, and in partnership with stakeholders.

SBC BLUEPRINT LINKAGES WITH OTHER GLOBAL INITIATIVES

The *SBC Blueprint* builds upon and advances important global initiatives, including the USAID Vision for Health System Strengthening (HSS) 2030, USAID SBC and HSS White Paper, UNICEF's HSS Approach, USAID's 2023 Gender Equality and Women's Empowerment Policy, USAID's Local Capacity Strengthening Policy, USAID Local Systems: A Framework for Supporting Sustained Development, and the Health Promotion Strategy for the African Region, and foundational frameworks, such as the World Health Organization (WHO) Building Blocks, among others. It does so by recognizing the interrelationships, interactions, and dependencies within health systems and the critical role of diverse actors in achieving resilience and sustainability. It also brings attention to key HSS functions, such as financing and budgeting, human resources (HR) for health, information systems and policies, etc. in support of improved SBC planning and programming. These functions are frequently underrepresented in SBC systems strengthening strategies.

In drawing these critical linkages, the *SBC Blueprint* emphasizes the need for cross-cutting coordination, stronger connections and collaboration between supply and demand-side interventions, and engagement of health and non-health actors to better address social and structural determinants of health, while strengthening local capacity. The *SBC Blueprint*, along with these initiatives, also supports achievement of the Sustainable Development Goals (SDGs) for peace and prosperity. Furthermore, the *SBC Blueprint* seeks to promote the four principles set out in the Nairobi Document by the Global Partnership for Effective Development Co-operation, namely country ownership, focus on results, inclusive partnerships, and transparency and mutual accountability.



To drive and sustain positive changes given the complexities at hand, a systems-level approach is needed to holistically address SBC-related factors. SBC solutions must be rooted in a profound understanding of the contexts in which individuals live and work, designed inclusively and through participatory means, while also considering scale and impact. This requires SBC-related structures, approaches, and processes that are complexity aware, adaptive, inclusive, equitable, and locally led.

The *SBC Blueprint* provides:

Guidance and tools to develop a shared SBC systems map and vision

Guidance on monitoring, evaluation, and learning alongside development and roll out of country level *SBC Blueprints*

Case examples

Minimum benchmarks to reach a sustainable vision for SBC systems strengthening, linked to SBC system attributes, key functions, and competencies

Planning and technical tools for countries to lead priority setting and action towards SBC systems and capacity strengthening improvements

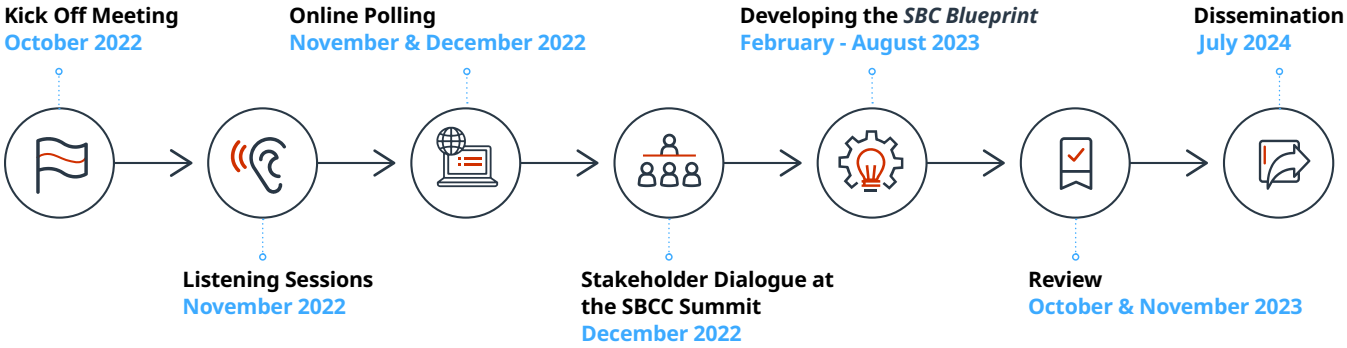
ADVANCING PRIOR SBC STRENGTHENING INVESTMENTS

The *SBC Blueprint* builds on and operationalizes decades of investments to strengthen SBC systems and capacity to advance health goals. This includes approaches and tools advanced through USAID projects like Breakthrough Action, Health Communication Capacity Collaborative, C-Change, through USAID bilateral SBC programs, and by UNICEF, which has championed the importance of strengthening systems to make SBC both achievable and sustainable. Despite these investments, SBC capacity strengthening efforts have often been fragmented and focused heavily on government and implementing partners' technical capacity to design and implement SBC/C interventions. In recent years, organizations like FHI 360 have taken a broader, systems strengthening lens to address ongoing capacity and systems-level needs for SBC. Taking into consideration both historical progress and investments in technical capacity strengthening with individuals and organizations in SBC, lessons learned in SBC systems strengthening, as well as in looking at remaining gaps, the *SBC Blueprint* further advances this work to date by integrating a greater emphasis on systemic factors, with a critical eye toward sustainability. It also seeks to enable country level actors to lead the process of strengthening their own SBC systems, from identifying key priorities to leading the development and monitoring of action plans. This will directly contribute to local leadership and governance in support of strengthened SBC systems.

DEVELOPING THE *SBC BLUEPRINT*

The *SBC Blueprint* was developed using a consultative and participatory process (see Figure 1). A Guiding Committee was formed comprised of SBC implementers, government, and academic representatives to ensure perspectives from across multiple countries, disciplines, and contexts were included in developing this document, and in leading this important global dialogue. Foundational to our process was the engagement of a wide cross-section of the SBC community, using a variety of channels, as described below. In total, we gathered sector-wide input through 12 virtual listening sessions, held with approximately 90 participants; multiple online polls that received over 1,100 responses; an SBC stakeholder dialogue held at the International SBCC Summit in Morocco, which enabled deeper dialogue with more than 45 SBC practitioners and experts; and external reviews with SBC experts, as noted in the acknowledgements section. The contributions from this participatory engagement informed this document.

Figure 1. Participatory *SBC Blueprint* development process



INTENDED AUDIENCES

The *SBC Blueprint* is intended to be used by SBC system actors: those leading, funding, or supporting SBC initiatives. Primary audiences are listed in Table 1.

Table 1. SBC system's actors and *SBC Blueprint* audiences

SBC Actor	Description	Can use the *SBC Blueprint* to:
Government institutions 	• Host country governments are often the lead authority for SBC-related work in their country • Focal institutions include the Ministry of Health (MOH) – and increasingly, Ministries of Education, Gender and Youth, and other relevant government departments (public financial management [PFM], communications/public relations, agriculture, information services, and social welfare) • Stakeholders exist at national and subnational levels	• Understand the current landscape of their country's SBC system, including mapping system actors • Formulate a vision for their SBC system and establish benchmarks, incorporating resource mobilization strategies (financial and HR) • Develop and implement SBC capacity and systems strengthening plans • Monitor and share progress • Advocate for internal and/or external SBC financing
Donors and United Nations (UN) agencies 	These include: • International donors like USAID that fund SBC programming • UN agencies (WHO, UNICEF, United Nations Population Fund) that fund SBC initiatives and support national SBC capacity strengthening • Foundations like the Bill and Melinda Gates Foundation and Children's Investment Fund Foundation • International financial institutions like the World Bank and regional development banks, which support governments with systems strengthening and increasingly, SBC investments	• Set, advance, and coordinate global SBC priorities and funding • Fund and/or deliver SBC capacity and systems strengthening activities • Establish and enforce standards and reporting on shared metrics • Support generation of SBC evidence and advocacy • Enable greater fiscal space for SBC investments in capacity strengthening and workforce
SBC implementing partners 	• International and local non-governmental organizations (NGOs), civil society organizations (CSOs), faith-based organizations (FBOs), and other partners play significant roles in SBC programming, often in partnership with government, in both development and humanitarian contexts • Bring expertise in SBC/SBCC, community mobilization and engagement, and program implementation, and/or represent specific health areas, cultural and religious affiliations, or vulnerable population groups like women, youth, lesbian, gay, bisexual, transgender, queer, intersex, and more (LGBTQI+) • Support generation of evidence and advocacy for SBC	• Help advance country level visions and plans • Tailor capacity and systems strengthening activities • Provide specialized technical skills in the form of technical assistance to other system actors • Develop and implement more holistic SBC strategies and programs • Advocate for improved SBC coordination between demand and supply side programs • Monitor and share progress and learning

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SBC Actor	Description	Can use the *SBC Blueprint* to:
Service delivery partners 	• May be public or private, international or local organizations • Provide health services – or support their strengthening (e.g., routine and emergency services, coordination, quality assurance, training and professional development, and resource management, among other functions)	• Provide access to essential health products and services, linked with demand creation/SBC activities • Ensure delivery of quality, respectful services within communities and at health facility level • Design service environments and modalities in ways that meet client needs
Community platforms 	• Provide a bridge between communities and facilities • Advocate for individuals' health needs, support quality of care and its responsiveness, and support local health governance • Serve as either channels for trusted SBC engagement with priority audiences, or as secondary/influencing audiences within SBC strategies • Tailor and contextualize SBC interventions to community needs Provide health and social services, or linkages/referrals	• Understand their role as part of a larger, SBC system • Advocate for their role and institutionalized function within SBC system processes, funding cycles, strategies, and plans • Expand linkages to a wider range of health and social services needed by community members
Academia 	• Colleges, universities, training, and research institutions • Contribute to SBC efforts at country level through evidence generation, monitoring and evaluation (M&E), and capacity strengthening • Support the development of future SBC professional cadres across levels, including health care providers and community health workers (CHWs)	• Understand and integrate the range of SBC system competencies needed into professional training and degree programs • Generate evidence around the impacts of SBC programming • Create a pipeline for skilled SBC human capital and support national capacity strengthening initiatives
SBC learning/ collaboration networks 	• Professional associations and/or university initiatives – specific to SBC and broader – and other groups with reach and impact • Support learning and sharing of SBC best practices • Generate buy-in and consensus • Tackle issues that are too great for one actor to take on alone	• Inform and guide dissemination of evidence, experiences, and learning related to SBC capacity and systems strengthening • Mobilize network members around shared SBC capacity and systems strengthening priorities • Conduct SBC-related advocacy • Disseminate professional opportunities that strengthen SBC systems' performance

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SBC Actor	Description	Can use the *SBC Blueprint* to:
Private sector 	• Private companies, providers, media, and others, such as creative, human centered design (HCD), and research agencies • Support SBC through co-financing; providing commodities, marketing support, and technology; and by sharing specialized skills and resources • Can expand access to products and services and ensure they are responsive to priority populations' needs	• Provide specialized technical skill sets • Fund/implement SBC initiatives aligned with national priorities • Provide quality and respectful products, services, and information aligned with SBC strategies • Leverage platforms to improve transparency
Media organizations 	• Television, radio, newspapers, and online platforms • Are essential channels for producing and disseminating SBC messaging and other content; promoting dialogue; and collecting community views on health issues and programs • Priority audience for capacity strengthening activities to improve quality reporting and address misinformation • May or may not be private sector organizations	• Support advocacy and accountability related to the development, implementation, and M&E of national *SBC Blueprint* plans of action

HOW TO USE THE *SBC BLUEPRINT*

The *SBC Blueprint* is a practical document to guide country level actors to achieve a vision for more sustainable SBC systems. This will contribute to global and national priority setting for SBC. The *SBC Blueprint* can also serve as an advocacy tool at global and country levels, supporting increased SBC prioritization and capacity and systems strengthening investments. The recommendations, case examples, and tools, developed as part of the *SBC Blueprint* are not intended to be used as a one-size fits all or a one-time approach. Rather, the *SBC Blueprint* provides multifaceted examples and practical tools, linked to a core set of systems' attributes and functions, which can be contextualized and adapted for countries to use to strengthen their SBC capacity and systems strengthening strategies, over time.

Practical *SBC Blueprint* tools

See *Blueprint for More Sustainable Social and Behavior Change Systems* to download *SBC Blueprint*-related tools. These are living documents, which will be adapted based on stakeholder feedback and added to over time. Initial tools include:

- Develop your SBC system vision
- Map your SBC system
- Map SBC system connections
- Assess and prioritize your SBC system attributes
- Assess and prioritize your SBC system functions
- Develop your *SBC Blueprint* implementation and monitoring plan

It is our hope that governments, SBC practitioners, and donors will use the *SBC Blueprint* to guide country level efforts to strengthen their own SBC system. This document and set of tools are intended to support this. Together, they will support users to go through a five-step process to imagine, design, validate, implement, and monitor a country level *SBC Blueprint* for themselves (see Figure 2).

Figure 2. Five-step *SBC Blueprint* process

STEP 1
Develop *SBC Blueprint* Vision

STEP 2
Map the SBC System

STEP 3
Diagnose the SBC System

STEP 4
Develop *SBC Blueprint* Implementation and Monitoring Plan

STEP 5
Implement, Monitor, Evaluate, and Adapt

The Future: A Vision for More Sustainable SBC Systems

The Future: A Vision for More Sustainable SBC Systems

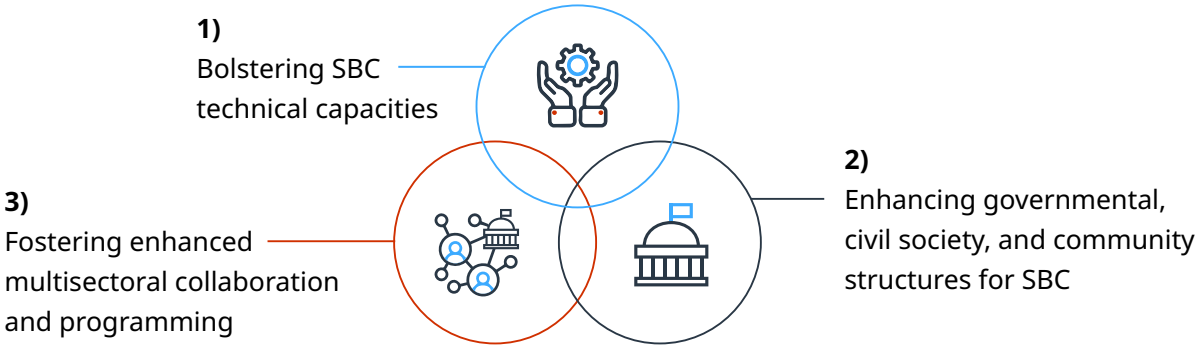
VISION FOR SUSTAINABLE SBC SYSTEMS

The *SBC Blueprint* seeks to support and foster locally led development by shifting leadership and power to local entities and stakeholders to set priorities and lead the development of national action plans that are fit for purpose and able to achieve national priorities and their vision. Given widespread global commitment and consensus on the importance of locally led development in achieving meaningful and sustainable health and development outcomes, and overall reductions in donor funding, it is critical that SBC actors work collaboratively to ensure that the system that governs SBC are adequately equipped to produce high quality outputs as part of overall HSS.

Our vision is sustainable, country-led SBC systems that can support the oversight, design, implementation, and evaluation of SBC initiatives that enable individuals, families, and communities to embrace and maintain healthy behaviors, while also driving positive social change and development.

We propose to achieve this vision through advancement of three key outcome-focused pillars in Figure 3 below:

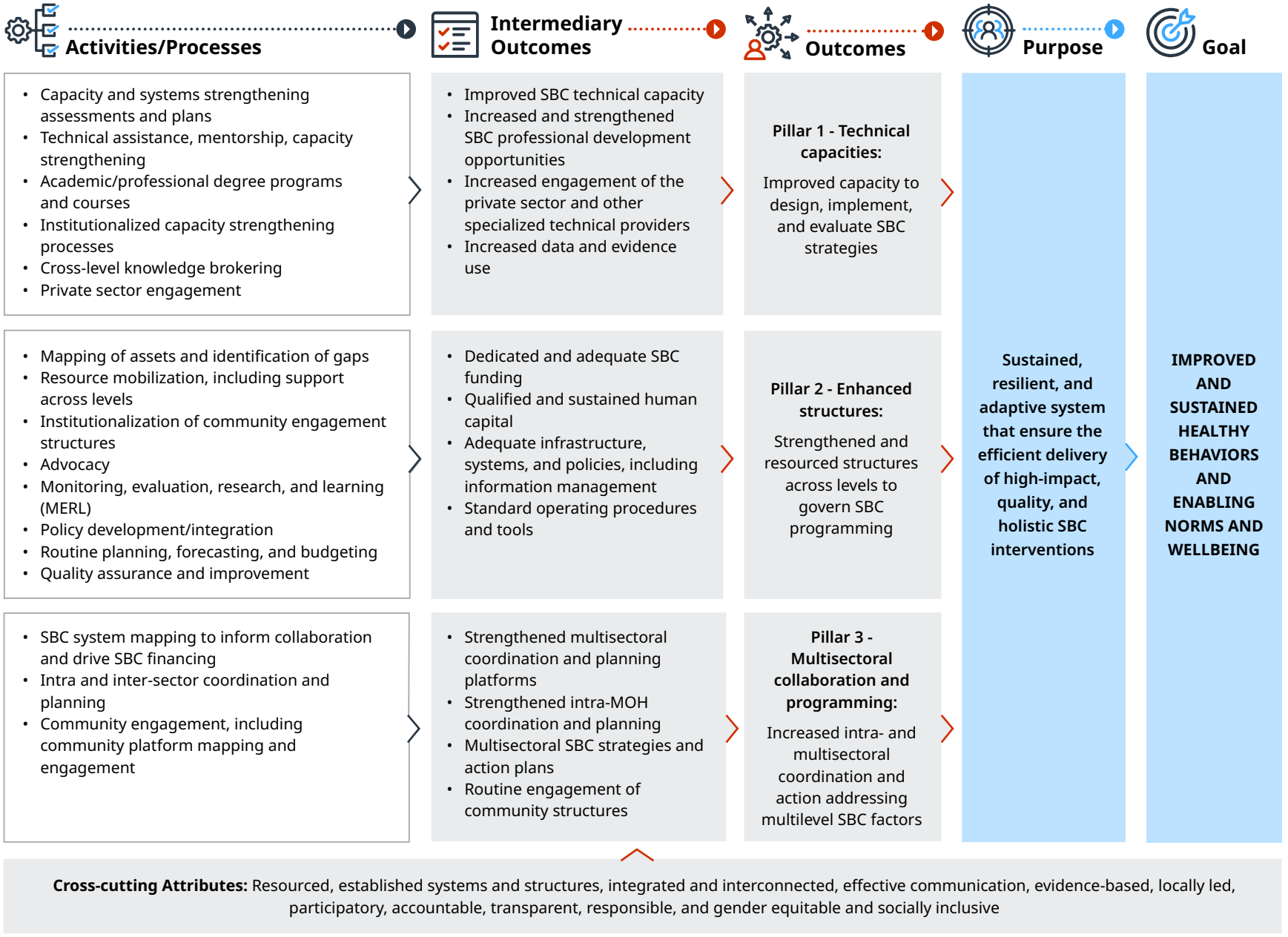
Figure 3: Pillars of sustainable SBC system

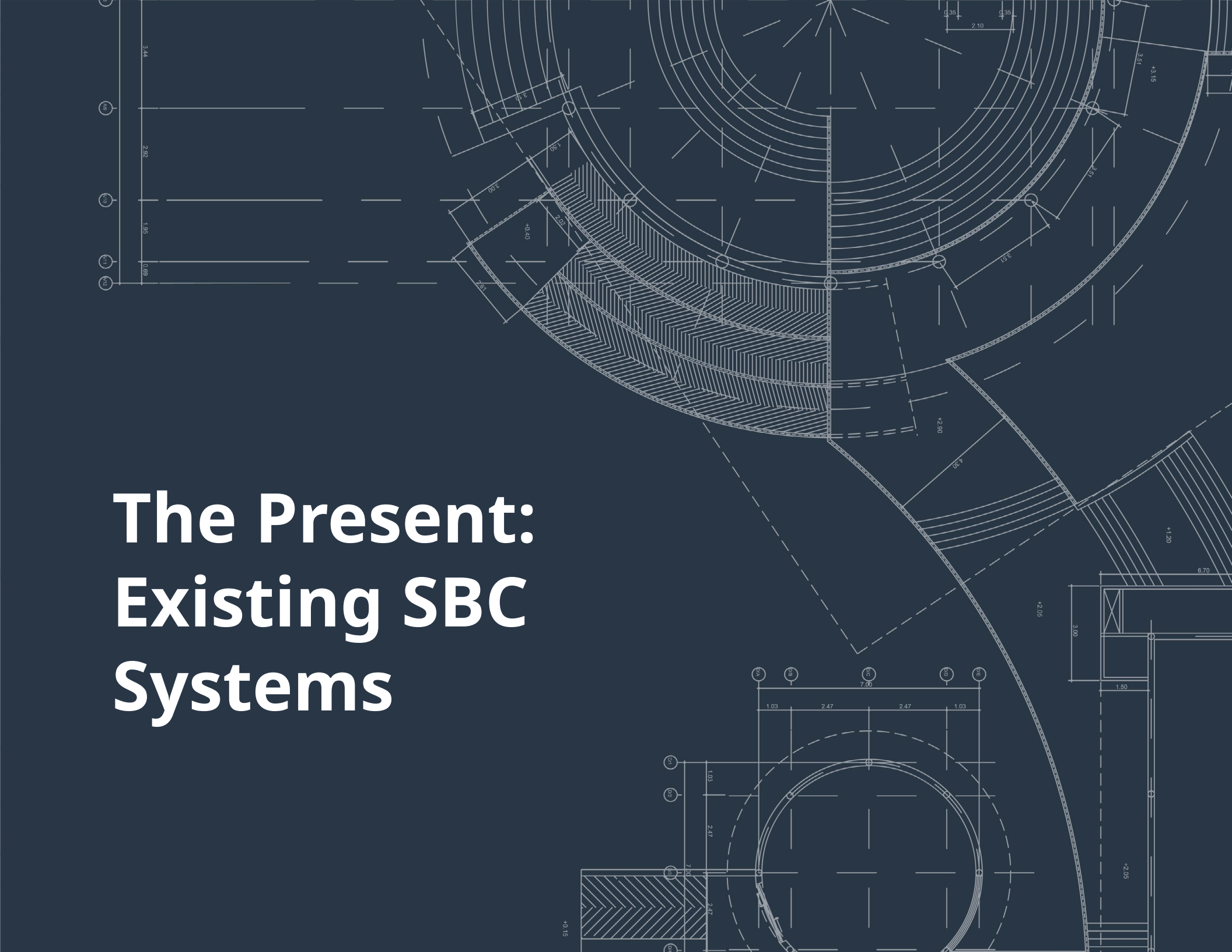


We recognize that addressing not only technical capacity, but also system level barriers is crucial for effective, efficient, and sustained SBC programming that can produce results overtime, and in ways that are resilient and adaptive. By prioritizing multisectoral linkages alongside the involvement of health system-centered SBC actors, we embrace the potential for more holistic SBC strategies, poised to generate transformative and enduring SBC impacts.

Towards this, we propose a new SBC theory of change for capacity and systems strengthening that supports sustained, resilient, and adaptive systems. The *SBC Blueprint's* approach also enables systems to ensure the efficient delivery of impactful SBC interventions; thereby contributing to improved and sustained behaviors and wellbeing (Figure 4).

Figure 4. A new theory of change and vision





The Present: Existing SBC Systems

The Present: Existing SBC Systems

What is an SBC system?

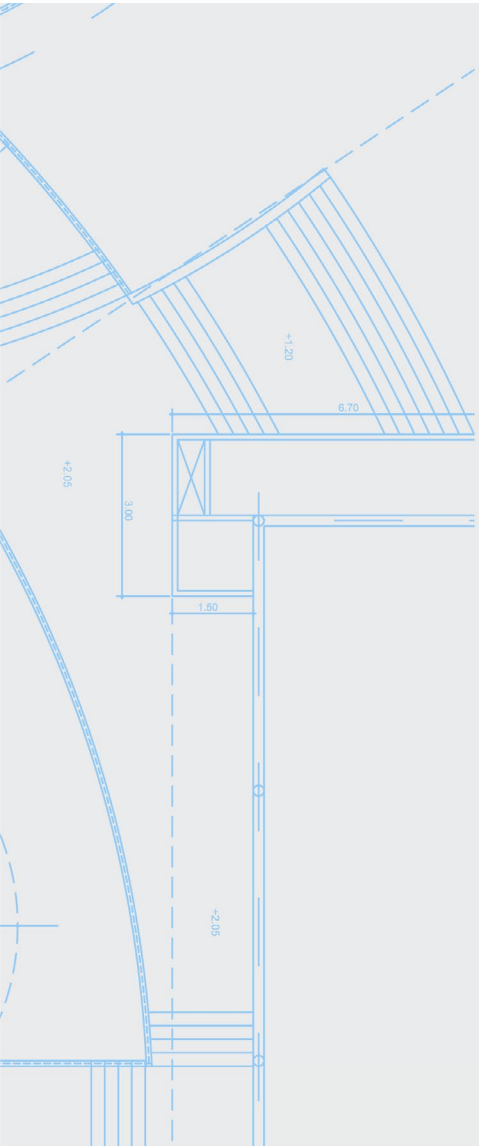
An SBC system includes an interconnected set of actors and networks, governments, civil society, private sector, academia, individual citizens, and communities working across sectors (horizontal) and administrative levels (vertical)—that jointly support improved outcomes. These represent both overlapping and dynamic sets of systems (including their relationships and processes) and actors, which contribute to improving health (USAID 2014, 2021).

ACTORS IN THE SBC SYSTEM

To realize the vision outlined in the section above for strengthened SBC systems, SBC actors must first assess their current SBC landscape, both at global and country levels. The systems that govern health-related SBC initiatives vary by country, type of government, and health system (e.g., centralized, decentralized). In most cases, SBC systems are integrated within the health system, with varying levels of connection to other departments within the MOH (e.g., health area specific units, PFM) and other sectors, such as education, gender and youth, agriculture, etc. In many countries, the responsibility for SBC-related work sits with a health promotion-focused unit within the national MOH. This unit is typically responsible for:

- Developing SBC/SBCC/health promotion strategies
- Coordinating SBC implementing partners and activities
- Developing SBC materials and media
- Reviewing, contributing to, and/or approving SBC materials and media products across MOH units or implementing partners
- Implementing SBC campaigns and conducting household- and community-level activities
- Conducting social listening
- Using SBC data analytics

Within MOH vertical – or disease-specific health units (e.g., family planning, nutrition) and special programs (e.g., National AIDS Control or malaria programs) – there may also exist SBC-related personnel and mandates. Health promotion-related structures may also exist at subnational levels, depending on the country context. Alternatively, this function may be advanced through designated individuals at district or regional level who fulfill other primary functions. In some countries, while subnational SBC-related structures exist, they are not funded or staffed (see SBC system gaps text box for these and other gaps).



SBC system gaps

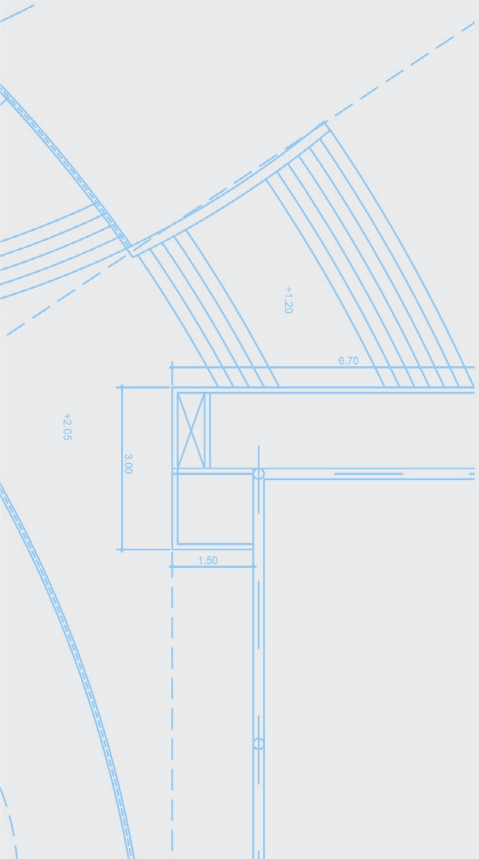
Emerging from the ***SBC Blueprint's*** consultative design process, common SBC systems gaps across contexts were identified. These focused primarily on limited system capacities to support the sustained design, implementation, and evaluation of SBC programming. If these challenges were systematically addressed, it is believed that achievement of SBC and broader health objectives would be increased, leading to sustained behavior change and improved health system performance. These include:

- An over **focus on health promotion** and communication-only approaches in professional training, national strategies, and country level activities, rather than more holistic SBC approaches
- Heavy **emphasis on individual determinants** and not enough on social and structural factors
- Inadequate **community engagement** and integration of **behavioral insights**
- Insufficient investment in **social accountability approaches** and overemphasis on demand creation, rather than promoting **trust** between service providers and communities and **ensuring services meet the needs of clients**
- Over **emphasis on individual behavior change objectives**, rather than social change or institutional change needs
- **Lack of coordination and collaboration** between different sectoral actors and between health areas and PFM units within MOHs
- **Low appreciation and inadequate funding** of SBC interventions and HR relative to investments in supply side interventions

> ***"As a field, SBC has advanced a lot, however, a lot of governments have not shifted from health promotion/health education to SBC. This is a challenge in terms of governments, across countries."*** (*SBC Blueprint* listening session participant).

A range of CSOs and community-platforms play a critical role in advancing the SBC system. Like governments, CSOs operate at various levels – national to community – and serve different functions, including, providing health services, implementing SBC and community-level activities, resource mobilization, and monitoring the quality of care and community/facility interface, among other roles. Trusted traditional and community-based platforms that are ingrained in the culture, norms, and values of a particular community include platforms like community health committees, traditional and religious structures, women's, LGBTQI+ and people with disability associations, etc. Such community platforms are key parts of the system that need to be leveraged to ensure SBC interventions' cultural relevance, strengthen trust and credibility, increase reach and access, elevate community voice, perspective, and equity, and foster greater sustainability.

The SBC system is also influenced by global actors and coordination and learning bodies, external to the country, including donors, private sector actors, and international NGOs.



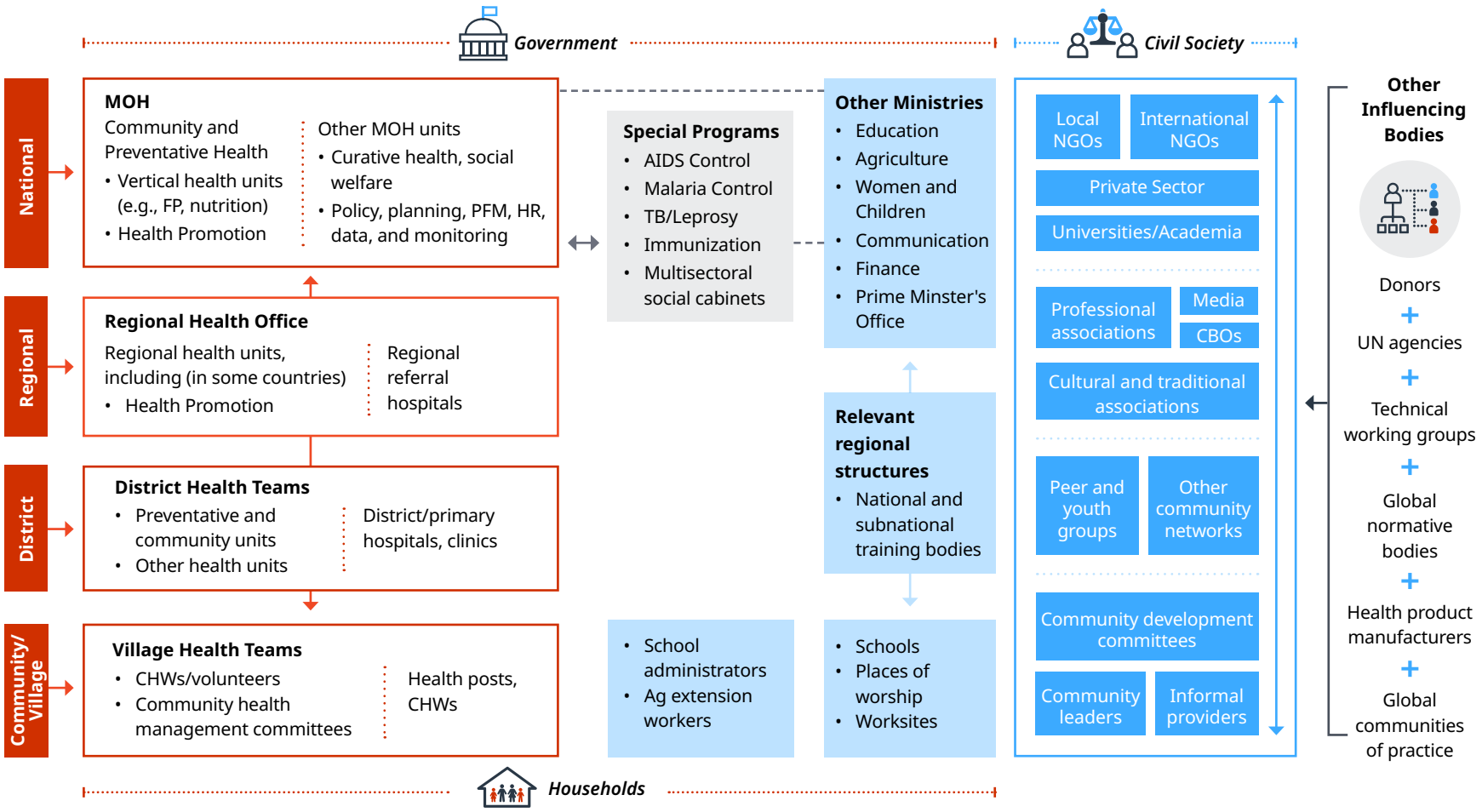
Tips for institutionalizing the role of community structures within the SBC system

1. Map and work through existing primary health care structures that bridge communities and facilities
2. Integrate SBC into routine planning and implementation, fostering collaboration between existing community structures, government, CSO, and private sector agencies
3. Integrate social accountability mechanisms, working with community structures to hold services accountable
4. Include community structures in SBC and organizational development-related capacity strengthening efforts, and the co-design of strategies and activities
5. Advocate for policy support that recognizes and supports the role of community structures in SBC programming
6. Document, share, monitor, and evaluate to improve SBC supervision and ongoing monitoring, and strengthen the role that community structures play

Source: Save the Children

Figure 5 below shows a generic map of an SBC system, reflecting these actors and illustrating where SBC-related functions typically reside within a health system, and where there are common connections to non-health programs and ministries. The interface between the public health system with civil society and other influencing bodies and actors is also depicted.

Figure 5. Illustrative SBC system's map



SBC SYSTEM VARIATIONS

SBC systems do not look the same everywhere and there are many variations. Below are some common variations we see within SBC systems at a country level.

Table 2. Common SBC system variations

Leadership of SBC	
	Where leadership for health SBC resides varies country-to-country, and in some countries, it resides within several different MOH units. In Ethiopia for example, SBC is governed by the Public Relations and Communications Office, with expertise within horizontal health case teams and the Health Extension Program; Maternal Health, Neonatal, and Child Health; Adolescent and Youth Health; Malaria Elimination Program; and Family Planning Program. In Ghana, it is led by the Health Promotion Division under the management of the Ghana Health Service.
Level of decentralization	
	SBC-related work is relatively centralized in some countries, whereas in others, there is greater autonomy subnationally, where SBC is planned for, funded, and coordinated. In many countries, SBC-related structures may exist at subnational levels but not have a strong mandate or requisite funding. In contexts, such as Zimbabwe, for example, there is a mandate for structures and decentralization of SBC, but funding and the authority of these structures is less robust, or nascent. In countries like India and Nigeria, SBC-related work resides within Ministry structures at national and sub-national/state levels, with oversight, planning, and funding that is more decentralized.
Role of civil society	
	In many contexts, government plays a predominant role in leading and coordinating SBC activities; in others, civil society assumes greater coordination and implementation functions. In countries like South Africa and Thailand, for example, structures for SBC-related work exist within the government but CSO actors play a vibrant role in engaging with communities and implementing SBC work, at times in collaboration with ministry partners.
Donor influence	
	In many contexts, donor funding drives and sustains significant SBC programming and related priorities; in these contexts, both donor and other global actors may exert greater influence over the SBC systems than in other contexts.

Table 3. Select "SBC system" examples

Nigeria

The SBC system in ***Nigeria*** is complex, varying from the national (FMoH) to state levels. The national level is overseen by the Department of Family Health, which is made up of five divisions including Health Promotion. The HPD is responsible for creating health-related public policies, strengthening community action, health promotion capacity strengthening, reorienting health providers, developing SBC materials, and creating public awareness campaigns. The division's work is hampered in areas related to intersectoral collaboration, management structure, infrastructure, and technical capacity. At the state level, there is a replica of the Health Promotion Division, which faces similar challenges. Across all Local Government Areas in Nigeria, there are community structures, such as Ward Development Committees, Village Development Committees, Health Facility Committees, and health promotion officers. These structures, however, are often not empowered or adequately engaged.

Singapore

Singapore's health promotion and disease prevention efforts at the national level are centralized and under the responsibility of the Health Promotion Board (HPB), a statutory body under the MOH. The HPB develops and implements national health campaigns at different stages of life – children, youth, adults and the elderly, within schools, the workplace, and community, to address various health concerns, such as diabetes prevention, smoking cessation, and mental health awareness. The HPB also works in partnership with other organizations in the adoption of healthier lifestyles. For example, for the Healthier Dining Program, HPB partners with food and beverage businesses to increase the availability and accessibility of healthier food options, such as increasing the availability and promotion of wholegrain rice and bread, as well as drinks with lower sugar content.

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South Africa

The Department of Health in ***South Africa*** has two key divisions related to SBC: Health Promotion and Communications. Health Promotion focuses on community engagement and health promotion in schools and clinics, while Communications handles mass media campaigns for health issues. The National Health Promotion Directorate develops policies and strategic plans, but implementation occurs at the provincial and district levels. There is no equivalent structure for health promotion or SBC overall, so civil society has played an important role in this function.

Uganda

The ***Uganda*** health system lacks regional SBC-related offices. Dotted connections, however, between entities exist, driven by development partners. These include SBC system connections to regional referral hospitals, which have varying relationships with district structures within their given geographical areas. Informally, District Health Offices, especially district health officers and district health educators are linked through national and regional forums. At the national level, the MOH advances SBC through its Community Health and Health Promotion and Education Departments. These two departments have some overlapping mandates. Other relevant departments include the Uganda AIDS Commission, which sits under the Office of the President. It also, at times, faces duplication in functions with the National AIDS Control Program, which sits under the MOH.

SYSTEMS' DRIVERS

Knowing what motivates different actors across the system can help inform strategies to increase their engagement and participation. By recognizing the opportunities and challenges that exist across actors and levels, it is possible to gain insight into how to best shape the behavior of those involved in the design and implementation of SBC capacity and systems strengthening plans and related advocacy agendas for each. All actors within the SBC system are influenced by a range of factors, which can impact their performance against core functions and contribute to the level of quality, impact, and sustainability of SBC programs, processes, and structures. This understanding can help SBC actors identify behavioral patterns, values, information flows, and relational networks that may affect how institutions, people, and systems operate. Table 4 below outlines some of the factors that can facilitate SBC system's work or impede it.

Table 4. Illustrative system-level incentives and disincentives

Actor	Incentives	Disincentives
Government agencies 	• Supportive policies that facilitate SBC work • Increased budget allocation • Recognition of successful SBC initiatives • Collaboration with NGOs and recognition by donors • Opportunities to generate trust among citizens	• Limited budget • Competing priorities • Bureaucratic challenges • Political changes • Lack of sustained commitment
NGO, CSO, and community structures 	• Funding from donors and partnerships with government • Recognition of expertise • Ability to achieve their organizational vision/serve their community • Opportunities to innovate	• Uncertain funding • Administrative burdens • Lack of coordination • Staff and volunteer turnover

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Actor	Incentives	Disincentives
Donors and UN agencies 	• Funding for effective SBC programs • Recognition for successful SBC work • Alignment with global health priorities	• Shifts in funding priorities • Onerous reporting requirements • Competing demands on resources
Academic and training institutions 	• Recognition for research contributions • Opportunities for professional growth • Resources to advance focal areas	• Limited research funding • Resource constraints • Slow integration of research findings into practice
Media organizations 	• Collaboration with public health organizations • Recognition for impactful reporting • Positive audience feedback • Alignment with social responsibility goals	• Pressures from commercial interests • Censorship • Competing interests • Potential manipulation
SBC learning/ collaboration networks 	• Collaboration opportunities • Capacity strengthening support • Potential for collective impacts • Recognition for best practices	• Limited resources • Coordination challenges among members • Duplication of efforts • Low levels of engagement
Private sector 	• Co-financing opportunities • Access to broader markets • Opportunities for corporate social responsibility • Building a positive public image and trust	• Conflicts of interest • Reputational risks • Divergent business priorities

CONNECTIONS WITHIN THE HEALTH SECTOR

Stronger connections are needed across SBC-focused actors within the health system. Often, SBC professionals and activities within vertical health programs are disconnected from the work of health promotion units, and vice versa. Leadership and planning for SBC within overall Ministry PFM units is frequently weak. More concerted approaches to collaboration, shared advocacy and SBC prioritization, and SBC financing are needed.

CONNECTIONS TO OTHER SECTORS

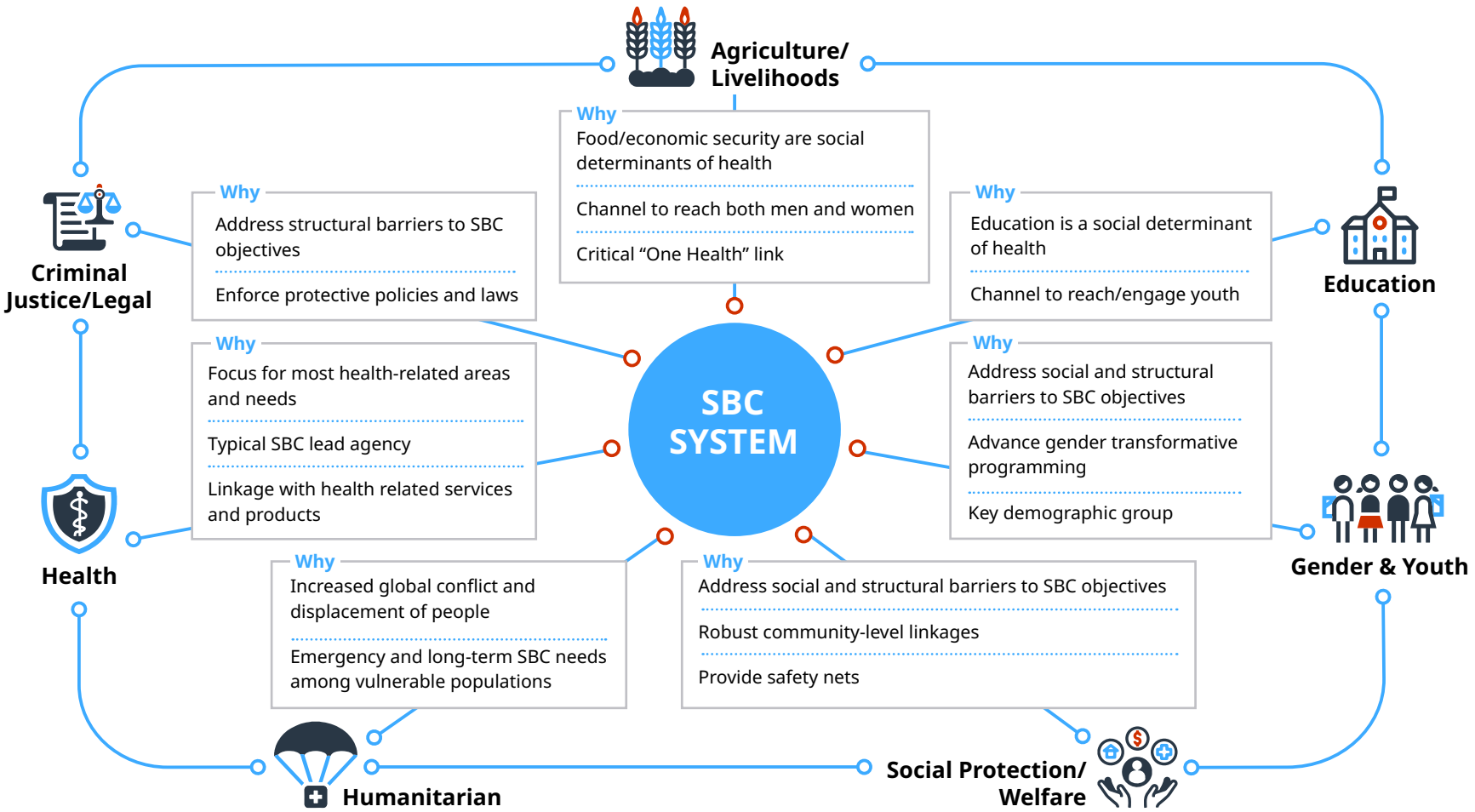
If achievement of the *SBC Blueprint's* vision is to be realized, more intentional and routine collaboration towards shared objectives across sectors and SBC actors is required. This is because determinants of health are both multifaceted and interdisciplinary. This requires both system and SBC actor-level changes related to collaboration, planning, financing, and management. Thus, it is important for SBC actors to increase collaboration and coordination with systems and sectors outside of health-focused SBC programming. Increased multisectoral collaboration offers the potential to:

- Optimize resources and avoid duplication of efforts
- Ensure maximum coverage to individuals and communities
- Enable more robust SBC strategies capable of addressing the wide range of individual, interpersonal, social, and structural factors, and social determinants of health, that impede or facilitate healthy behaviors

We believe this will lead to increased sustainability within the systems that govern SBC, as well as greater sustainability of SBC outcomes that are delivered by the system.

Some illustrative systems/actors where increased coordination is needed, at various levels of SBC implementation can be found in Figure 6 below. Effective collaboration with many of these sectors would enable stronger SBC strategies capable of better addressing determinants of priority behaviors and the social determinants of health. Neighborhoods, the built environment, and other social and community contextual factors are also critical to consider by CSOs and community-level stakeholders when devising SBC strategies. The quality of SBC initiatives produced by the SBC system is directly related to how the system functions and interacts with other systems.

Figure 6. Rationale for the SBC systems' connections with other sectors for health-related objectives



Note: within all sectors there are objectives that can be addressed and met through use of SBC strategies. This document focuses on those with primarily a health-related end objective.

Ensuring strong supply and demand-side linkages

To ensure effective SBC interventions, the SBC system must establish strong linkages with supply side actors and systems. This includes:

Collaboration with suppliers, providers, and other stakeholders involved in the production and delivery of products and services. SBC practitioners can:

- Identify supply side actors as part of SBC system mapping
- Establish partnerships that outline commitments and collaboration objectives

Coordination to ensure that health products and services offered are responsive to the community's needs and available when they are needed. SBC practitioners can:

- Engage in joint planning, resource sharing, routine mechanisms/forums for coordination as part of partnership plans

Alignment of SBC activities with product/service availability. SBC practitioners can:

- Co-plan community events and activities by synchronizing activities and campaigns with service delivery schedules
- Create ongoing communication channels between service delivery and SBC partners so that there is shared knowledge when there is key product unavailability to inform SBC activities and communication with community members

Integration of feedback mechanisms to monitor, address and identify system's level barriers to access (e.g., provider attitudes). SBC practitioners can:

- Collect feedback on service and product availability and quality with community members via community events, post-service (exit interviews), or through community platforms designed to increase community/facility linkages, like community health committees and/or through social accountability platforms

By establishing these linkages, the SBC system can enhance the effectiveness and sustainability of SBC efforts, ensuring that the necessary resources are in place to support desired health outcomes.

Most SBC actors recognize the importance of intra- and multisectoral collaboration for SBC to: a) address multilevel and shared determinants of health and other development objectives, and b) ensure demand side interventions are aligned with supply side strengthening. Numerous barriers, however, impede the SBC system in achieving this type of coordination and collaboration. These include but are not limited to systemic obstacles that make collaboration appear insurmountable to those advancing day-to-day SBC work in the face of numerous other challenges. Some examples include:

- Inconsistent budgetary priorities and allocations across ministries, units, and sectoral actors
- Lack of ownership or incentives to foster intra- or intersectoral collaboration
- Intra- and inter-ministerial conflicts and disputes
- Inadequate coordination within the government, donors, and SBC implementers
- An overall absence of long-term vision and shared objectives across and within sectors
- Regulatory discrepancies and conflicts (e.g., health regulations may clash with marketing or advertising regulations for products like breast milk substitutes, alcohol, or nicotine)
- Stakeholder fragmentation
- Lack of a “lead unit” for SBC-related work in non-health sectors and sometimes, even within the health sector
- Data sharing constraints and lack of interoperability

To overcome these barriers and foster effective collaboration, a range of facilitating actions may be required. Some illustrative examples are included in Table 5.

Table 5. Strategies to overcome barriers to cross-sector collaboration

Strengthening policy frameworks	
	Enhancing both health systems and financing requires the integration of SBC initiatives into policy dialogues and their prioritization within health financing strategies. This involves the strategic allocation of resources for SBC through policy frameworks emphasizing intra- and inter-sectoral collaboration. These frameworks should clearly define the roles, responsibilities, and coordination mechanisms among pertinent sectors, with a focus on incorporating SBC indicators into benefit package designs to maximize the effectiveness of strategic purchasing for SBC services.
Establishing intra- and intersectoral committees or task forces	
	Forming dedicated committees or task forces comprising representatives from different sectors can facilitate regular communication, collaboration, and joint decision-making. These platforms can serve as spaces for sharing best practices, resolving conflicts, and strategy alignment.
Promoting shared funding mechanisms	
	Establishing Equity Funds and/or other shared funding mechanisms promotes intra- and inter-sectoral collaboration through pooled financial resources, fostering coordinated efforts among health units and sectors to achieve risk pooling objectives. Institutionalizing pooling enhances cost-effectiveness by reducing duplications and fragmentation. Harmonizing policies across schemes ensures the complementarity of resource pools, including benefit entitlements and provider payment mechanisms. Integrating SBC financing assessments and cross-program efficiency analyses is crucial for aligning health system functions.
Encouraging knowledge exchange and capacity strengthening	
	Promoting knowledge exchange platforms, training programs, and workshops that bring together professionals from diverse health units and sectors can enhance understanding and strengthen capacity for collaborative approaches. This allows for the exchange of expertise, lessons learned, and best practices.
Contributing to shared indicators	
	Shared indicators for priority areas can help align goals across units/actors, facilitate communication and shared action, improve accountability, and increase impacts. These can be advanced through participatory efforts between actors to identify and define common goals, and establishing joint processes for their uptake and roll out.
Engaging civil society and communities	
	Actively involving CSOs, community representatives, community platforms, and other stakeholders fosters grassroots participation and ensures that interventions are community driven. Engaging local communities in decision-making and implementation processes enhances the relevance and effectiveness of SBC initiatives in ways that address local needs, which are inherently multifaceted. CSOs are often more frequently engaged in multisectoral work, than their government counterparts, operating across a variety of sectors to advance their mandates.

By addressing the barriers and implementing these facilitators, intra- and inter-sectoral collaboration in the SBC sector can be strengthened. This can enable the development and implementation of integrated SBC strategies, maximizing the impact of SBC efforts, and leading to improved health and development outcomes. Some strong examples of multisectoral collaboration and/or integration can be observed in the areas of:

- Resilience, food security, and nutrition
- Humanitarian and crisis response
- Global Health Security Agenda/One Health
- Global and national responses to HIV
- Water, sanitation, and hygiene
- Population, health, and environment
- Mental health and psychosocial support
- Healthy City initiatives to improve physical and social environments

Examples of multisectoral coordination that removes siloes

Colombia: The Ministry of Health and Social Protection in Colombia has a Prevention and Promotion Directorate with two sub-directorates focused on communicable and non-communicable diseases. They have developed SBC strategies for dengue prevention, COVID-19, and Human Papillomavirus (HPV) vaccination and promote a Healthy Cities, Environments, and Rurality Strategy at the departmental/municipal level. The country's private Health Promotion entities deliver and/or promote use of SBC strategies among their affiliates. Other Ministries, such as Sports and Education, also lead SBC programs at the municipal level.

Cambodia: The Cambodian Government established the National Committee for Early Childhood Care and Development (ECCD) as a multisectoral mechanism to achieve the country's National Action Plan on ECCD (2022-2026). The Committee, with representation from across 11 different government ministries has a commitment of over 10 million United States Dollars for five years, to 1) provide opportunities for quality, equitable, and inclusive early childhood education, 2) promote early childhood health and care, 3) provide adequate nutrition to women and young children, 4) ensure the safety of young children, and 5) provide responsive care, protection, and development for young children.

The *SBC Blueprint*: Getting to More Sustainable SBC Systems

The *SBC Blueprint*: Getting to More Sustainable SBC Systems

WHAT IS A SUSTAINABLE SBC SYSTEM?

Sustainable SBC systems are comprehensive in their approach and enduring, enabling country level support for long-term SBC efforts, short-term response needs, and contributing to the SDGs. Practically, this includes the presence of sufficient capacities and resources to design, implement, monitor, and oversee quality SBC interventions that respond to identified and mutually agreed upon needs and priorities.

Characteristics of a sustainable SBC system includes a variety of attributes – like accountability, transparency, responsiveness, etc. – that enable the successful execution of a set of core system-level functions. A sustainable SBC system recognize that social change and behavior change are complex and ongoing processes requiring long-term commitment, investment, and collaboration to create positive change at individual, interpersonal, social, and structural levels.

A strong SBC system also reflects values that advance:

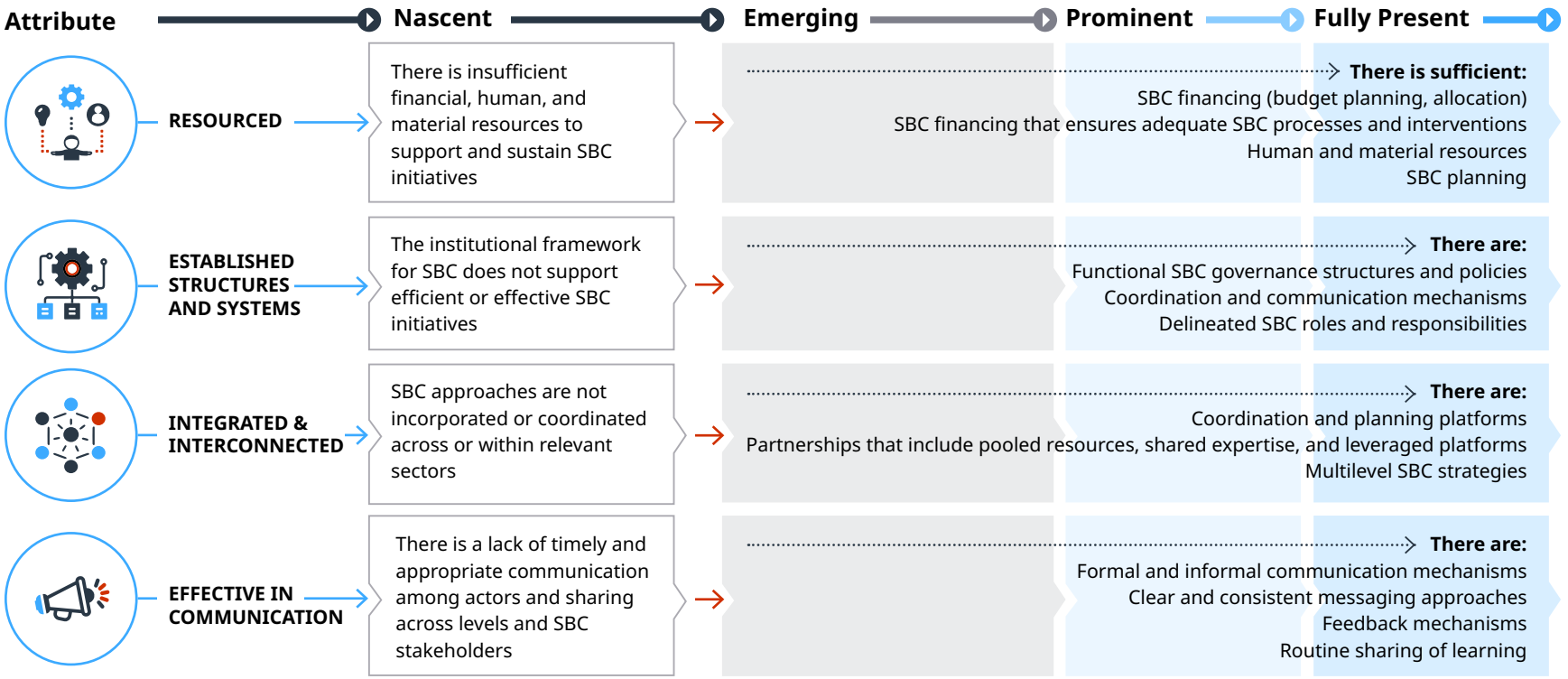
- Gender and social inclusion
- Equity
- Meaningful participation and local ownership
- Use of evidence-based practices and data
- Collaboration and partnership
- Ethics and professionalism
- Sustainability
- Resilience

> ***"A structure that is not funded is as good as a structure that is not there."***
>
> – *SBC Blueprint* ***Guiding Committee member***

ATTRIBUTES OF A SUSTAINABLE SBC SYSTEM

Attributes are inherent qualities or features of a system that support SBC (see Figure 7). While we may strive for an SBC system to embody these attributes to the highest degree, each country level SBC system will exhibit them at different levels. This variation highlights areas for continuous strengthening. The attributes overlap and are not mutually exclusive. Each attribute is important on its own, as well as in relation to the presence or absence of other system attributes. Country level SBC systems can be placed on a continuum for each attribute or set of complementary attributes, ranging from nascent (where the attribute is not reflected) to fully present. Most country level SBC systems fall somewhere within this spectrum. Attributes and system functions have a mutually dependent relationship. Strengthening SBC-related functions can lead to a more prominent display of strong SBC system attributes.

Figure 7. SBC system attributes



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Attribute	Nascent	Emerging	Prominent	Fully Present
EVIDENCE AND DATA BASED	SBC initiatives are not informed or driven by data, research, and community insight			**There is:** Research and data that are complexity aware, available, and used Co-design and implementation of SBC research and activities with communities Collaborating, learning, and adapting and routine use of data
LOCALLY LED	Lack of local active involvement, participation, and ownership of SBC initiatives			**There is:** Prioritization and strategic direction led by local actors Community leadership and ownership Commitment to SBC Technical and institutional capacity
PARTICIPATORY	System actors work independently to adapt and address SBC priorities			**There is:** Transparent decision-making, informed by SBC stakeholders and communities Collaboration and partnership Communication around decision-making, its criteria, and SBC outcomes
ACCOUNTABLE	Lack of functional, or any, mechanisms to ensure SBC actors and institutions are responsible for SBC actions and outcomes			**There is/are:** Commitment to transparency A culture of engagement and responsiveness System actions that foster trust and credibility
TRANSPARENT	Lack of openness and accessibility of information, processes, and decision-making			**There is:** Access to information (budgets, expenditures, plans, reports) Clear and inclusive decision-making processes Routine M&E and learning dissemination Adherence to SBC ethical and professional standards
RESPONSIVE	Lack of flexibility, adaptiveness, and capability to address evolving SBC needs and stakeholder feedback			**SBC initiatives:** Seek out stakeholder and community input routinely Use research/needs assessments/co-design processes to understand and address needs Are adaptive to changing priorities Offer timely and effective communication Can respond rapidly when needed
GENDER EQUITABLE AND SOCIALLY INCLUSIVE	Gender and social inclusion principles and needs are not adequately considered, relative to the make up of the SBC system, nor in advancement of its work			**SBC initiatives ensure:** Aspects related to gender are considered in research, design, implementation, and M&E Gender and other social inclusion factors are considered as part of the establishment and strengthening of structures that govern SBC (HR, policies, leadership) SBC initiatives address social vulnerabilities and advance gender transformative approaches

FUNCTIONS OF A STRONG SBC SYSTEM

The functions of an SBC system are the specific tasks and activities that the system performs to support SBC interventions. These functions are aimed at promoting positive social and behavioral outcomes within a target population. The following are key functions associated with an SBC system:

1. Planning, strategy, and policy development

This includes the development of comprehensive SBC plans, strategies, and policies. It includes conducting needs assessments, defining target audiences, setting objectives and SBC-related targets, selecting appropriate channels and behavior change techniques, and designing implementation frameworks, in alignment with national to community-level needs. It also entails development of appropriate SBC budgets and related financial forecasting to ensure the sustained delivery of SBC strategies and plans (linked with resource allocation and management below) and supporting the scale up of evidence-based practice. This function also requires engagement with non-SBC actors that previously may not have been engaged in SBC initiative planning, like PFM and cross-sectoral agencies.

Some questions to consider:

- Do national strategies for vertical health areas have delineated SBC sections?
- Do SBC strategies include indicators to be measured and reported on?
- Are SBC strategies or strategy components costed?
- Have evidence and community priorities and needs informed SBC strategies?
- Were stakeholders across sectors, relevant to topic, engaged to ensure SBC strategies address not only individual but also social and structural factors?
- Are there opportunities to develop in-country behavioral science or insights labs within the Office of the President or Prime Minister, MOH, or within academic universities to strengthen government policies, laws, and systems?

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2. Collaboration, coordination, and partnerships

Collaboration, coordination, and partnership building are crucial functions of an SBC system. This involves establishing and nurturing relationships with various stakeholders, including government agencies, NGOs/CSOs, community leaders, and other key actors both within and outside of the health system. Collaboration facilitates the coordination of efforts, sharing of expertise, and leveraging of resources for more comprehensive and sustainable SBC interventions.

Some questions to consider:

- Are there functional technical working groups (TWGs) or other structures that guide coordination and collaboration across SBC actors towards national objectives?
- Are there relevant, functional coordinating mechanisms also at subnational levels?
- Are there mechanisms in place to ensure that national SBC priorities and plans are advanced and reported on across implementing partners?

3. Resource allocation and management

This includes identifying, growing, and securing the necessary resources (funding, HR, material resources) and effectively managing and distributing these resources to support the quality implementation of SBC initiatives. Related to human capital, this function includes both the provision of adequate numbers and types of SBC-related personnel (as aligned with roles needed) and ensuring they are qualified and equipped to perform their job. This function also requires engagement with non-SBC actors that previously may not have been engaged in SBC initiative planning, like PFM and cross-sectoral agencies.

Some questions to consider:

- Are the SBC components of national strategies incorporated in broader MOH five and 10-year costed strategies and quarterly, annual, and multi-year budget cycles?
- Have HR personnel been costed and planned for, sufficient to carry out SBC-related needs and relative to national objectives and goals?
- Are there SBC staff capacity strengthening plans in place to ensure staff have resources and training needed to perform their job?
- From SBC system and stakeholder mapping, are there opportunities to leverage activities and/or generate cost share to achieve SBC objectives and goals?

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4. Technical oversight

This function entails ensuring that SBC initiatives align with and advance national priorities, as appropriate; that materials and media are of high quality, technically accurate, and culturally appropriate; and that SBC actors and institutions are delivering SBC implementation and MERL activities according to professional and ethical standards.

Some questions to consider:

- Are SBC initiatives aligned with national priorities?
- Are there processes in place to ensure that materials and media produced and used are of high quality, technically accurate, and are contextually relevant?
- Are SBC programming and MERL activities conducted in accordance with professional and ethical standards? Are there accountability mechanisms in place for this?
- Is there an adaptive management strategy or process in place to improve SBC initiatives, materials, and/or media using feedback and data?

5. Capacity strengthening and SBC professional development

This function ensures a pipeline of trained and qualified SBC professionals performing different functions across the SBC system, including both technical and management-related functions. At lower levels, this may include in- or pre-service training with frontline workers or other cadres directly engaging with community members around SBC needs.

Some questions to consider:

- What training programs are currently in place for SBC professionals?
- Does the system ensure continuous training and qualification of SBC professionals in both technical and management functions?
- How does the system ensure that SBC professionals are updated with the latest knowledge and best practices in their field?
- What resources or support are provided to SBC professionals to enable them to carry out their functions effectively?
- How are the roles and responsibilities of SBC professionals defined and communicated within the system?

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6. SBC intervention design

This function includes the creation and production of SBC messages, materials, media, and activities. It involves behavioral prioritization, formative research, message development, material design, and activity development. It also includes identifying and using appropriate channels per audience and change objective and engagement/reach objectives. Intervention examples may include advocacy, social mobilization, SBCC, community engagement, interpersonal communication, provider behavior change, nudging, product/service linkages and referrals (health, financial, etc.), service design improvements, etc.

Some questions to consider:

- Who is responsible for the creation and production of SBC messages, materials, media, and activities?
- How are behavioral priorities determined and who is involved in this decision-making process?
- What methodologies are used for formative research, message development, and media design?
- Are there processes in place that standardize how change and engagement/reach objectives are measured?
- How are communication and non-communication strategies considered and integrated during the SBC design phase?

7. SBC intervention implementation

This function encompasses the actual delivery of SBC interventions and involves coordinating and managing the execution of SBC strategies and activities with appropriate dosage and sequencing. SBC program implementation also involves ensuring the quality and fidelity of interventions (linked with technical oversight above).

Some questions to consider:

- What mechanisms are in place to guide the coordination and execution of SBC strategies and activities?
- What strategies are in place to ensure the appropriate dosage, sequencing, and layering of SBC interventions?
- How is technical oversight linked with the implementation of SBC interventions?
- What systems and processes are in place to track the effectiveness of interventions and to guide adjustments to strategies?
- What processes are followed to ensure that all actors in SBC program implementation are adequately trained and supported?

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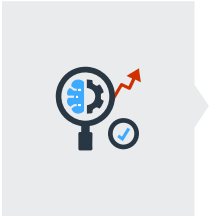
8. SBC monitoring, evaluation, research, and learning (MERL)



This function includes systematically tracking and assessing the progress, effectiveness, and impact of SBC interventions and setting up and maintaining routine feedback and accountability systems. It includes designing complexity aware MERL approaches, collecting data, analyzing resources, measuring SBC outcomes, and adjusting activities routinely, based on the findings, as well as fostering adaptive management through use of data and stakeholder and community engagement. It also includes increasing capacity for evidence generation, knowledge management activities, and the dissemination of learning.

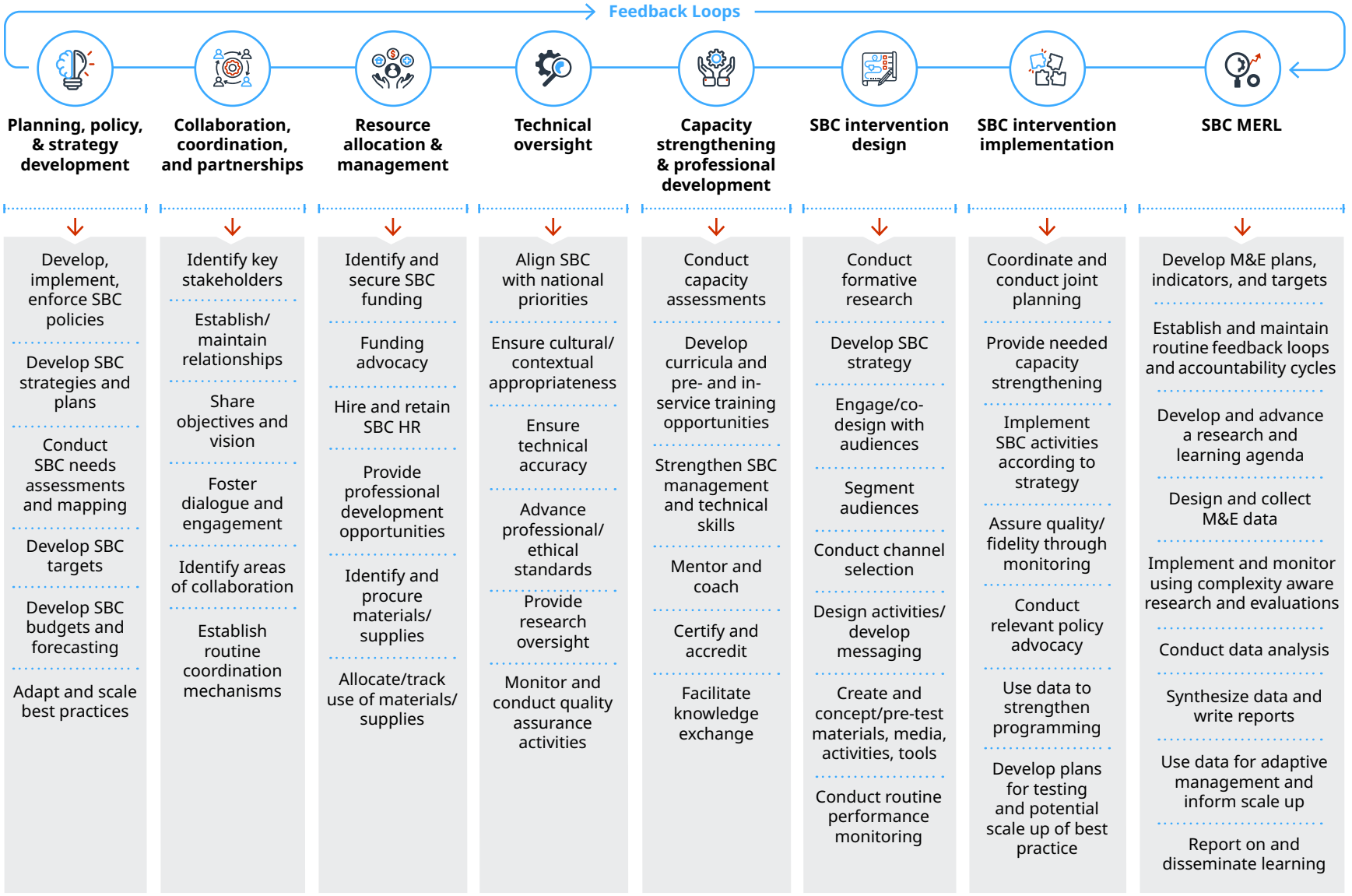
Some questions to consider:

- Are SBC indicators routinely collected as part of health management information systems (HMIS)?
- Are there processes in place to systematically track progress of SBC interventions?
- Are there established metrics used to measure the effectiveness and impact of SBC interventions?
- Is there consideration of complexity aware monitoring within SBC programming?
- How is collaborating, learning, and adapting fostered in the system? Do processes use data and include stakeholder and community engagement?
- Are there individuals and systems responsible for knowledge management/dissemination of learning and findings?

These functions work together in an integrated manner to ensure the effective planning, implementation, evaluation, and oversight of SBC initiatives within the SBC system. Each function plays a vital role in supporting the overall goal of achieving sustainable positive SBC outcomes.

In Figure 8, we have mapped sets of SBC system functions to inform capacity and institution strengthening plans and activities. For each SBC system function, there are several sub-functions or activities that need to be carried out to successfully deliver on the primary function.

Figure 8. SBC functions and sub-functions



REQUIRED SBC SYSTEM-LEVEL COMPETENCIES

Competencies are the knowledge, skills, and abilities that individuals or organizations need to possess to effectively deliver on the functions of an SBC system. Competencies can include a range of areas such as communication, behavior change theory and models, research and data analysis, program management, and advocacy, etc. Across SBC system functions and sub-functions, there are a set of core competencies (Table 6) that are required to achieve each SBC system need. SBC competencies can span several functions and can be categorized into management (operational, financial) and technical competencies. SBC-related competencies that relate to the function and attributes of a strong SBC system should be measured and addressed as part of more holistic SBC-focused capacity and systems strengthening strategies. Relevant competencies will also vary among type of actor. For example, government actors will have different competencies than NGOs or other actors. In addition, some competencies can be considered "core" competencies while other may be more advanced skills.

To support strengthening of an SBC system at a country level:

- Table 6 provides illustrative core technical competencies
- Table 7 provides illustrative core management competencies

Table 6. Illustrative SBC technical competencies

Capacity area	Illustrative competencies
SBC understanding 	• Able to apply SBC theories and models • Able to articulate and prioritize SBC strategy goals and objectives, including desired behavior changes and determinants, with consideration of gender and social inclusion principles • Can identify and apply evidence-based SBC practices, drawing from a range of behavioral sciences • Knowledge of SBC/research professional and ethical standards • Can demonstrate health area SBC subject matter expertise
SBC design 	• Able to apply participatory methods and facilitation (e.g., HCD) to engage individuals and communities in SBC design • Able to plan respectful community entry • Can develop SBC strategies, programs, materials, and tools • Able to segment audiences • Can develop effective SBC activities and messages and employ co-design approaches with communities and other stakeholders (e.g., service delivery partners) • Able to effectively manage and engage creative agencies, research agencies, and other expertise

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Capacity area	Illustrative competencies
SBC implementation 	• Able to engage health (e.g., service delivery partners) and non-health-related implementing partners as appropriate to strategy • Able to strengthen SBC technical capacity across cadres • Can conduct SBC quality assurance activities • Able to deliver SBC activities with high quality and fidelity to strategy • Able to apply M&E data for routine quality improvement of SBC programs • Can develop SBC training and capacity strengthening interventions • Can demonstrate facilitation, training, mentoring, and coaching skills
SBC MERL 	• Show understanding of research design and methods, including those that are complexity aware • Able to design MERL plans, develop indicators and targets • Can conduct formative research/needs assessments • Can implement routine MERL activities • Able to synthesize data, write reports, conduct dissemination activities • Can carry out research oversight and adhere to research ethics
SBC systems' linkages 	• Able to align SBC programs with national health and SBC priorities • Can develop/integrate SBC in policies and strategies • Can develop/integrate SBC indicators into HMIS • Able to facilitate partnerships and collaboration across levels and actors • Able to articulate non-health-related factors to address in SBC strategies • Can identify and coordinate with others to maximize reach, cost effectiveness, and impacts
Policy advocacy 	• Able to develop and implement a policy advocacy agenda for SBC across MOH divisions, PFM, non-health ministries, HR and information management units, and service delivery actors, among others • Able to advocate with national information systems for inclusion of SBC-related indicators • Can identify and foster champions for SBC in MOH and other sector ministries

Table 7. Illustrative SBC financial and management competencies

Capacity area	Illustrative competencies
General skills 	• Can demonstrate system's thinking and planning skills • Can demonstrate data-driven decision-making ability and use of adaptive management approaches • Able to demonstrate cultural competence • Able to demonstrate professional and ethical standards • Can apply strategic thinking • Can demonstrate results-based management approaches
Planning and management 	• Can conduct SBC strategic planning • Can procure SBC-related supplies and services and manage vendors • Can manage SBC materials and supplies inventories • Able to accurately cost and forecast financial needs
Financial resourcing 	• Able to appropriately identify SBC costs and budget • Able to advocate for SBC resources • Can demonstrate understanding of the funding landscape and SBC funding cycles • Able to integrate SBC financial needs into annual and semi-annual plans • Can exercise strong financial management skills • Can conduct cost analyses • Able to advocate for sustainable health financing mechanisms and policies to prioritize SBC investments • Can monitor and evaluate the effectiveness and efficiency of health financing strategies in supporting SBC programs, including tracking expenditures, assessing value for money, and measuring impact on health outcomes • Can identify and access diverse health funding sources such as government allocations, donor grants, health insurance, and social health protection schemes for SBC programs • Capable of integrating health financing considerations into strategic planning and budgeting processes for SBC interventions, ensuring alignment with health sector priorities and financial sustainability
Human resources 	• Able to develop, implement, and institutionalize pre- and in-service training and professional development initiatives • Can conduct HR planning and performance management • Able to strengthen SBC staff technical and management capacities
SBC systems' linkages 	• Able to conduct stakeholder and network mapping and analyses • Can identify and coordinate with others to maximize reach, cost effectiveness, and impacts • Can build and sustain relationships with other organizations/institutions and develop partnerships • Able to effectively engage with private sector actors • Can collaborate with information management-focused units for SBC data collection and reporting needs

THE ROLE OF ADVOCACY

Advocacy plays a pivotal role in advancing the scope and effectiveness of SBC initiatives, particularly by addressing both demand and supply-side challenges and coordination and collaboration needs. Crucially, advocacy agendas must support true SBC versus SBCC/health promotion agendas and ensure approaches to address social and behavioral challenges are appropriately grounded in evidence and use strategies appropriate to shift relevant factors. A more expansive understanding will support comprehensive strategies that better address diverse community needs. Furthermore, it is essential to augment support for SBC within supply-side functions, such as healthcare and education, where structural and institutional bottlenecks often impede effective implementation. Targeted advocacy agendas are needed that not only highlight the necessity of SBC, but also ensure the structural readiness of institutions to support these changes effectively. SBC advocates can push for reforms and resources that enhance the capacity of these systems to support SBC activities. Significant focus must be placed on financing SBC initiatives, especially through collaboration with ministries of finance. By securing adequate funding and ensuring that financial policies support SBC strategies, advocates can better ensure sustainable and scalable impacts.

Monitoring, Evaluation, Research, and Learning (MERL)

Monitoring, Evaluation, Research, and Learning (MERL)

The purpose of routine MERL related to SBC and capacity and systems strengthening activities is to systematically track and assess the progress, effectiveness, and impact of the SBC system and its changes overtime. It involves collecting and analyzing data to understand how the system is functioning, identifying areas for improvement, and informing adaptive management decisions. This includes:

1. Routine monitoring of SBC activities via implementers and country HMIS to ensure alignment with plans
2. Evaluation of SBC intervention impacts
3. Routine monitoring of SBC management and technical competencies tied to capacity strengthening activities
4. Assessment of the structures and mechanisms that support the SBC system tied to systems strengthening activities
5. Evaluation of relevant collaboration efforts to measure the level of partnership and shared planning
6. Support for adaptive management to refine capacity and systems strengthening work

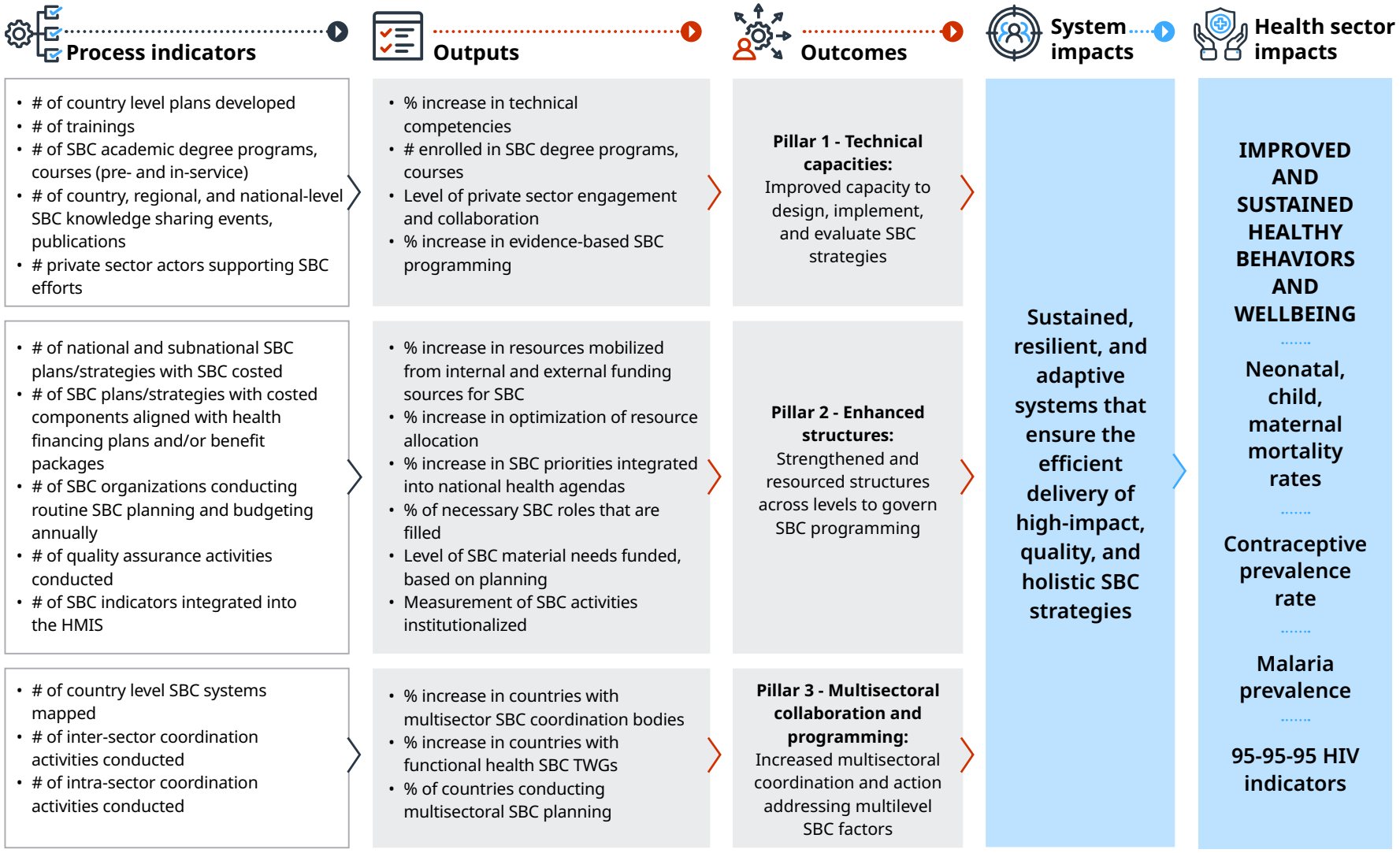
SBC MERL indicator integration

Through the Ghana Communicate for Health project, FHI 360 worked with the MOH, other implementing partners, and UNICEF to integrate SBC indicators into Ghana's HMIS. Of the 34 indicators added, 22 were focused on process and outputs, and adopted for tracking via paper registries. FHI 360's follow-on project, the Ghana Accelerating Social and Behavior Change (ASBC) activity, further refined these indicators and improved collection of disaggregated data for decision-making. Revised reporting tools were tested with 417 staff across four regions, resulting in updated reporting tools for national scale up and use. The government also selected three SBC indicators for inclusion in its Holistic Assessment Tool, a framework for identifying health system strengths and weaknesses. Today, ASBC is advocating for more sustainable, electronic data collection methods. Example indicators include:

- % of SBC plan activities implemented
- # of SBC advocacy activities conducted
- # trained in interpersonal communication skills
- # reached through SBC activities
- % of clients satisfied with services
- % of audiences practicing desired behaviors

By conducting routine MERL activities focused on monitoring and measuring changes in: a) behaviors and social norms, b) SBC system competencies, c) structures for SBC, and d) multisectoral collaboration, stakeholders can gain valuable insights into the functioning of the system and its overall performance. This information can enable them to identify strengths and weaknesses, adapt SBC and capacity and systems strengthening strategies and interventions, and foster continuous learning and improvement. It ultimately supports the overall goal of strengthening the SBC system's capacity to effectively drive social change and behavior change and achieve sustainable outcomes. See Figure 9 for example SBC capacity and systems strengthening indicators as aligned with the proposed results framework, presented in Figure 4.

Figure 9. Illustrative SBC systems strengthening indicators



Data sources:
Health sector impacts: Data sources to measure health sector impacts include national surveys, such as the Demographic and Health Survey, Malaria Indicator Survey, Performance Monitoring for Action surveys, and other national surveys. These surveys may also provide information on shifts in behaviors and norms overtime and may be complemented by other national or implementer-led baseline surveys and HMIS data, where applicable to service seeking behaviors.

Other indicators: Data sources may include routine M&E data, reporting on SBC indicators as part of HMIS systems, special surveys, capacity assessments, and through qualitative studies and assessments.

At the country level, as national *SBC Blueprints* are developed and implemented, it is our hope that a community of SBC practitioners will coalesce around sharing and disseminating learning on sustainable SBC systems. As part of this idea, there is hope that we can develop a shared learning agenda that will guide our work. Some initial proposed learning agenda questions are below.

Illustrative learning agenda questions

1. What is the current vision and theory of change for SBC systems in different contexts? How can these be articulated and shared among stakeholders?
2. What are the major barriers and challenges to achieving a more sustainable SBC system? How can these challenges be identified and addressed? What are the facilitators? How can these be leveraged?
3. What are the capacity strengthening needs of country level SBC actors? How can these needs be identified and prioritized among actors in the system?
4. What are the best practices and lessons learned from other countries or regions that have successfully strengthened their SBC system? How can these insights inform the development of actionable steps for SBC systems strengthening elsewhere?
5. How can M&E mechanisms be integrated into the SBC system to track progress, identify gaps, and support evidence-based decision-making?
6. How can partnerships and collaborations be fostered among different stakeholders to strengthen the SBC system and achieve shared goals? Does increased intra- and cross-sector engagement result in more impactful SBC strategies?
7. How can sustainability and long-term funding for SBC be ensured? What strategies and approaches can be explored to secure financial resources for ongoing capacity and systems strengthening?

Conclusions and Recommendations

Conclusions and Recommendations

The *SBC Blueprint* presents a comprehensive framework that addresses the complex challenges of SBC initiatives in diverse contexts. It aims to create a shared vision for sustainability within the SBC field at the country level, advocating for greater investments in SBC system-level strengthening alongside traditional technical capacity strengthening. By fostering collaboration, coordination, and partnerships across sectors, the *SBC Blueprint* seeks to enable country level actors to achieve sustainable improvements in health behaviors and social norms, by strengthening the systems responsible for achieving these.

Recognizing the interconnectedness of health and development, the *SBC Blueprint* emphasizes the importance of addressing social and structural determinants of health, alongside individual and interpersonal factors, to achieve lasting impacts on public health outcomes. This requires an expanded, more holistic definition of SBC than is currently employed. It acknowledges the need for sustainable, country-led SBC system that can effectively oversee, design, implement, and evaluate SBC initiatives. To achieve this vision, the *SBC Blueprint* proposes three key outcome pillars: bridging SBC technical capacities; enhancing governmental, civil society, and community structures for SBC; and fostering enhanced multisectoral collaboration and programming. These outcome pillars, together with the core attributes and functions of a sustainable SBC system, described above, provide a roadmap for countries to strengthen their SBC capacity and institutional strengthening approaches over time.

Overarching recommendations

1. **Strengthen SBC policy frameworks:** Governments should develop comprehensive SBC policy frameworks that explicitly promote intra- and inter-sectoral collaboration for SBC. These frameworks should outline roles, responsibilities, and mechanisms for coordination and cooperation among relevant sectors.
2. **Foster collaboration and partnerships:** SBC actors, including government agencies, NGOs, civil society, and international organizations, should actively engage in collaborative efforts and partnerships to maximize resources and align strategies for comprehensive and sustainable SBC interventions.

3. **Invest in capacity strengthening:** Governments and donors should prioritize capacity strengthening and SBC professional development to ensure a skilled and qualified workforce capable of implementing evidence-based SBC initiatives effectively.
4. **Embrace data-driven decision-making:** Regular MERL activities and indicators should be integrated into SBC systems to track progress, assess effectiveness, and inform adaptive management decisions. Sharing data across sectors and improving data quality are crucial for evidence-based decision-making.
5. **Promote local ownership:** Local communities and CSOs should be actively involved in the design, implementation, and evaluation of SBC interventions, ensuring that initiatives are community-driven and address local needs.
6. **Address barriers to collaboration:** Efforts should be made to overcome barriers to intra- and inter-sectoral collaboration, such as inconsistent budget priorities, lack of ownership incentives, and inter-ministerial conflicts. Strengthening regulatory frameworks and stakeholder engagement can also facilitate collaboration.
7. **Foster a learning community:** Establish, or build upon, communities of SBC practitioners to share experiences, lessons learned, and best practices related to sustainable SBC systems. These communities can contribute to a shared learning agenda that guides future efforts in the field.

By following these recommendations and working together to build more sustainable SBC systems, we can better address urgent global challenges and contribute to improved health equity, social change, and positive development outcomes for all. The *SBC Blueprint* provides the framework necessary to enable this transformation, empowering countries to lead their own SBC efforts and contribute to the achievement of the SDGs.

Recommendations to advance *SBC Blueprints* at the country level

This document lays out key considerations for countries in developing their own *SBC Blueprint* – or plan for SBC capacity and systems strengthening – and provides the tools, necessary to guide this process. In taking these recommendations forward, it is suggested that country governments and SBC actors:

1. ***Work to develop their own vision of what sustainability for SBC looks like in their context*** and what objectives they hope to achieve in developing an *SBC Blueprint* to strengthen these. These may include objectives around SBC system performance, like improved contributions to national goals and objectives using SBC strategies, increased quality and capacity for SBC, and strengthened structures to oversee and carryout SBC functions. These visions should include clearly defined objectives and milestones toward their achievement.
2. Using participatory approaches, ***map the SBC system in their country*** to enable identification of all actors and stakeholders where engagement, collaboration, and connections should, and do exist, to achieve the goals outlined in the country's vision. This mapping should identify strengths and weaknesses within the current system and identify potential areas for improved collaboration. It should also identify opportunities for shared objectives and initiatives to leverage.
3. ***Create an SBC Blueprint using the country's vision and system mapping as a guide.*** In a collaborative effort with key identified stakeholders, country teams can use the *SBC Blueprint's* tools (current and future) to create a detailed plan. This plan should outline specific SBC capacity and systems strengthening objectives, activities, resources, and capacity needs, as well as leadership structures necessary to realize national SBC visions.
4. ***Align SBC programming.*** SBC initiatives within the country should be aligned with their *SBC Blueprint.* This can be facilitated through SBC and other TWGs, coordinating bodies, and inclusion in national strategies. All stakeholders should be committed to the implementation of their national *SBC Blueprint.*

5. ***Implement, monitor, and evaluate.*** National *SBC Blueprints* should guide implementation of capacity and systems strengthening activities across actors, supported by ongoing capacity strengthening, technical assistance, and M&E. M&E should include continuous reporting to stakeholders and partners, as well as adaptive management mechanisms for updating *SBC Blueprints* routinely. As the SBC system strengthens and evolves over time, objectives and milestones should be adjusted. Focus on the integration of SBC indicators, suitable for integration within national HMIS, also needs to be front and center of any SBC systems strengthening work.
6. ***Promote best practices.*** As countries implement their own *SBC Blueprint*, it is highly recommended that they share their experience and best practices among country, regional, and global stakeholders. This can be facilitated through knowledge sharing platforms and networks.

It is our hope that SBC practitioners and donors will use the *SBC Blueprint* to guide country level efforts to strengthen their own SBC system. This document (and future tools and resources linked to the *SBC Blueprint*) are intended to support this. Together, they will support users to go through a systematic process to imagine, design, validate, implement, and monitor a country level *SBC Blueprint* for their needs.

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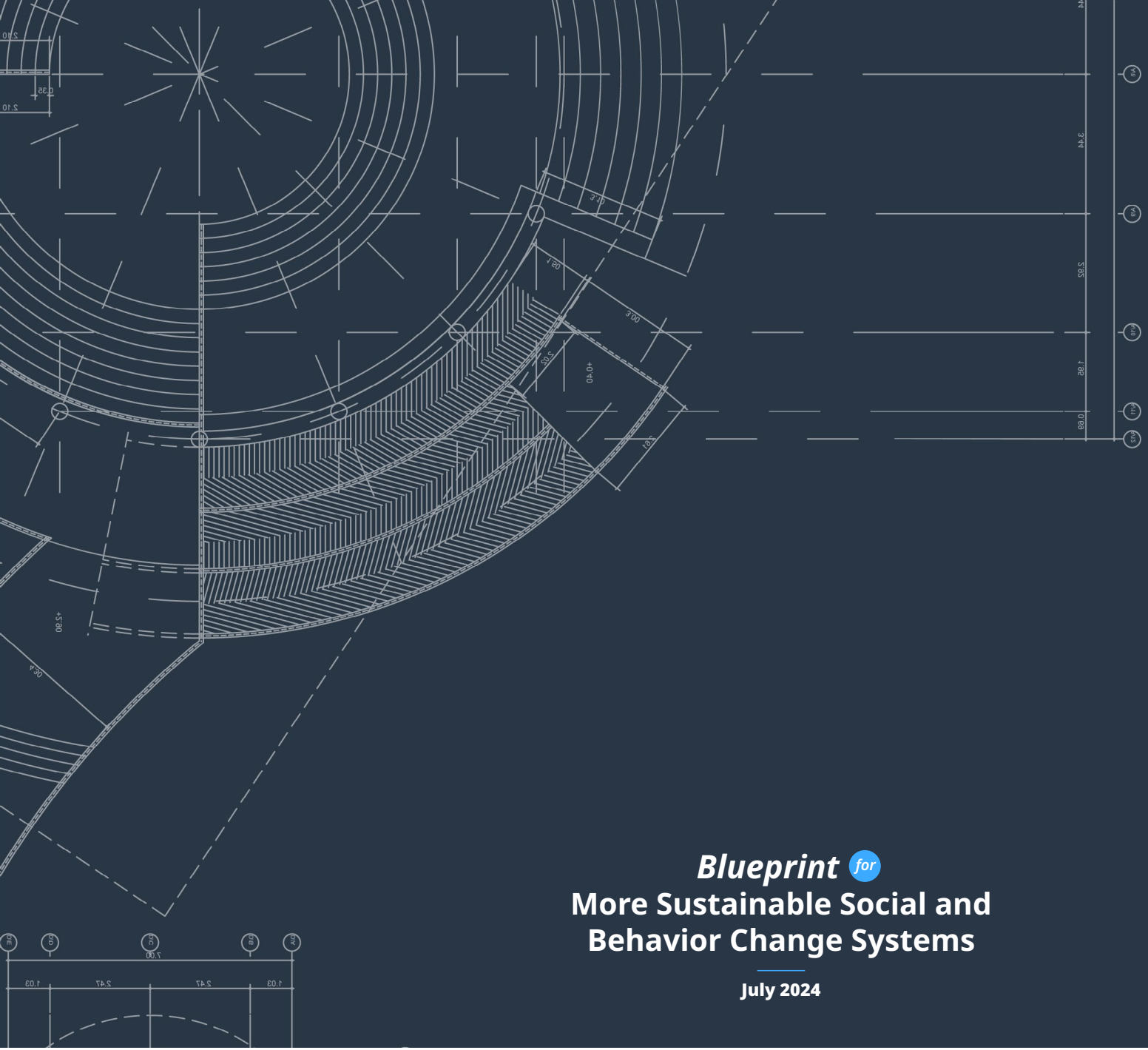

Blueprint for More Sustainable Social and Behavior Change Systems

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