FP Accelerator Plus

BNA Tool Annexes: Module C SBC

Annex C1: SBC background and recommendations

Background on Social & Behaviour Change (SBC) programming

SBC approaches aim to produce changes in individual behaviours, social norms, and the enabling environment to increase reproductive autonomy and contraceptive uptake. SBC programmes involve interventions at the individual, community, and societal levels to promote the adoption of healthy practices. SBC programmes usually draw from behavioural science and theory including in disciplines related to communication, social psychology, anthropology, behavioural economics, sociology, human-centred design, and social marketing. They also are informed by health promotion practices that foster communication, collaboration and dialogue between health systems/services and local communities.

SBC is frequently used to promote family planning in societies with high fertility norms or settings with social and gender norms that restrict women's autonomy and access to comprehensive sexual and reproductive healthcare. SBC interventions commonly aim to address various behavioural determinants influencing the uptake and continuation of modern contraception including norms about family, sexuality, and fertility; couple communication or involvement in FP; perceived personal and social costs; fears and misconceptions around contraceptive methods and their side-effects; low health literacy, including perceptions of pregnancy risk; and religious or other social disapproval of preventing pregnancy.

SBC can also be used to address the challenges that vulnerable groups face in accessing family planning services, for example by addressing conservative values and attitudes that might limit adolescent or youth access to services.

SBC interventions can also play an important role in improving client engagement with health services, enabling community participation in quality improvement processes, and reinforcing linkages with other areas of health and social development. As such, SBC complements the areas of service delivery and the enabling environment to strengthen family planning programs.

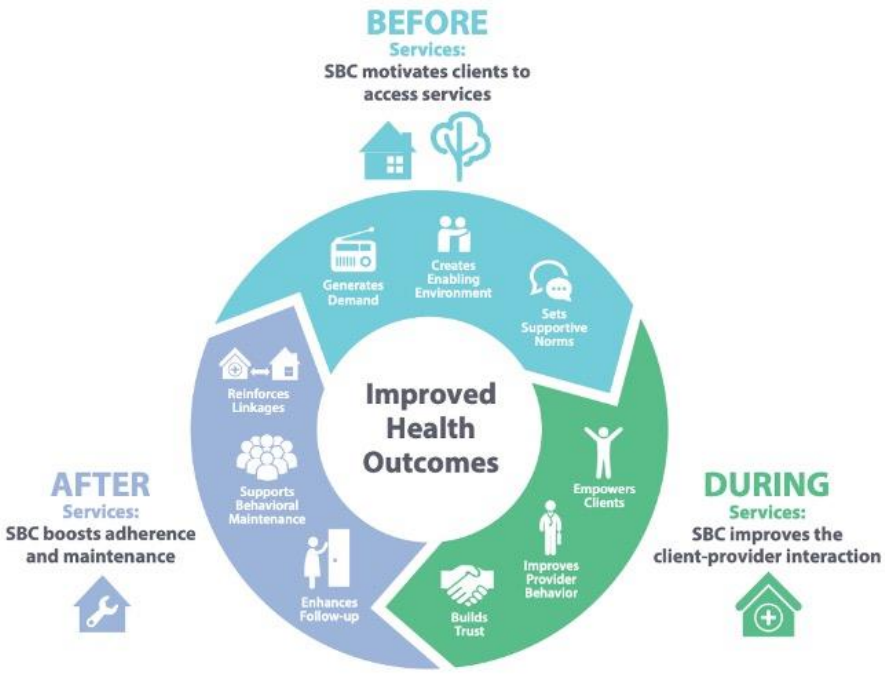
Common SBC interventions considered in the BNA include:

- **Mass media:** Programmes designed to reach a large audience using TV, radio and social media. They can be used to shift social norms, for example through carefully designed TV or radio soap operas.
- **Community engagement** including:
  - **Interpersonal communication:** One-on-one or couple communication designed to inform, educate and empower individuals, couples and families on family planning and broader sexual and reproductive health themes. Delivered either in the home, community or health facility.
  - **Community group engagement:** The approach works with and through community groups to influence social norms, engender community support, and in turn, influence individual behaviours, rather than by targeting individuals. Programmes use participatory methods and techniques (such as reflective dialogue, mapping, dramas, etc.). They involve community members and are often facilitated by external workers (NGO staff, district health teams, community health workers).
- **Digital health for SBC:** Use of mobile phones, tablets or other digital technology in support of SBC goals, including for marketing communication and addressing social and behavioural barriers to FP use or continuation; or for links to or follow-up from service contacts.

Other interventions can also be used to achieve SBC, including sex and relationships education delivered via school-based programmes or peer-to-peer influencers. These approaches are not covered in this BNA.

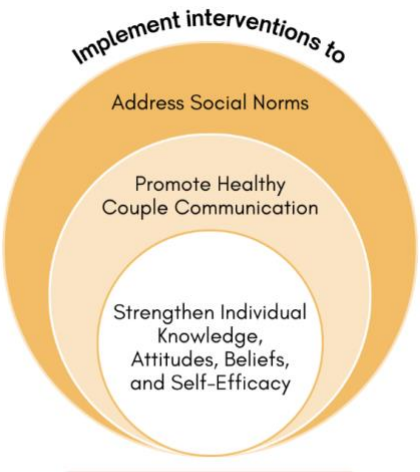
SBC interventions are also commonly implemented through a 'circle' of care before, during and after engagement with health services, as shown in Figure 1 below.

Figure 1: SBC Circle of Care [Source, Breakthrough Action]



SBC interventions usually aim to effect change in one of three levels: changes in social norms, the promotion of healthy couple or family communication, and strengthening of individuals' knowledge, attitudes, beliefs, or self-efficacy (Figure 2).

Figure 2: Outcomes of SBC activities [Source: USAID HIP on SBC]



Recommendations on SBC

Principles and recommended practices of SBC discussed here are summarized from recommendations in the SBC HIPs, UNICEF's SBC Guidance, and various WHO guidelines including: *Ensuring human rights in the provision of contraceptive information and services,*[1] *Community and provider-drive social accountability intervention for family planning service provision: experiences from the field*,[2] *Recommendations on digital interventions for health system strengthening,*[3] and *WHO recommendation on community mobilization through facilitated participatory learning and action cycles with women's groups for maternal and newborn health*.[4]

General principles and recommended practices of SBC for FP are:

1) SBC uses a people-centred approach, including ensuring participation of relevant communities and stakeholder groups in SBC intervention design and implementation processes.
2) SBC should use existing community platforms and social infrastructure (e.g. civil society groups, religious organizations, local media etc.).
3) SBC should be rights-based and gender-sensitive, ensuring reproductive autonomy free from coercion, alongside fully free and informed choice of services and contraceptive methods. Interventions should address the norms, values and attitudes that surround sex, reproduction, gender and contraception.
4) SBC activities should be coordinated between different authorities and organizations implementing them, to avoid confusion and mixed messaging.
5) SBC activities should ensure access to quality family planning services.

Design and implementation principles and recommended practices for SBC are:

6) SBC is based on a deep understanding of the local context, including use of formative research in behavioural intervention design, and adaptation of interventions to the local situation and needs.
7) SBC objectives should be clear, including selection of intended behavioural changes in different groups.
8) SBC activities and communication should be adapted to the situation and needs of different groups, and 'audiences' segmented according to relevant profiles (demographic, psychographic, life stage, behavioural factors, literacy, phone ownership etc etc.)
9) SBC communication should be multi-channel, or 'transmedia', to achieve maximum impact.
10) SBC should follow evidence-based design processes, including formative research, iterative design, tailored messaging, and monitoring & evaluation. Messages should be fully tested with target audiences and/or co-designed with them. Monitoring and evaluation should seek to measure changes in priority determinants, including social and gender norms, and behaviours. SBC design should be based on behavioural theory and insights.
11) SBC should be systems-oriented, with intervention design adapted to address how individual behaviours are influenced by broader social, economic and political systems.

Health service principles and recommended practices for SBC are:

12) All health services should ensure they are part of a continuum of education and health promotion activities on family planning, delivering information, education and counselling –to both individuals and couples.
13) All health facilities should meaningfully engage the communities they serve in reproductive health provision, with client/patient inputs and feedback used routinely for quality improvement.

SBC interventions identified in WHO systematic review

This table details the types of intervention included in WHO's recent systematic review on bottlenecks to demand generation strategies. It should be noted that this review did not investigate the broader enabling environment for SBC, and included a selection of SBC interventions, not all.

*Table *: Summary of the reports of demand generations strategies*

Main Demand Generation strategy	Outcomes	Number of studies	Summarized review finding	GRADE-CERQual Assessment
Unique demand generations strategies				
Interpersonal communication	Adoption, Coverage, Sustainability	16	Interpersonal communication increases the use of modern contraceptive methods. The effect on sustainability is uncertain.	Moderate confidence
Mass media	Adoption, coverage	8	Mass media exposure increases knowledge and positive attitudes. Mass media may increase the intention to use modern contraceptive methods. The effect of new media is uncertain.	Moderate confidence
Demand side financing	Awareness, Adoption, Coverage	7	Demand-side financing approach (using vouchers or small cash incentives) probably increase awareness of contraceptives and the use of modern contraceptive methods among poor women.	Moderate confidence
Multifaceted demand generations strategies				
Interpersonal communications plus Mass media	Adoption, Coverage, Sustainability	12	Interpersonal communications plus Mass media increase adoption, use and sustainability of modern contraceptive methods among women and among men as well.	Moderate confidence
Interpersonal communications plus mass media	Awareness, Coverage, Sustainability	2	Interpersonal communications plus financing plus mass media increase the awareness and use of modern contraceptive methods and may promote sustainability	Low confidence
Interpersonal communications plus financing	Adoption, Coverage	1	Interpersonal communications plus financing may increase the intention to use and the actual use of contraceptive methods, particularly in people below poverty line.	Very Low confidence

Bottlenecks to SBC scale-up identified in WHO systematic review

People

- Knowledge about family planning methods, especially regarding side effects and health concerns
- Woman's preference and acceptability
- Engagement of partners in discussing family planning
- Interest to discuss family planning
- Motivation to use family planning
- Reach of mass media
- Social acceptability to approach unmarried women to discuss contraception
- Traditional and religious beliefs regarding the number of children

Financing

- Affordability of family planning services
- Financial benefits associated with practicing family planning

Health workforce

- Providers' age, gender, and religion
- Family planning nurses and community healthcare workers sharing sound knowledge
- Number of Health workforce, especially female healthcare workers

Leadership and governance

- Concurrent multiple demand generation programs within the same area in need
- Consistency of implementing family planning programs
- Degree of reliance on donor driven management and funding
- Endorsement of family planning by the government
- Integration of community-based health workers into healthcare system
- Integration of NGO trained field workers into the healthcare system

Medical products

- Availability of modern contraceptive methods
- Number of methods available to women

Service delivery

- Accessibility to family planning services
- Ease of use of the family planning method

Annex C2: BNA Planning tool

This is a suggested timeframe for implementing BNA activities (modules A-C). This assumes that the different module content can be assessed simultaneously. The editable version is contained in the BNA Excel file.

		Enter progress here:	Week no.							
TASK	ASSIGNED TO, e.g.:	PROGRESS	1	2	3	4	5	6	7	8
Preparation										
Assessment tool review	BNA consultant	0%								
Problem definition, assessment adaptation and optional preparatory field visit	BNA consultant	0%								
Ethics exemption (if required)	BNA consultant	0%								
PPFP Assessment										
National data review	BNA consultant	0%								
Guidance & policy alignment assessment	BNA consultant	0%								
Case studies	BNA consultant	0%								
Open-ended questionnaire	BNA consultant	0%								
Questionnaire analysis	BNA consultant	0%								
Workshop preparation	BNA consultant	0%								
PPFP Consensus workshop	BNA consultant	0%								
Task-sharing assessment										
National data review	BNA consultant	0%								
Guidance & policy alignment assessment	BNA consultant	0%								
Case studies	BNA consultant	0%								
Open-ended questionnaire	BNA consultant	0%								
Questionnaire analysis	BNA consultant	0%								
Workshop preparation	BNA consultant	0%								
TS Consensus workshop	BNA consultant	0%								
SBC assessment										
National data review	BNA consultant	0%								
Guidance & policy alignment assessment	BNA consultant	0%								
Case studies	BNA consultant	0%								
Open-ended questionnaire	BNA consultant	0%								
Questionnaire analysis	BNA consultant	0%								
Workshop preparation	BNA consultant	0%								
SBC Consensus workshop	BNA consultant	0%								

Annex C3: Policy & Guidance Alignment Assessment for SBC

This review includes assessment of policies and guidance, but it may be useful to also review a selection of recent SBC materials and media to see how these align with or adhere to recommended principles of SBC (Q15-16) . The types of documents to review were listed in the core protocol (Table 3), but more specifically the following could be included:

1. FP/RH policies/strategies/guidance that should incorporate* SBC for FP/RH
2. Health promotion and/or SBC policies/strategies/guidance that should incorporate* FP
3. Policies/strategies/guidance on specific BNA interventions for RH (mass media, community engagement (including interpersonal communication & group engagement), digital)
4. Policies/strategies/guidance on related health communication workstreams (e.g. counselling, health promotion)
5. Broader policies/strategies/guidance on social and gender norms for RH

*Any policy/strategy/guidance that needs to involve behavioural and social norms change

Q #	Question	Level of policy and guidance alignment (full/partial/none)	Rationale for level assigned (e.g. conflicting guidance, unclear guidance, ad hoc evidence of implementation etc.)	Information sources (if document, state name of document & year; if key informant, state name/role)
1	FP/RH policy & guidance documents recommend scale-up of SBC interventions			
2	FP/RH policy & guidance documents recommend use of community health workers for RMNCH health promotion, including FP			
3	FP/RH policy & guidance documents recommend use of mass media to promote FP			
4	FP/RH policy & guidance documents recommend use of community engagement, including interpersonal communication and groups, to promote FP			
5	FP/RH policy & guidance documents recommend use of digital health to promote FP			

Q #	Question	Level of policy and guidance alignment (full/partial/none)	Rationale for level assigned (e.g. conflicting guidance, unclear guidance, ad hoc evidence of implementation etc.)	Information sources (if document, state name of document & year; if key informant, state name/role)
6	FP/RH policy & guidance documents aim to address social and gender norms that may inhibit use of FP			
7	FP/RH policy & guidance documents aim to involve men and promote healthy couple communication			
8	FP/RH policy & guidance documents aim to strengthen the knowledge, attitudes, beliefs and self-efficacy of individual women and girls			
9	FP/RH policy & guidance documents recommend community engagement, including working with community leaders, religious leaders, or other trusted opinion leaders, to promote FP			
10	FP/RH and SBC policy & guidance documents adhere to recommended and evidence-based principles for SBC (see Annex 1), including: - adherence to rights-based programming principles - community participation - adaptation to local context and target population - use of evidence-based structured design processes - monitoring, evaluation and learning of interventions			
11	FP/RH and SBC policy & guidance documents advise on effective approaches for SBC in family planning, along with strength of evidence in the local context			
12	There are clear indicators for success for SBC in policy and guidance documents			

Q #	Question	Level of policy and guidance alignment (full/partial/none)	Rationale for level assigned (e.g. conflicting guidance, unclear guidance, ad hoc evidence of implementation etc.)	Information sources (if document, state name of document & year; if key informant, state name/role)
13	Policy & guidance documents advising mass media include guidance on formative research, pre-testing messaging, targeting of communication, selection of appropriate channels, audience segmentation, working with local community platforms or infrastructure, and the need to address equity in SRH.			
14	Policy & guidance documents advising community health groups empower participants for collective action and promote community agency			
15	SBC materials produced by MOH (national, state/regional, district) align with recommended principles of SBC (Annex 1): - Mass media materials (including radio/TV campaigns, advertising campaigns, influencer campaigns etc.) - Community engagement materials (including leaflets, training guides, etc.) - Digital materials (including SMS campaign content, videos, apps, social media, etc.)			
16	SBC materials produced by NGOs (health implementers, community organisations, faith-based organisations etc.) align with recommended principles of SBC (Annex 1): - Mass media materials (including radio/TV campaigns, advertising campaigns, influencer campaigns etc.) - Community engagement materials (including leaflets, training guides, etc.) - Digital materials (including SMS campaign content, videos, apps, social media, etc.)			

Annex C4: Data review for SBC

				Responses *(Enter ND if no data available)*				
Background: Current FP status	**Module**	**Potential Data source**	**Suggested breakdown**	**All WRA**	**Rural WRA**	**Urban WRA**	**<20 WRA**	**>=20 WRA**
Modern contraceptive prevalence (% among women of reproductive age)	**All**	DHS or PMA	Rural/urban, <20/>=20					
% all women of reproductive age relying on Long Acting or Permanent methods of FP	**All**	DHS or PMA	Rural/urban, <20/>=20					
% all current contraceptive users relying on Long Acting or Permanent methods of FP	**All**	DHS or PMA	Rural/urban, <20/>=20					
% of women with unmet need for FP	**All**	DHS or PMA	Rural/urban, <20/>=20					
% of women knowing at least 3 modern methods	**All**	DHS or PMA	Rural/urban, <20/>=20					
% of FP users with full method information index (informed of side effects, told what to do if experience side effects, informed of other methods of FP)	**SBC**	DHS or PMA	Rural/urban, <20/>=20					
% of women intending to use FP in the future (or next 12 months)	**SBC**	DHS or PMA	Rural/urban, <20/>=20					
% of women practicing covert FP use	**SBC**	DHS or PMA	Rural/urban, <20/>=20					
% of women not using FP due to health concerns or fears of side effects	**SBC**	DHS or PMA	Rural/urban, <20/>=20					
% of female non-users intending to use FP in the future	**SBC**	DHS or PMA	Rural/urban, <20/>=20					
% of women FP users making decisions about FP on their own or jointly with their husband	**SBC**	DHS or PMA	Rural/urban, <20/>=20					
% of women FP non-users making decisions about FP on their own or jointly with their husband	**SBC**	DHS or PMA	Rural/urban, <20/>=20					
% of FP clients involved in decisions about their care during FP consultations	**SBC**	DHS SPA FP exit	Rural/urban, <20/>=20					

				Responses *(Enter ND if no data available)*				
Background: Current FP status	**Module**	**Potential Data source**	**Suggested breakdown**	**All WRA**	**Rural WRA**	**Urban WRA**	**<20 WRA**	**>=20 WRA**
% of women exposed to different FP messages (via different channels: radio/TV, newspapers, mobile phone, online)	**SBC**	DHS	Rural/urban, <20/>=20					
% of women exposed to different media in the population (in past month or year) -TV -radio - online/digital	**SBC**	KAPB or media surveys	Rural/urban, <20/>=20					
% of women with access to phones: - mobile phones - smart phones	**SBC**	KAPB or communication surveys	Rural/urban, <20/>=20					
% of facilities with available visual aids for FP (flip charts, leaflets)	**SBC**	DHS SPA Inventory						
No. or % of districts with active health promotion teams	**SBC**	HMIS (?)						
No. or % of health facilities with community outreach for RMNCH *	**SBC**	HMIS (?)						
No. of organisations (NGOs, media, faith-based organisations) implementing SBC activities related to FP (either nationally or in selected regions (illustrative).	**SBC**	Estimate from reports						

*It would be helpful to identify the scale of SBC programming occurring in health facilities. This could be identified via budget line allocation, or via reports (facility, district health team, etc.)

Annex C5: Case studies summary (use one table per module)

Title of project or programme with short description (Select 2-3 case studies) (include the strategies and key populations included)	Where was the project or programme implemented? (States, regions, districts)	Who implemented it?	What behavioural outcomes were desired and what were the achievements?	What were some of the health systems factors that made the project a success? (Review Bottlenecks Framework)	What were some of the challenges? (Review Bottlenecks Framework and SBC principles)	Any other relevant information including lessons learned?

Annex C6: Key Informant Questionnaire for SBC

WHO Family Planning Accelerator Plus

Bottlenecks Assessment (BNA)

KII Questionnaire – SBC

Introduction

Who is running this assessment?

This questionnaire is part of a national 'FP Bottlenecks Assessment' being coordinated by the World Health Organization, investigating the scale-up of evidence-based practices in family planning.

What is the purpose of this questionnaire?

This questionnaire will ask about your opinions on a range of potential health systems 'bottlenecks' (or barriers or factors) that may be inhibiting scale-up of effective approaches for social and behaviour change in family planning (FP). SBC covers a range of health promotion and social and behaviour change-focused interventions including:

- the use of mass media
- community engagement including via interpersonal communication or community groups
- digital health engagement (mobile, web, apps, social media etc.)

SBC can include communication and health promotion within health facilities, community outreach activities led by health facilities, national campaigns, or activities implemented by civil society (NGOs, CBOs). Its objective is usually to impact one of three key outcomes: social norms change, promoting healthy couple communication, and strengthened individual knowledge, attitudes, beliefs and self-efficacy.

You will be asked to rate your agreement out of 5 with a series of statements (from fully agree to fully disagree). You can also add comments about each statement if you wish. At the end, you can mention any potential barriers or challenges that have not been raised in the questionnaire.

Why am I being asked to complete it?

You have been purposefully selected as a person with considerable knowledge on family planning programming in this country, on approaches to SBC. Your opinions will be greatly valuable for the Bottlenecks Assessment.

What happens afterwards?

A consensus-building workshop will be held with a range of different stakeholders to identify the most important bottlenecks, and to identify solutions to address them.

Is my contribution anonymous?

Everything you write in this questionnaire or tell us in person will be anonymized. We will only ask questions about your work role.

What happens if I refuse or don't have time to participate?

Nothing, please just let us know that you are not able to complete the questionnaire and we will seek another informant. There will be no impact on your employment.

Section		Q #	Preliminary questions	Circle the correct response:	Any comments
Background		**1.**	What type of organization do you work for (circle number that applies)?	1. Government 2. Professional association 3. NGO or civil society 4. Private 5. Other_____	
		2.	What is your role in that organisation (circle number that applies)?	1. Policy 2. Programme management 3. Researcher/M&E 4. Clinician or health worker (community or facility, please specify) _____ 5. Other_____	
		3.	At what level to you provide support to FP programmes (circle number that applies):	1. National 2. Sub-national or regional 3. District 4. Community 5. Other_____	
		4.	How long have you been working in or supporting FP programmes (circle number that applies):	1. <1 year 2. 1-3 years 3. 3-10 years 4. >10 years	

BNA Framework Theme	Categories	Q #	Respondents to state their level of agreement with the following statements: (1) Fully agree (2) Somewhat agree (3) Neutral (4) Somewhat disagree (5) Fully disagree DK= don't know	Response rating 1-5 or DK:	Any comments
Implementation status		**5.**	**SBC for family planning is adequately implemented and scaled-up nationally** ***Consider these statements when rating:*** • SBC for FP is well implemented and scaled across both the public and private/NGO health sector. • SBC on FP is integrated into broader development programming including education, WASH, humanitarian, livelihoods, environment, etc. • Mass media campaigns are implemented to address social and gender norms impacting reproductive health and to promote FP. • Health facilities work to address social and gender norms impacting RH and promote FP in their catchment populations through various community engagement activities (e.g. community outreach, mobilization, home-based counselling, campaigns such as 'FP days', digital marketing and engagement (mobile, online), etc.) • There is broad scale digital engagement on RH (via phones, apps, social media, web, etc.) to address social and gender norms impacting reproductive health and to promote FP. • Health facilities actively try to inform, educate, and empower clients coming for FP about methods and their side effects before, during and after their visits. • Health facilities actively try to inform, educate, and empower clients coming for maternal & child, HIV or other linked health services about FP. • Health facilities actively try to engage men in family planning, either via couples counselling or via other strategies to reach and educate men and adolescent boys.		

BNA Framework Theme	Categories	Q #	Respondents to state their level of agreement with the following statements: (1) Fully agree (2) Somewhat agree (3) Neutral (4) Somewhat disagree (5) Fully disagree DK= don't know	Response rating 1-5 or DK:	Any comments
Governance	**Leadership & commitment**	**6.**	**There is strong leadership and commitment to support scale-up of SBC for FP** ***Consider these statements when rating:*** • There is political support for SBC for FP at the national level • SBC is included in national FP goals • SBC for FP has champions advocating for the practice at the national level • SBC for FP has champions advocating for the practice at the state/regional level • The MOPH sets out objectives, guidance and principles for SBC but allows states/regions and districts to determine locally relevant communication approaches		
	Accountability	**7.**	**There is strong accountability for SBC for FP across institutions and among policy makers and programme managers** ***Consider these statements when rating:*** • There is accountability and coordination across different institutional structures (public, private and non-governmental authorities) to enable effective SBC policy development and programming. • A public officer has accountability* to deliver scale-up of SBC for FP at the national level (is someone responsible for ensuring scale-up of SBC in the MoH or other public institution?) • A public officer has accountability* to deliver scale-up of SBC for FP at the state/regional level **Accountable means someone is responsible and answerable for the correct and thorough delivery of scale-up*		
	Regulation	**8.**	**There is strong regulation to ensure effective SBC for FP.**		

BNA Framework Theme	Categories	Q #	Respondents to state their level of agreement with the following statements: (1) Fully agree (2) Somewhat agree (3) Neutral (4) Somewhat disagree (5) Fully disagree DK= don't know	Response rating 1-5 or DK:	Any comments
			Consider these statements when rating: • There are no laws or policies that require partner consent to receive FP • There are no laws or policies that restrict access for adolescents or unmarried women. • There are no limitations to promoting contraception in the mass media • The private/non-governmental sector is adequately regulated in its SBC activities		
	Guidance formulation	**9.**	**There is sufficient guidance (including policies, guidelines and tools) to support scale up of SBC for FP** ***Consider these statements when rating:*** • Policy & practice guidance to support implementation of SBC for FP exists and is up to date. • Policy & practice guidance to support implementation of SBC for FP is available to relevant district health teams and health facilities • Policy & practice guidance on SBC is endorsed by the MoPH • International standards and guidance on SBC have been adapted to the national and/or state context • SBC guidance exists that covers key principles including needs for formative research, pre-testing messaging, targeting of communication, communication channel selection, audience segmentation, coordination with existing community infrastructure, and community engagement. • SBC guidance advises structured design processes (including insight gathering, theory-based design, monitoring, iteration, redesign, dissemination, scale-up) • There is guidance to support the review of SBC materials/media and their alignment with national priorities		

BNA Framework Theme	Categories	Q #	Respondents to state their level of agreement with the following statements: (1) Fully agree (2) Somewhat agree (3) Neutral (4) Somewhat disagree (5) Fully disagree DK= don't know	Response rating 1-5 or DK:	Any comments
			• National SBC guidance allows for flexibility in implementation according to context		
Financing	**Budgeting**	**10.**	**There is adequate budget available at all levels for scale-up of SBC for FP.** ***Consider these statements when rating:*** • There is a costed implementation plan for scale-up of SBC for FP • SBC for FP has been included in the FP2020/30 CIP • SBC for FP has been included in the Global Financing Facility (GFF) Investment Case. • Adequate funds are allocated to SBC for FP in national budgets • Adequate funds are allocated to SBC for FP in state/regional budgets		
	Donors	**11.**	**Donors sufficiently contribute to financing scale-up of SBC for FP** ***Consider these statements when rating:*** • Donor priorities are aligned with MOH policies and priorities for SBC scale-up. • Donors commitments are sufficiently financed in budgets.		
	Insurance	**12.**	**National health insurance schemes cover access to contraception through community health workers**		
	Spending allocation	**13.**	**Government expenditure on SBC matches the allocated budget**		

BNA Framework Theme	Categories	Q #	Respondents to state their level of agreement with the following statements: (1) Fully agree (2) Somewhat agree (3) Neutral (4) Somewhat disagree (5) Fully disagree DK= don't know	Response rating 1-5 or DK:	Any comments
	Planning	**14.**	**There is a coherent national plan for SBC scale-up** ***Consider these statements when rating:*** • The extent of SBC FP coverage or gaps have been mapped nationally • A strategic plan for expanding coverage of FP related SBC exists and has been effectively communicated and actions are included within annual operating plans. • Strategic plans for SBC FP delineate desired behaviour changes, determinants of behaviour change, audience, channels, costs, geography, M&E and costing • Potential challenges to implementation are identified and addressed proactively		
	Equity	**15.**	**There are financing mechanisms and policy actions in place to ensure equitable scale-up of SBC** ***Consider these statements when rating:*** • Budget is allocated to areas where rates of FP use are low and unmet needs for FP are high. • Budgeting and programming address the needs of adolescents and women from poor and/or rural contexts. • Programmes address the needs of other marginalized women including women living with HIV, women with disability, women from minority ethic groups and female sex workers. • Data are reviewed regularly to ensure equitable allocation of budget.		
People	**Communication, knowledge & awareness**	**16.**	**There is a high level of knowledge and awareness of recommended SBC policies and practices:** ***Consider these statements when rating:***		

BNA Framework Theme	Categories	Q #	Respondents to state their level of agreement with the following statements: (1) Fully agree (2) Somewhat agree (3) Neutral (4) Somewhat disagree (5) Fully disagree DK= don't know	Response rating 1-5 or DK:	Any comments
			• There is effective national dissemination of relevant policies and guidance. • Policymakers & programme managers at the national and state/regional levels fully understand and know recommended principles and practices for SBC • Health promotion/communication teams at various levels of the health system fully understand and know recommended approaches to SBC for FP • There are effective communication channels in place to ensure that stakeholders remain engaged and informed about SBC activities and progress.		
	Acceptability	**17.**	**There is acceptance of recommended SBC policies and practices by key stakeholders** ***Consider these statements:*** • Recommendations on SBC interventions and activities are supported by local evidence. • Policymakers & programme managers at national and regional/state levels fully agree with the need to scale-up SBC for FP • Senior healthcare managers fully agree with the need to scale up SBC for FP • Health promotion and health communication managers see SBC for FP as relevant to their work • Facility managers see SBC for FP as relevant to their work		
	Consultation	**18.**	**Key stakeholders are adequately consulted about SBC recommended approaches, guidance and rollout** **Consider these statements:**		

BNA Framework Theme	Categories	Q #	Respondents to state their level of agreement with the following statements: (1) Fully agree (2) Somewhat agree (3) Neutral (4) Somewhat disagree (5) Fully disagree DK= don't know	Response rating 1-5 or DK:	Any comments
			• Stakeholders, including target audiences, have been adequately consulted during the creation of SBC practice guidance. • Groups that may be opposed to FP promotion are sufficiently consulted (e.g. for religious, cultural, anti-choice reasons, etc.) • There are established mechanisms for feedback, monitoring, and evaluation to ensure that the scale-up is effective and meeting the needs of clients and communities.		
	Coordination	**19.**	**There is good coordination between different stakeholders to ensure effective scale-up of SBC for FP** ***Consider these statements when rating:*** • National policies and budgeting are effectively transferred to state/regional policies • The MOPH effectively coordinates the different public, NGO and private stakeholders in their efforts to scale-up SBC for FP • There are regular interagency meetings during the year that discuss and plan for practice scale-up (with participation of MoH, donors, NGOs, UN, professional associations etc.) • Technical working groups (TWGs) on SBC/FP exist to support coordination, resourcing, learning, etc. • There are regular interagency meetings during the year that discuss and plan for SBC scale-up (with participation of MoH, donors, NGOs, UN, professional associations etc.) • The FP teams jointly plan with the health promotion/community health engagement teams in the MOPH for SBC scale-up • The FP teams jointly plan with the Department of Education for SBC scale-up in SRH • The FP and/or health promotion teams can coordinate demand generation/SBC efforts across different agencies, health teams, NGOs, and other civil society groups		

BNA Framework Theme	Categories	Q #	Respondents to state their level of agreement with the following statements: (1) Fully agree (2) Somewhat agree (3) Neutral (4) Somewhat disagree (5) Fully disagree DK= don't know	Response rating 1-5 or DK:	Any comments
			• SBC coordinators/TWGs can quality-control SBC activities, for example using guidelines or checklists (including control for potential rights-violations) • Health facilities work with civil society and NGOs to promote FP in the community, including to marginalized groups. • Health promotion/communication experts regularly advise the MOH and participate in planning meetings to scale up SBC. • District health teams and facilities coordinate with schools or educational departments to support promotion of FP among adolescents • National or regional activities (e.g. campaigns, mass/digital media) are coordinated and non-duplicative.		
	Networks	**20.**	**There are effective professional networks supporting scale-up of SBC for FP** ***Consider these statements when rating:*** • The RH TWG prioritises and plans to support SBC scale up • SBC is actively and regularly promoted through professional networks. • There are networks or communities of practice that support SBC scale-up and help with coordination of efforts • The country has learned from other similar country contexts on how to scale-up SBC		
	Community engagement	**21.**	**There is adequate community engagement on SBC for FP** **Consider this statement:**		

BNA Framework Theme	Categories	Q #	Respondents to state their level of agreement with the following statements: (1) Fully agree (2) Somewhat agree (3) Neutral (4) Somewhat disagree (5) Fully disagree DK= don't know	Response rating 1-5 or DK:	Any comments
			• Engagement is tailored to address local social and gender norms that affect reproductive health decisions • Health services and/or district health teams deliver community outreach on FP, including home-based SBC • Facilities and district health teams work with trusted community or religious leaders to promote FP • SBC initiatives are designed in collaboration with local communities • SBC coordinators /health promotion teams work with religious leaders to promote FP in settings of religious resistance • SBC coordinators/health promotion teams work with men and boys to promote male engagement in SRH • SBC coordinators/health promotion teams make efforts to ensure that SBC activities are rights-based and non-coercive • Health facilities offering FP have effective client feedback and engagement mechanisms in place (surveys, suggestion boxes, review groups, etc.)		
Information	**Reporting**	**22.**	**There is adequate reporting on SBC activities.** ***Consider these statements when rating:*** • There are agreed reporting standards and key performance indicators for monitoring of SBC for FP activities, including within health facilities, within community health programmes, and for national SBC activities and campaigns • There is an agreed goal or target for SBC coverage. • Data on SBC coverage, or information on different SBC initiatives (in both public and private/NGO sectors), is received and monitored at national and state/regional levels		

BNA Framework Theme	Categories	Q #	Respondents to state their level of agreement with the following statements: (1) Fully agree (2) Somewhat agree (3) Neutral (4) Somewhat disagree (5) Fully disagree DK= don't know	Response rating 1-5 or DK:	Any comments
			• SBC approaches are routinely monitored and evaluated, while allowing for design iteration and adaptive programming		
	Data & HMIS	**23.**	**There is an effective HMIS to support data collection on SBC activities and/or referral from demand-generation activities, and data is used regularly for performance management.** ***Consider these statements when rating:*** • Data trends on SBC coverage or outcomes on knowledge or acceptance of FP are shared with district health teams, facilities, and program managers to allow regular assessment and comparison of performance • HMIS (used by facilities or CHWs) can capture referrals from community outreach/engagement efforts • Client surveys capture data on how and why FP clients attended services and/or chose specific methods • Data on SBC and its outcomes (knowledge, attitudes, practices, social norms, client perceptions of quality) is used regularly to assess and manage programming response		
	Guidelines & tools	**24.**	**Updated guidance on SBC for FP is available and widely used.** ***Consider these statements when rating:*** • Guidance on facility-based health communication on FP exists and is available at all service delivery points • Health facilities are and community health programmes are equipped with guidance and tools to deliver community outreach for FP		
	Client SBC/IEC	**25.**	**SBC/IEC materials exist to support SBC for FP**		

BNA Framework Theme	Categories	Q #	Respondents to state their level of agreement with the following statements: (1) Fully agree (2) Somewhat agree (3) Neutral (4) Somewhat disagree (5) Fully disagree DK= don't know	Response rating 1-5 or DK:	Any comments
			Consider these statements when rating: • SBC/IEC materials/apps on FP provision exist for both health facilities and community outreach work, and are routinely distributed and available for use by providers with clients/for client takeaway		
	Health promotion	**26.**	**Communication on FP is integrated with health promotion activities.** ***Consider these statements when rating:*** • Successful behavioural interventions to promote social norm change and FP uptake (individuals or couples) via mass media are known and scaled • Successful behavioural interpersonal interventions to promote social norm change and FP uptake (individuals or couples) are known and scaled. • Successful behavioural interventions to promote social norm change and FP uptake (individual or couple) via community groups or other forms of community engagement are known and scaled		
Medicines & technology	**Infrastructure**	**27.**	**There is adequate health infrastructure to deliver SBC for FP** ***Consider these statements when rating:*** • Mass media and mobile phone technologies have sufficient market penetration/population coverage to be used as effective SBC tools • Community health infrastructure exists and is used for health promotion • There are effective linkages between community health and static health facilities		
	Supplies	**28.**	**District health teams, health facilities and community health programmes have sufficient commodities, equipment, tools and other supplies required to deliver SBC for FP**		

BNA Framework Theme	Categories	Q #	Respondents to state their level of agreement with the following statements: (1) Fully agree (2) Somewhat agree (3) Neutral (4) Somewhat disagree (5) Fully disagree DK= don't know	Response rating 1-5 or DK:	Any comments
			Consider these statements when rating: • Community health teams are fully equipped with supplies needed for any CHW or other community delivery of contraception		
Service delivery	**Management**	**29.**	**There is effective health management to support SBC** ***Consider these statements when rating:*** • There is a designated manager in health facilities who is accountable for SBC activities in catchment populations • Implementation of SBC is included in performance review processes of district and facility managers. • Quality control and audit processes cover implementation of SBC including counselling, SBC/IEC materials and community outreach • Clinical leaders advocate for and promote improved client and couple communication in their facilities • The relevant healthcare and health promotion managers have sufficient capacity to manage the scale-up of SBC for FP on top of their other responsibilities • Management tools and procedures exist to support managers address constraints with implementing SBC • Managers regularly monitor trends in SBC activities and outcomes (knowledge, attitudes, social norms) to assess potential needs and gaps • Facility and health promotion mangers regularly conduct learning reviews on SBC to assess what is working well and what needs change/adaptation.		

BNA Framework Theme	Categories	Q #	Respondents to state their level of agreement with the following statements: (1) Fully agree (2) Somewhat agree (3) Neutral (4) Somewhat disagree (5) Fully disagree DK= don't know	Response rating 1-5 or DK:	Any comments
			• Managers regularly conduct client journey mapping and/or client flow analysis to identify how to deliver education and counselling to clients attending for different services		
	Supervision	**30.**	**There is adequate supervision to support SBC** ***Consider these statements when rating:*** • There are supervisors who are trained to advise on and quality-assure health promotion and SBC efforts for FP, including supervision of CHW activities • FP providers are competency assessed in their counselling skills		
	Team work & coordination	**31.**	**Community health teams and CHWs work in a coordinated way with health facilities**		
	Service organization & scheduling	**32.**	**The organization of services makes SBC feasible** ***Consider these statements when rating:*** • Health services have capacity to deliver SBC interventions to promote or educate on FP throughout the client journey (before, during and after service delivery) • Community health services have capacity for effective SBC and demand generation activities in the communities they serve • Health service operating hours are accessible for the whole community population in need of FP including adolescents		
	Referral systems	**33.**	**There are effective referral systems between community outreach workers/SBC agents/CHWs and static health facilities**		
	Fees	**34.**	**There are no fees for accessing FP services, or specific methods**		
Human Resources	**Training & education**	**35.**	**There is adequate training on SBC for FP**		

BNA Framework Theme	Categories	Q #	Respondents to state their level of agreement with the following statements: (1) Fully agree (2) Somewhat agree (3) Neutral (4) Somewhat disagree (5) Fully disagree DK= don't know	Response rating 1-5 or DK:	Any comments
			Consider these statements when rating: • Training needs for CHW FP provision are regularly assessed • There is adequate training for district and/or facility-based health promotion teams on effective SBC approaches		
	Capacity	**36.**	**Staff working on FP across the health system have capacity to deliver SBC for FP** ***Consider these statements:*** • Staff in national, regional and district health teams working on FP have capacity in their roles to deliver SBC scale-up. • Health facility staff have relevant competencies to deliver counselling and other health education and communication on FP to clients • Staff turnover is low enough to allow institutionalisation of SBC approaches •		
	Roles	**37.**	**SBC is included in the relevant provider and manager job descriptions** ***Consider these statements:*** • SBC for FP is included in role descriptions of FP technical programme managers at national, regional and district levels. • CHWs have defined roles which include SBC for demand generation • There are assigned roles in health facilities and the district health team for health communication/education/promotion and SBC • Counselling skills are included in family planning provider job descriptions		

BNA Framework Theme	Categories	Q #	Respondents to state their level of agreement with the following statements: (1) Fully agree (2) Somewhat agree (3) Neutral (4) Somewhat disagree (5) Fully disagree DK= don't know	Response rating 1-5 or DK:	Any comments
	Skills & competencies	**38.**	**FP and health promotion technical staff have sufficient skills and competencies to design and implement effective SBC approaches for SBC** • Staff working to support FP across the health system have relevant skills and competencies for SBC including in health communication and education, social and behaviour change, and community health.		
	Motivation	**39.**	**Health workers involved in SBC have positive attitudes towards the policy** ***Consider these statements when rating:*** • CHWs are motivated to inform, educate, and counsel clients and their partners on FP • CHWs are adequately remunerated, and performance managed to deliver SBC for FP • Facility-based FP providers are motivated to inform, educate, and counsel clients and their partners on FP • Staff working in FP provision have positive attitude towards the community (non-judgemental, empathetic, respectful) • There is a supportive institutional culture that prioritises effective communication and community engagement.		
		40.	**Are there any other challenges, barriers, or 'bottlenecks' that are inhibiting effective scale-up of SBC for FP in this country that you would like to mention? Consider the different SBC interventions used for FP (mass media, community engagement, digital engagement) and different objectives of SBC (social norms change, healthy couple communication, and improved knowledge/attitudes/beliefs/self-efficacy).** *Enter response here:*		

BNA Framework Theme	Categories	Q #	Respondents to state their level of agreement with the following statements: (1) Fully agree (2) Somewhat agree (3) Neutral (4) Somewhat disagree (5) Fully disagree DK= don't know	Response rating 1-5 or DK:	Any comments

Annex C7: BNA Workshop for SBC

Workshop overview

Workshop Aims: The aim of this workshop is for the group of stakeholders to come to consensus on the most important bottlenecks inhibiting scale-up of effective social & behaviour change communication for FP (SBC) in this country, and to identify solutions to address the challenges and barriers.

Who attends: See core module for detailed list of suggested participants. Participants should include

(i) Policymakers and programme managers at national & state levels
(ii) Facility managers, clinicians, and professional association representatives
(iii) Civil Society representatives

Facilitation: The workshop should be facilitated by an experienced facilitator, as well as expert consultant in SBC for FP.

Workshop timing and format: The workshop should last two days. The suggested format is as follows:

Session No.	Session Name	Session Aims	Timings
	DAY 1		
1	Introductions	For the group to know each other and break the ice	45 mins
2	SBC overview	Expert(s) on SBC to present key recommended evidence-based policies and practices on SBC With Q&A	30 mins
3	Implementation status report	Present and understand: • Policy & guideline alignment • Data review • Questionnaire findings Q&A after each	1 hr 30 mins
4	Case studies	Relevant participants to present lessons learned on EBPP implementation case studies	1 hr
5	Bottlenecks framework update	Bottlenecks framework presentation Any missing bottlenecks? Q&A and update to framework	45 mins
6	Bottleneck group work: ranking	3 groups: Group 1: Governance and financing Group 2: People and information Group 3: Medicines/technology, service delivery & human resources	2 hrs

		To review BNA ranking tool (see below), discuss, and group rate importance of bottlenecks Prioritise the potential bottlenecks inhibiting SBC scale-up Come to consensus on the top 10 bottlenecks	
	Day 2		
7	Group report back	3 groups to report back rankings	1 hr 30
8	Root cause analysis	Group work on root causes of the key bottlenecks	2 hrs 30
9	Solutions identification	Group work on solutions identification	2 hrs
10	Group report back and wrap up		1 hr 30

Session 1: Introductions

Facilitators to lead icebreaker to allow everyone to get to know each other. Facilitators to present workshop aims.

Session 2: SBC overview

Expert(s) on SBC to present key recommended evidence-based practices on SBC. Facilitators should review Annex 1 (above) and ensure the presentation covers a) key principles of SBC programming; b) key interventions recommended for SBC programming; and c) the desired behavioural goals of SBC programming.

Session 3: Implementation status report

Consultant to present their findings from the desk review and questionnaire:

- Policy & guideline alignment
- Data review
- Questionnaire findings

Allow Q&A after each presentation.

Session 4: Case studies

Participants who led or were involved in EBP case studies to present their experiences of EBPP implementation. The presentation should focus on HOW the programme worked, i.e. what health systems factors helped or hindered the implementation process. Any relevant outcome results can also be presented.

Session 5: BNA framework update

Presentations to be followed by Q&A and group discussion and feedback on findings of the reports. Discussion on 'any missing bottlenecks?' – either not identified from original WHO framework or new ones raised during discussion.

Outcome: Consensus on current state of implementation scale-up and locally relevant bottlenecks.

Session 6: Bottlenecks ranking exercise

Split into 3 groups, ensuring a mix of participant types (policy/programme, clinical, civil society) across the three groups:

Group 1: Governance and financing

Group 2: People and information

Group 3: Medicines/technology, service delivery & human resources

Use the ranking tool (see Annex 8), groups to rate the potential bottlenecks inhibiting scale-up of SBCC. Ensure one facilitator per group. Group to elect note-taker to feed back later.

Group to consider the following (place of flipchart on wall in each group room!):

- How big of a problem is this factor in preventing scale-up of SBC for FP ?
- If it was addressed, would we see likely improvements in scale and quality of SBC?
- Is this a problem preventing nationwide scale-up of SBC?
- How urgently does this bottleneck need to be solved?
- How many other bottlenecks does this problem cause?

Groups to proceed as follows:

1) Facilitators to present the prioritisation sheets and encourage group to read the potential bottlenecks at each level (the DETAIL is important!).
2) Group participants to first rank the 10-14 bottlenecks individually they have been allocated, in terms of priority factors inhibiting scale-up of SBC. (1=least important)
3) Facilitators to display all the 10-14 sub-categories on flipcharts and ask everyone to come and write their ranked number against each sub-category.
4) Facilitators to calculate an average ranking score for each bottleneck factor and summarise the top ranked 5 factors.
5) Facilitator to ask for 'voices of dissent' to set out their case for bottlenecks that are missing from the top 5 or which have been prioritised at a low level.
6) Group to come to consensus through discussion on the final top 5 priority bottlenecks.

Group 1: Governance & Financing	**Group 2: People & Information**	**Group 3: Medicines/technology, service delivery & HR**
Governance: • Leadership & commitment • Accountability • Regulation • Guidance formulation & coherence **Financing** • Budgeting • Donors • Insurance • Spending • Planning • Equity	**People:** • Communication, knowledge & awareness • Acceptability • Consultation • Coordination • Networks • Community engagement **Information** • Reporting • Data & HMIS • Guidelines & tools • Client SBC/IEC • Health promotion	**Medicines & technology:** • Infrastructure • Supplies & LMIS • Innovation **Service delivery:** • Management • Supervision • Team work • Service structure & scheduling • Referral systems • Fees **Human Resources:** • Training & education • Capacity • Roles • Skills & competencies • Motivation
Total no. of potential bottlenecks: 10	**Total no. of potential bottlenecks: 11**	**Total no. of potential bottlenecks: 14**

Outcome: Groups have identified 5 important bottlenecks to present to the workshop on Day 2 (15 altogether across the 3 groups)

***Facilitators** to write up the 15 top bottlenecks onto a flipchart using large post-it notes (so they can be moved/edited if needed) before session 7.*

Session 7: Group report back and final ranking

Each group to report back on its work, including the types of factors they discussed, the bottleneck ranking, and the rationale for the most important bottlenecks chosen.

Ask the wider group to reflect on what they find surprising or interesting in the rankings. Ask again for 'voices of dissent' for any important bottlenecks that have not been prioritised by other groups.

Once there is consensus on the final 15 bottlenecks, edit the flipcharts to make sure all 15 are displayed.

Give each participant 9 gold stars (or other coloured sticker). Ask them to consider all their discussions and place a gold star on each bottleneck that they would like to discuss solutions for in the next session. Remind them of the five key questions:

- How big of a problem is this factor in preventing scale-up of SBC?
- If it was addressed, would we see likely improvements in scale and quality of SBC?
- Is this a problem preventing nationwide scale-up of SBC?
- How urgently does this bottleneck need to be solved?
- How many other bottlenecks does this problem cause?

Also ask them to consider a 6th question:

- Can this bottleneck be resolved with careful planning and resource-allocation?

Once that has been completed, the facilitators highlight or circle the final 9 factors (bottlenecks) for solutions planning. Ask the group to any final voices of dissent along with justified pleas for swapping.

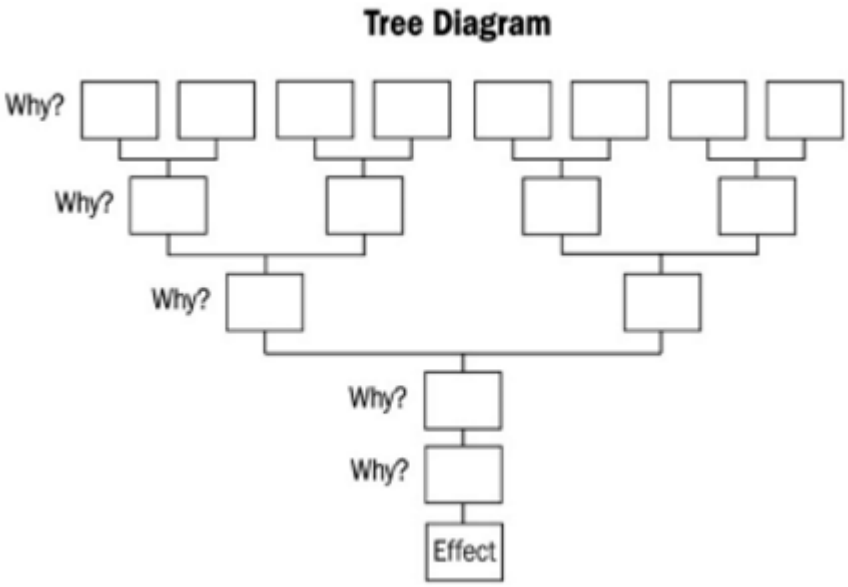
Session 8: Root cause analysis

Divide the large group into three again. The groups can be kept the same or mixed again, depending on dynamics/need.

Divide up the 9 bottlenecks (3-3-3), and either ask participants to select a specific group, or allocate them into groups. Ensure groups are mixed representation again.

Ask each group to develop a 'Problem tree' for each of their 3 bottlenecks. First write the effect (i.e. the bottleneck), and then ask **The 5 Why's** to analyze the root cause of the bottleneck and some solutions. As the diagram shows, there may be multiple reasons, and they should find the root cause of as many as possible!

Figure 1: Root Cause Analysis, URC/USAID Assist Project



Example Root cause analysis

If the group chose 'Accountability' , the group might brainstorm as follows in one branch of the tree (but do all branches during the workshop!):

Effect: There is no accountability for SBC in the MOPH (national and state)

Question 1: **Why** is there no accountability for SBC in the MOPH?

Answer 1: Because SBC falls between the cracks of the Family Planning Unit and the Health Promotion Team

Question 2: **Why** does SBC fall between the cracks of the FP and Health Promotion units?

Answer 2: Because nobody has it in their job description

Question 3: **Why** does nobody have it in their job description?

Answer 3: Because nobody in senior management realises that SBC isn't being addressed

Question 4: **Why** does nobody in senior management realise that SBC isn't being addressed?

Answer 4: Because SBC outcomes are not reported as KPIs for the family planning.

Question 5: **Why** are FP social norms/behaviours/intentions not reported as a national FP KPIs?

Answer 5: Because the relevant people don't know where the datapoints are and because the MOH is not required to report it to the UN/FP2030.

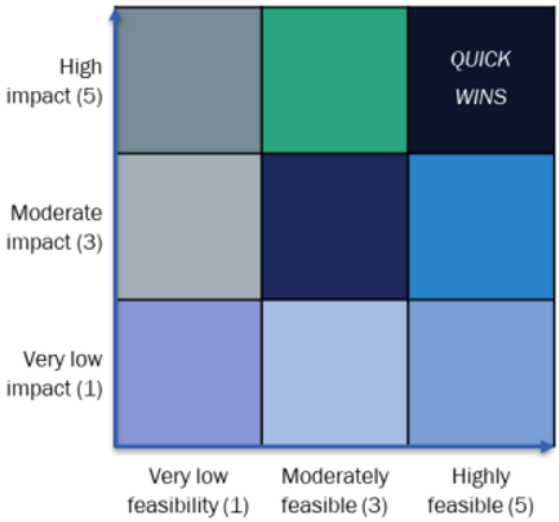
Session 9: Solutions identification

After a break, ask the groups to reconvene to discuss solutions based on their root cause analysis. In the example above, the solutions might be:

1) Convene an expert group to develop and test a KPI for SBC programming
2) Work with the relevant Ministry director to agree on the national KPI for SBC

When discussing solutions, try and focus on 'quick wins' – actions that are both highly feasible and likely to have high impact. Feasibility should consider costs, cost-effectiveness and available budgets. Impact should consider likely health and health system outcomes, equity and sustainability.

Figure 2: Impact feasibility matrix, Health Policy Plus



As solutions are discussed and agreed, enter them into the **solutions grid** (see next page) (paper or digitally on laptop), and suggest people/groups/organizations who can support in implementing solutions.

Session 10: Report back and wrap up

The three groups should present back their root cause analyses and solutions planning. Note areas of common root causes and/or solutions across the groups. Ask the broader group for comment after report back. Build consensus on final solutions identified. .

Discuss next steps required for dissemination and ensure interested and relevant stakeholders are engaged in the process.

SBC Bottlenecks Solutions Grid

Proposed solution	Which bottleneck does it address?	Check: How feasible is this solution?*	Check: How impactful will this solution be?	Which organizations can support with this solution?	Other comments

**consider available budget, time and funding*

Annex C8: SBC Bottlenecks Ranking Tool

This tool is to be used during the group work in the BNA SBC workshop. There are 3 tables for the 3 groups:

1) Governance & Financing
2) People & Information
3) Medicines & Technology / Service Delivery / Human Resources

SBC Workshop Group 1: Governance & Financing

Groups to use this sheet to rank the potential bottlenecks that are inhibiting scale-up of SBC.

***10 is the most important bottleneck, 1 is the least important**

BNA Framework Theme	Categories	Group to consider these statements and then rank how important is this bottleneck *10 is the most important bottleneck, 1 is the least important	Individual Ranking	Final group ranking
Governance	**Leadership & commitment**	**There is strong leadership and commitment to support scale-up of SBC for FP.** ***Consider these statements when rating:*** • There is political support for SBC for FP at the national level • SBC is included in national FP goals • SBC for FP has champions advocating for the practice at the national level • SBC for FP has champions advocating for the practice at the state/regional level • The MOPH sets out objectives, guidance and principles for SBC but allows states/regions and districts to determine locally relevant communication approaches		
	Accountability	**There is strong accountability for SBC for FP across institutions and among policy makers and programme managers** ***Consider these statements when rating:*** • There is accountability and coordination across different institutional structures (public, private and non-governmental authorities) to enable effective SBC policy development and programming. • A public officer has accountability* to deliver scale-up of SBC for FP at the national level • A public officer has accountability* to deliver scale-up of SBC for FP at the state/regional level **Accountable means someone is responsible and answerable for the correct and thorough delivery of scale-up*		
	Regulation	**There is strong regulation to ensure effective SBC for FP.** ***Consider these statements when rating:***		

BNA Framework Theme	Categories	Group to consider these statements and then rank how important is this bottleneck *10 is the most important bottleneck, 1 is the least important	Individual Ranking	Final group ranking
		• There are no laws or policies that require partner consent to receive FP • There are no laws or policies that restrict access for adolescents or unmarried women • The private/non-governmental sector is adequately regulated in its SBC activities		
	Guidance formulation	**There is sufficient guidance (including policies, guidelines and tools) to support scale up of SBC for FP** ***Consider these statements when rating:*** • Policy & practice guidance to support implementation of SBC for FP exists and is up to date. • Policy & practice guidance to support implementation of SBC for FP is available to relevant district health teams and health facilities • Policy & practice guidance on SBC is endorsed by the MoPH • International standards and guidance on SBC have been adapted to the national and/or state context • SBC guidance exists that covers key principles including needs for formative research, pre-testing messaging, targeting of communication, communication channel selection, audience segmentation, coordination with existing community infrastructure, and community engagement. • SBC guidance advises structured design processes (including insight gathering, theory-based design, monitoring, iteration, redesign, dissemination, scale-up) • There is guidance to support the review of SBC materials/media and their alignment with national priorities • National SBC guidance allows for flexibility in implementation according to context		
Financing	**Budgeting**	**There is adequate budget available at all levels for scale-up of SBC for FP.** ***Consider these statements when rating:*** • There is a costed implementation plan for scale-up of SBC for FP		

BNA Framework Theme	Categories	Group to consider these statements and then rank how important is this bottleneck *10 is the most important bottleneck, 1 is the least important	Individual Ranking	Final group ranking
		• SBC for FP has been included in the FP2020/30 CIP • SBC for FP has been included in the Global Financing Facility (GFF) Investment Case. • Adequate funds are allocated to SBC for FP in national budgets • Adequate funds are allocated to SBC for FP in state/regional budgets		
	Donors	**Donors sufficiently contribute to financing scale-up of SBC for FP** ***Consider these statements when rating:*** • Donor priorities are aligned with MOH policies and priorities for SBC scale-up. • Donors commitments are sufficiently financed in budgets.		
	Insurance	**National health insurance schemes cover access to contraception through community health workers**		
	Spending allocation	**Government expenditure on SBC matches the allocated budget**		
	Planning	**There is a coherent national plan for SBC scale-up** ***Consider these statements when rating:*** • The extent of SBC FP coverage or gaps have been mapped nationally • A strategic plan for expanding coverage of FP-related SBC exists and has been effectively communicated • SBC scale-up is included in current year national & state/regional annual health operating plans • Strategic plans for SBC FP delineate desired behaviour changes, determinants of behaviour change, audience, channels, costs, geography, M&E and costing • Potential challenges to implementation are identified and addressed proactively		
	Equity	**There are financing mechanisms and policy actions in place to ensure equitable scale-up of SBC** ***Consider these statements when rating:*** • Budget is allocated to areas where rates of FP use are low and unmet needs for FP are high.		

BNA Framework Theme	Categories	Group to consider these statements and then rank how important is this bottleneck *10 is the most important bottleneck, 1 is the least important	Individual Ranking	Final group ranking
		• Budgeting and programming address the needs of adolescents and women from poor and/or rural contexts. • Programmes address the needs of other marginalized women including women living with HIV, women with disability, women from minority ethic groups and female sex workers. • Trend data are reviewed regularly to ensure equitable allocation of budget.		

SBC Workshop Group 2: People & Information

Groups to use this sheet to rank the potential bottlenecks that are inhibiting scale-up of SBC.

***11 is the most important bottleneck, 1 is the least important**

BNA Framework Theme	Categories	Group to consider these statements and then rank how important is this bottleneck *11 is the most important bottleneck, 1 is the least important	Individual Ranking	Final group ranking
People	**Communication, knowledge & awareness**	**There is a high level of knowledge and awareness of recommended SBC policies and practices:** ***Consider these statements when rating:*** • There is effective national dissemination of relevant policies and guidance. • Policymakers & programme managers at the national and state/regional levels fully understand and know recommended principles and practices for SBC • Health promotion/communication teams at various levels of the health system fully understand and know recommended approaches to SBC for FP • There are effective communication channels in place to ensure that stakeholders remain engaged and informed about SBC activities and progress.		
	Acceptability	**There is acceptance of recommended SBC policies and practices by key stakeholders** ***Consider these statements:*** • Recommendations on SBC interventions and activities are supported by local evidence. • Policymakers & programme managers at national and regional/state levels fully agree with the need to scale-up SBC for FP • Senior healthcare managers fully agree with the need to scale up SBC for FP • Health promotion and health communication managers see SBC for FP as relevant to their work • Facility managers see SBC for FP as relevant to their work		
	Consultation	**Key stakeholders have been adequately consulted about SBC recommended approaches and guidance**		

BNA Framework Theme	Categories	Group to consider these statements and then rank how important is this bottleneck *11 is the most important bottleneck, 1 is the least important	Individual Ranking	Final group ranking
		Consider these statements: • Stakeholders, including target audiences, have been adequately consulted during the creation of SBC practice guidance. • Groups with potential opposition to family planning promotion are sufficiently consulted (e.g. religious, cultural, anti-choice etc.) • There are established mechanisms for feedback, monitoring, and evaluation to ensure that the scale-up is effective and meeting the needs of clients and communities.		
	Coordination	**There is good coordination between different stakeholders to ensure effective scale-up of SBC for FP** ***Consider these statements when rating:*** • National policies and budgeting are effectively transferred to state/regional policies • The MOPH effectively coordinates the different public, NGO and private stakeholders in their efforts to scale-up SBC for FP • There are regular interagency meetings during the year that discuss and plan for practice scale-up (with participation of MoH, donors, NGOs, UN, professional associations etc.) • There are regular interagency meetings during the year that discuss and plan for SBC scale-up (with participation of MoH, donors, NGOs, UN, professional associations etc.) • Technical working groups (TWGs) on SBC/FP exist to support coordination, resourcing, learning, etc. • The FP teams jointly plan with the health promotion/community health engagement teams in the MOPH for SBC scale-up • The FP teams jointly plan with the Department of Education for SBC scale-up in SRH • The FP and/or health promotion teams are able to coordinate demand generation/SBC efforts across different agencies, health teams, NGOs, and other civil society groups		

BNA Framework Theme	Categories	Group to consider these statements and then rank how important is this bottleneck *11 is the most important bottleneck, 1 is the least important	Individual Ranking	Final group ranking
		• SBC coordinators/TWGs are able to quality-control SBC activities, for example using guidelines or checklists (including control for potential rights-violations) • Health facilities work with civil society and NGOs to promote FP in the community, including to marginalized groups. • Health promotion/communication experts regularly advise the MOH and participate in planning meetings to scale up SBC. • District health teams and facilities coordinate with schools or educational departments to support promotion of FP among adolescents • National or regional activities (e.g. campaigns, mass/digital media) are coordinated and non-duplicative.		
	Networks	**There are effective professional networks supporting scale-up of SBC for FP** ***Consider these statements when rating:*** • The RH TWG prioritises and plans to support SBC scale up • SBC is actively and regularly promoted through professional networks. • There are networks or communities of practice that support SBC scale-up and help with coordination of efforts • The country has learned from other similar country contexts on how to scale-up SBC		
	Community engagement	**There is adequate community engagement on SBC for FP** **Consider this statement:** • Engagement is tailored to address local social and gender norms that affect reproductive health decisions • Health services and/or district health teams deliver community outreach on FP, including home-based SBC • Facilities and district health teams work with trusted community or religious leaders to promote FP • SBC initiatives are designed in collaboration with local communities		

BNA Framework Theme	Categories	Group to consider these statements and then rank how important is this bottleneck *11 is the most important bottleneck, 1 is the least important	Individual Ranking	Final group ranking
		• SBC coordinators /health promotion teams work with religious leaders to promote FP in settings of religious resistance • SBC coordinators/health promotion teams work with men and boys to promote male engagement in SRH • SBC coordinators/health promotion teams make efforts to ensure that SBC activities are rights-based and non-coercive • Health facilities offering FP have effective client feedback and engagement mechanisms in place (surveys, suggestion boxes, review groups, etc.)		
Information	**Reporting**	**There is adequate reporting on SBC activities.** ***Consider these statements when rating:*** • There are agreed reporting standards and key performance indicators for monitoring of SBC for FP activities, including within health facilities, within community health programmes, and for national communication campaigns • There is an agreed goal or target for SBC coverage. • Data on SBC coverage, or information on different SBC initiatives (in both public and private/NGO sectors), is received and monitored at national and state/regional levels • SBC approaches are routinely monitored and evaluated, while allowing for design iteration and adaptive programming		
	Data & HMIS	**There is an effective HMIS to support data collection on SBC activities and/or referral from demand-generation activities, and data is used regularly for performance management.** ***Consider these statements when rating:*** • Data trends on SBC coverage or outcomes on knowledge or acceptance of FP are shared with district health teams, facilities, and program managers to allow regular assessment and comparison of performance		

BNA Framework Theme	Categories	Group to consider these statements and then rank how important is this bottleneck *11 is the most important bottleneck, 1 is the least important	Individual Ranking	Final group ranking
		• HMIS (used by facilities or CHWs) can capture referrals from community outreach/engagement efforts • Client surveys capture data on how and why FP clients attended services and/or chose specific methods • Data on SBC and its outcomes (knowledge, attitudes, practices, social norms, client perceptions of quality) is used regularly to assess and manage programming response		
	Guidelines & tools	**Updated guidance on SBC for FP is available and widely used.** ***Consider these statements when rating:*** • Guidance on facility-based health communication on FP exists and is available at all service delivery points • Health facilities are and community health programmes are equipped with guidance and tools to deliver community outreach for FP		
	Client SBC/IEC	**SBC materials exist to support SBC for FP** ***Consider these statements when rating:*** • SBC/IEC materials/apps on FP provision exist for both health facilities and community outreach work, and are routinely distributed and available for use by providers with clients/ for client takeaway		
	Health promotion	**Communication on FP is integrated with health promotion activities.** • Successful behavioural interventions to promote social norm change and FP uptake (individuals or couples) via mass media are known and scaled • Successful behavioural interpersonal interventions to promote social norm change and FP uptake (individuals or couples) are known and scaled. • Successful behavioural interventions to promote social norm change and FP uptake (individual or couple) via community groups		

BNA Framework Theme	Categories	Group to consider these statements and then rank how important is this bottleneck *11 is the most important bottleneck, 1 is the least important	Individual Ranking	Final group ranking
		or other forms of community engagement are known and scaled		

SBC Workshop Group 3: Medicines & Technology / Service Delivery / Human Resources

Groups to use this sheet to rank the potential bottlenecks that are inhibiting scale-up of SBC.

***14 is the most important bottleneck, 1 is the least important**

BNA Framework Theme	Categories	Group to consider these statements and then rank how important is this bottleneck *14 is the most important bottleneck, 1 is the least important	Individual Ranking	Final group ranking
Medicines & technology	**Infrastructure**	**There is adequate health infrastructure to deliver SBC for FP** ***Consider these statements when rating:*** • Mass media and mobile phone technologies have sufficient market penetration/population coverage to be used as effective SBC tools • Community health infrastructure exists and is used for health promotion • There are effective linkages between community health and static health facilities		
	Supplies	**District health teams, facilities and community health programmes have commodities, equipment, tools and other supplies required to deliver SBC for FP** ***Consider these statements when rating:*** • Community health teams are fully equipped with supplies needed for any CHW or other community delivery of contraception		
Service delivery	**Management**	**There is effective health management to support SBC** ***Consider these statements when rating:*** • There is a designated manager in health facilities who is accountable for SBC activities in catchment populations • Implementation of SBC is included in performance review processes of district and facility managers. • Quality control and audit processes cover implementation of SBC including counselling, SBC/IEC materials and community outreach • Clinical leaders advocate for and promote improved client and couple communication in their facilities		

BNA Framework Theme	Categories	Group to consider these statements and then rank how important is this bottleneck *14 is the most important bottleneck, 1 is the least important	Individual Ranking	Final group ranking
		• The relevant healthcare and health promotion managers have sufficient capacity to manage the scale-up of SBC for FP on top of their other responsibilities • Management tools and procedures exist to support managers address constraints with implementing SBC • Managers regularly monitor trends in SBC activities and outcomes (knowledge, attitudes, social norms) to assess potential needs and gaps • Facility and health promotion mangers regularly conduct learning reviews on SBC to assess what is working well and what needs change/adaptation. • Managers regularly conduct client journey mapping and/or client flow analysis to identify how to deliver education and counselling to clients attending for different services		
	Supervision	**There is adequate supervision to support SBC** ***Consider these statements when rating:*** • There are supervisors who are trained to advise on and quality-assure health promotion and SBC efforts for FP, including supervision of CHW activities • FP providers are competency assessed in their counselling skills		
	Team work & coordination	**Community health teams and CHWs work in a coordinated way with health facilities**		
	Service organization & scheduling	**The organization of services makes SBC feasible** ***Consider these statements when rating:*** • Health services have capacity to deliver SBC interventions to promote or educate on FP throughout the client journey (before, during and after service delivery) • Community health services have capacity for effective SBC and demand generation activities in the communities they serve • Health service operating hours are accessible for the whole community population in need of FP including adolescents		

BNA Framework Theme	Categories	Group to consider these statements and then rank how important is this bottleneck *14 is the most important bottleneck, 1 is the least important	Individual Ranking	Final group ranking
	Referral systems	**There are effective referral systems between community outreach workers/SBC agents/CHWs and static health facilities**		
	Fees	**There are no fees for accessing FP services, or specific methods**		
Human Resources	**Training & education**	**There is adequate training on SBC for FP** ***Consider these statements when rating:*** • Training needs for CHW FP provision are regularly assessed • There is adequate training for district and/or facility-based health promotion teams on effective SBC approaches		
	Capacity	**Staff working on FP across the health system have capacity to deliver SBC for FP** ***Consider these statements:*** • Staff in national, regional and district health teams working on FP have capacity in their roles to deliver SBC scale-up. • Staff turnover is low enough to allow institutionalisation of SBC approaches • Health facilities have capacity to deliver counselling and other health education and communication on FP to clients		
	Roles	**SBC is included in the relevant provider and manager job descriptions** ***Consider these statements:*** • SBC for FP is included in role descriptions of FP technical programme managers at national, regional and district levels. • CHWs have defined roles which include SBC for demand generation • There are assigned roles in health facilities and the district health team for health communication/education/promotion and SBC • Counselling skills are included in family planning provider job descriptions		
	Skills & competencies	**FP and health promotion technical staff have sufficient skills and competencies to design and implement effective SBC approaches for SBC**		

BNA Framework Theme	Categories	Group to consider these statements and then rank how important is this bottleneck *14 is the most important bottleneck, 1 is the least important	Individual Ranking	Final group ranking
		• Staff working to support FP across the health system have relevant skills and competencies for SBC including in health communication and education, social and behaviour change, and community health.		
	Motivation	**Health workers involved in SBC have positive attitudes towards the policy** ***Consider these statements when rating:*** • CHWs are motivated to inform, educate and counsel clients and their partners on FP • CHWs are adequately remunerated and performance managed to deliver SBC for FP • Facility-based FP providers are motivated to inform, educate and counsel clients and their partners on FP • Staff working in FP provision have positive attitude towards the community (non-judgemental, empathetic, respectful) • There is a supportive institutional culture that prioritises effective communication and community engagement.		

SBC Bibliography

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4. WHO. *WHO recommendation on community mobilization through facilitated participatory learning and action cycles with women's groups for maternal and newborn health*. file:///C:/Users/kathr/Downloads/9789241507271_eng.pdf (2014).