Practical guide

Inclusive Social and Behaviour Change (SBC) in Sexual and Reproductive health and Rights (SRHR)

Global Inclusive Health Division

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Foreword

In 2022, HI published an institution-wide strategic framework about Social and Behavioural Change (SBC)[1] to introduce, justify, and ensure a quality SBC strategy to guide country programs that want to incorporate such an approach in their activities in different sectors. **Please, read it first!**

Such documents worked as a sort of roadmap to create a localized SBC strategy[2], an essential tool to launch and implement a SBC plan.

The following step is to understand the added value of a SBC plan for those sectors where individual and collective behaviors and practices shape the impact and effectiveness of our interventions.

In this document, we translate the SBC methodology in practical terms in the sexual and reproductive health and rights (SRHR) sector.

[1] Inclusive Social Behavioural Change (iSBC) strategic framework. HI, 2022

[2] This document builds on the guidance offered by the Compass for SBC. Many sections are a direct adaptation of the content available on the website.

Introduction

Social and behavioural determinants, including factors like knowledge, attitudes, policies, motivations, beliefs, social norms, and individual agency, have the potential to either positively or negatively impact an individual's sexual and reproductive health-seeking behaviours, as well as their demand for and access to SRH services.

The intersection of disability and gender exposes women and adolescent girls with disabilities to dual discrimination entrenched in misconceptions and stigmatizing attitudes within families, communities, healthcare providers, and systems. These pervasive attitudinal barriers significantly hinder their access to essential SRH information and services.

SBC refers to the use of evidence-based and theory-driven approaches to positively influence the social and behavioural drivers that affect people's health and well-being. It's a comprehensive approach that integrates knowledge of the social context, including norms, culture, and societal structures, with behavioural insights to promote actions that support health and development.

SBC is pivotal in addressing the unique challenges faced by women and girls with disabilities in the field of sexual and reproductive health and rights (SRHR). To design effective SBC projects, it is crucial to recognize and address the specific barriers this group encounters, such as limited access to health information, stigma, and physical obstacles within healthcare facilities.

Inclusive SBC interventions should be tailored to the communication needs and preferences of women and girls with disabilities, ensuring that materials are accessible and that messaging reinforces their autonomy and rights. Collaborating with organizations that advocate for persons with disabilities provides valuable insights into the lived experiences of these women and girls, allowing for more nuanced and effective programming. Thus, it is important that persons with disabilities and their representative organizations meaningfully participate in all steps of an SBC intervention.

The importance of inclusive SBC design is underscored by the principle of health equity. By acknowledging and prioritizing the needs of women and girls with disabilities, SBC projects can not only improve SRHR outcomes for this group but also contribute to the dismantling of systemic barriers, fostering a more inclusive society that upholds the health rights of all its members.

Part 1 - Principles & benchmark

1. A Socio-Ecological Approach

The most critical thing for us to understand before we do anything is that we need to look at every issue through the lens of the **socio-ecological model (SEM).**

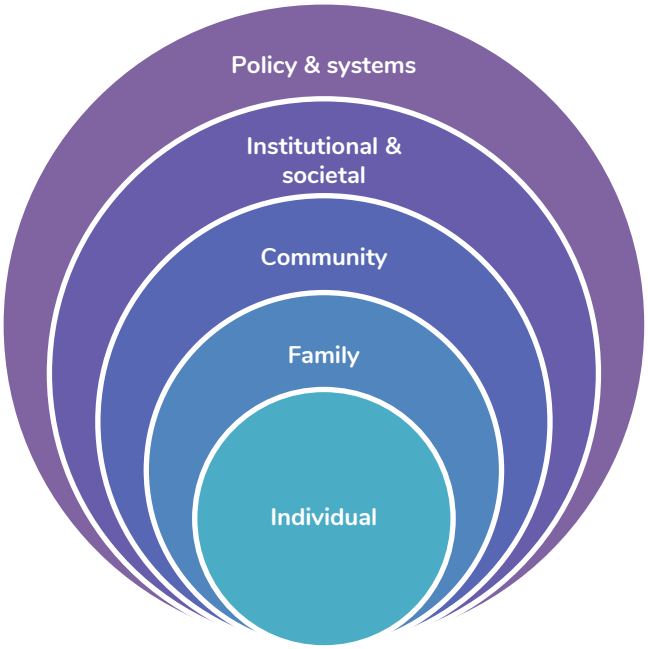


Figure 1: The Socio-Ecological Model

Meet the residents of Inclusion Island that will help us explore SBC and what it means to design SBC projects!

The residents of Inclusion Island represent these various layers of the SEM and we will explore SBC intervention design through their eyes. They each have a role to play to ensure that Elena has quality SRHR services.

Table 1: Characters representing the five levels of the SEM

	Elena is a woman of reproductive age living with a disability. She is engaged to Karun and does not have children. However, she would like to learn more about how she can access SRH information and services. She represents the 'individual' level of the SEM.
	Pravan is Inclusion Island's premier policymaker on all issues related to SRHR. He represents the 'policy and systems' level of the SEM
	Denise is one of the community's family planning nurses. She represents the 'institutional and societal' level of the SEM.
	Herlinda is Elena's mother. She represents the 'family' level of the SEM.
	Karun is Elena's fiancée. He represents another segment of the 'family' level of the SEM.
	Stanley is the community spiritual leader. He represents the 'community' level of the SEM.
	Tanvi is a journalist who reports on health and rights in the community. She represents another segment of the 'institutional and societal level of the SEM.

2. The key stakeholders through the socio-ecological model (SEM)

Examining a project through all five levels of the SEM is crucial for creating comprehensive and effective interventions. Each level provides unique insights and perspectives, contributing to a holistic understanding of the complex factors influencing behaviours and outcomes.

2.1 Individual Level

At the individual level, understanding the beliefs, attitudes, and behaviours of specific people is vital. Personal choices and motivations are often influenced by individual experiences, knowledge, and perceptions. By addressing individual-level factors, interventions can target specific behaviours and tailor messages to resonate with individuals, fostering personal responsibility and accountability.

2.2 Family Level

Families serve as the primary social unit influencing behaviours. Dynamics within families, such as communication patterns, support systems, and role modelling, significantly impact individual choices. Interventions at this level focus on strengthening family bonds, enhancing communication, and promoting positive role models. By engaging families, projects can create supportive environments for desired behaviours to flourish.

2.3 Community Level

Communities provide a broader context that shapes individual and family behaviours. Cultural norms, social networks, and community resources play pivotal roles. Interventions at the community level involve engaging community leaders, promoting social norms that support positive behaviours, and leveraging community assets. Understanding and respecting local cultures and traditions are vital for the acceptance and sustainability of interventions.

Focus on gender norms

"Gender norms are social norms defining acceptable and appropriate actions for women and men in a given group or society. They are embedded in formal and informal institutions, nested in the mind, and produced and reproduced through social interaction"[3]. The influence that gender and social norms have on an individual's behaviour also depends on the cultural context. Additionally, when it comes to intersectionality, like the intersection between gender and disability norms, this can increase the vulnerability or stigma a person may face. Examples of harmful gender and socials norms regarding SRHR of women and adolescent girls with disabilities are:

- In some contexts, it is common that women and adolescent girls with disabilities are viewed as non-sexual beings and therefore do not need SRHR services. This can lead to limited access to SRHR information and services for women and adolescent girls with disabilities.

[3] Cislaghi, B., & Heise, L. (2020). Gender norms and social norms: Differences, similarities and why they matter in prevention science. *Sociology of Health & Illness*, 42(2), 407–422.

- In some contexts, it is a widespread belief that SRH services are only available to married women. So, unmarried women with disabilities face a double-stigma in not being able to access SRHR services.

2.4 Institutional and Societal Level

Institutions, such as schools, workplaces, and religious organizations, influence behaviours through policies, practices, and organizational culture. At the societal level, social institutions and cultural norms impact entire communities. Interventions at these levels aim to create supportive policies within institutions, fostering environments that encourage positive behaviours. Advocacy efforts can influence societal norms, leading to widespread acceptance and adoption of desired behaviours.

2.5 Policy and Systems Level

Policies and systems, both at the macro level of governance and the micro level of organizations, set the framework for behaviour. Laws, regulations, and organizational policies profoundly impact the choices available to individuals, families, and communities. Interventions at this level involve advocating for policy changes, ensuring access to essential services, and aligning systems to support desired behaviours. By influencing policies and systems, projects can create sustainable, population-wide impact.

Incorporating all five levels of the socio-ecological model ensures a comprehensive approach to project design and implementation. By recognizing the interconnectedness of these levels, interventions can address underlying determinants of behaviour, leading to lasting and meaningful change. This holistic perspective strengthens the effectiveness and sustainability of projects, fostering healthier individuals, families, communities, and societies as a whole.

3. The P-Process

The P-Process was developed by Johns Hopkins University Centre for Communication Programs in 1982 and updated in 2013. It is a highly esteemed framework for the design of SBC(C) projects. Established in 1982, it offers a systematic, evidence-based guide for planning, executing, monitoring, and evaluating health communication strategies and materials. The process is iterative and dynamic, reflecting the changing nature of communication, technology, social norms, individual behaviour, and decision-making. It integrates various disciplines like design theory, behavioural economics, social psychology, and anthropology. The P-Process serves as a roadmap, taking practitioners from a basic concept of behaviour change to a strategic, participatory, and theoretically grounded program with tangible impacts. It is a five-step approach: **Inquire, Design, Create and Test, Mobilize and Monitor and Evaluate and Evolve**. During each of these five steps, we should have meaningful collaboration with and participation of persons with disabilities and their representative organizations. Full guidance on how to implement each step is available on the Compass for SBC.

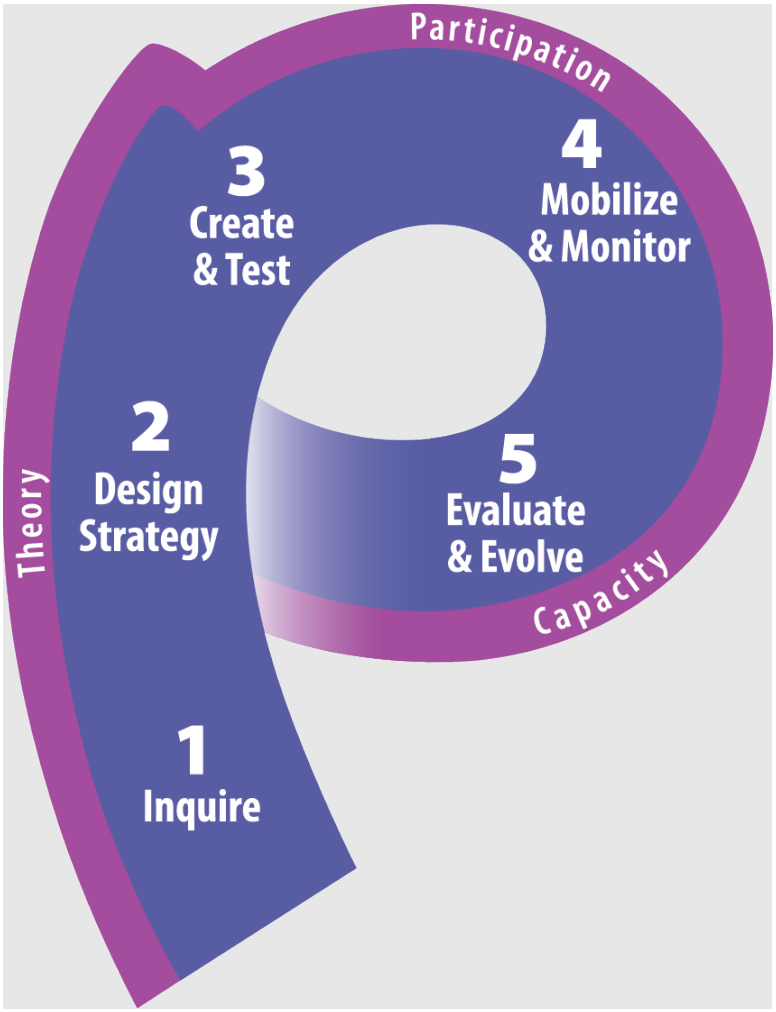
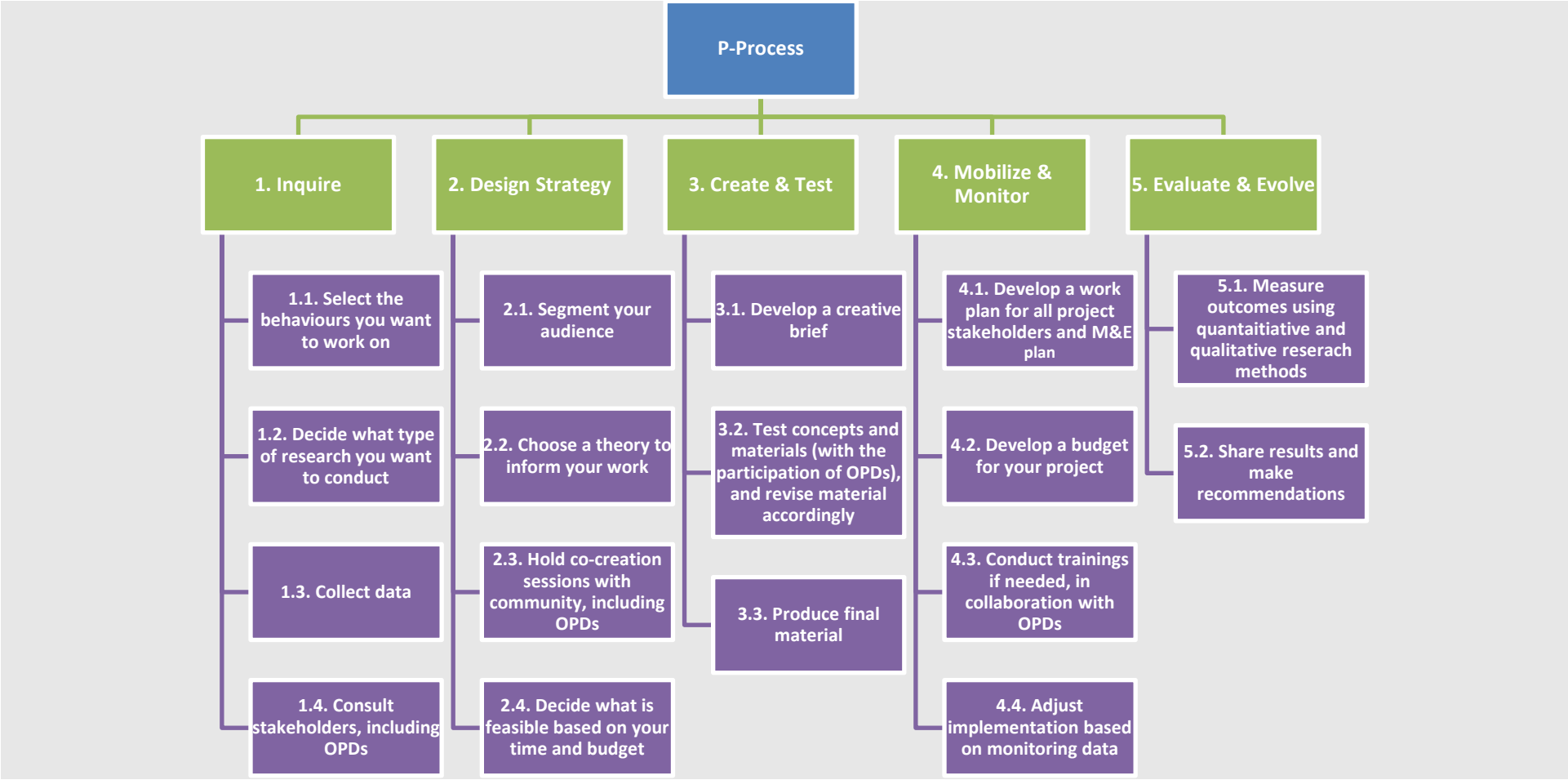


Figure 2: The P-Process. Johns Hopkins University Center for Communication Programs (2013)

4. Overview on the P-Process components adapted for Inclusive SBC for SRHR



Part 2 – Implementation steps

Step 1: Inquire

Memo

Why do this step? To set a vision and conduct an analysis of the situation, the audiences, and programs.

Who should do this step? Core team who will be designing and implementing the project.

Time needed. At least two weeks. *Please note that the whole project should run for minimum 1 year to ensure having enough time for going through all the phases of the SBC process, from enquiry to evaluation, letting time for meaningful participation in all stages.

In the Inquire phase, the project designer identifies the objectives of the SBC program, defines the target audience, and conducts a situational analysis. This step involves understanding the social and behavioural factors that influence the desired change. Clear goals and a deep understanding of the audience are essential to designing effective Interventions.

1.1 Select the behaviours you want to work on

In the "Inquire" phase, the focus is on gathering comprehensive information. This involves conducting research to understand the target audience, their beliefs, attitudes, behaviours, and the socio-cultural context in which they operate. Inquiring also includes studying successful and unsuccessful interventions in similar contexts. This step is fundamental as it forms the evidence base upon which the entire communication strategy will be built.

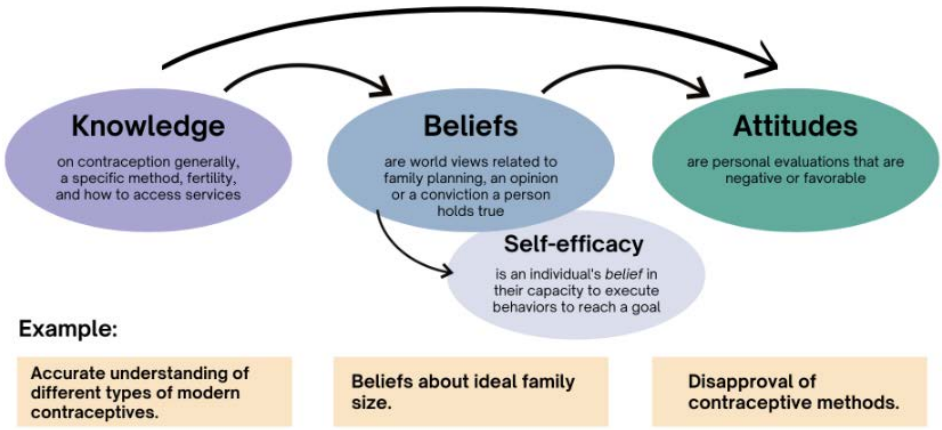


Figure 3: Knowledge, beliefs, attitudes, and self-efficacy definitions and example[4]

[4] High Impact Practices in Family Planning (HIPs). Knowledge, beliefs, attitudes and self-efficacy: strengthening an individual's ability to achieve their reproductive intentions. Washington, DC: HIP Partnership; 2022 May.

Understanding the interplay among beliefs, attitudes, and behaviour is crucial (Figure 1). For instance, misconceptions about contraception often stem from inadequate or inaccurate knowledge, such as the misconception in some contexts that family planning use might lead to promiscuity or infertility. Additionally, beliefs related to contraceptive-induced menstrual changes, like the notion that amenorrhea can result in the accumulation of "bad blood" harmful to health or fertility, are prevalent. These beliefs can foster negative attitudes towards family planning, contributing to non-use or discontinuation.

It is helpful to start off with a set of target behaviours that you would want to guide research. Addressing these target behaviours at different levels of the SEM ensures a comprehensive approach to promoting the SRHR of people living with disabilities. By integrating these efforts, societies can create environments that respect and support the autonomy, choices, and well-being of individuals with disabilities in matters related to their SRHR.

Table 2: Target behaviours for each level of the SEM

	• Individuals with disabilities actively learn about their SRHR, including informed consent, access to healthcare, and family planning options. • Individuals with disabilities feel empowered and are confident to seek SRHR services.
	• Governments enact and enforce legislation safeguarding the SRHR of persons with disabilities, addressing issues such as informed consent, and accessible healthcare services. • National policies are developed to ensure inclusive sexuality education in schools, covering diverse abilities and needs to promote awareness and understanding among younger generations. • Policies are implemented to provide information related to sexual and reproductive health in accessible formats, such as braille, sign language, and easy-to-read materials, ensuring that individuals with disabilities can access vital information. • Public services, including family planning clinics and counselling centres, are mandated to be universally accessible, accommodating various disabilities and ensuring equal service provision. • OPDs have the capacity to advocate for the rights of persons with disabilities to seek SRHR services.
	• Healthcare institutions implement accessible facilities and services, ensuring that individuals with disabilities can easily access SRH information, counselling, and medical examinations. • Healthcare providers receive training on disability and inclusion and inclusive practices to offer respectful and appropriate SRH services to persons with disabilities.

	• Families foster open communication with members who have disabilities about their sexual and reproductive health needs and concerns.
	• Family members actively learn about the SRHR of persons with disabilities. • Family members support individuals in accessing appropriate healthcare services, including SRH education and counselling.
	• Community members participate in awareness campaigns and workshops promoting inclusive sexual and reproductive health education that caters to people with diverse abilities. • Community organizations create safe spaces for individuals with disabilities to discuss SRH topics, share experiences, and access support networks.
	• Journalists ensure accurate, respectful, and unbiased reporting on SRHR topics related to persons with disabilities, avoiding harmful stereotypes or stigmatization. • Journalists conduct in-depth research, consulting experts and advocacy organizations, to provide well-informed and evidence-based reporting on disability-inclusive SRHR initiatives. • Journalists collaborate with experts, including healthcare professionals, disability rights activists, and scholars, to gain insights and expertise when reporting on SRHR issues concerning persons with disabilities. • Media organizations form partnerships with disability advocacy groups, supporting initiatives that raise awareness about SRHR challenges and rights of individuals with disabilities.

1.2 Decide what type of research you want to conduct

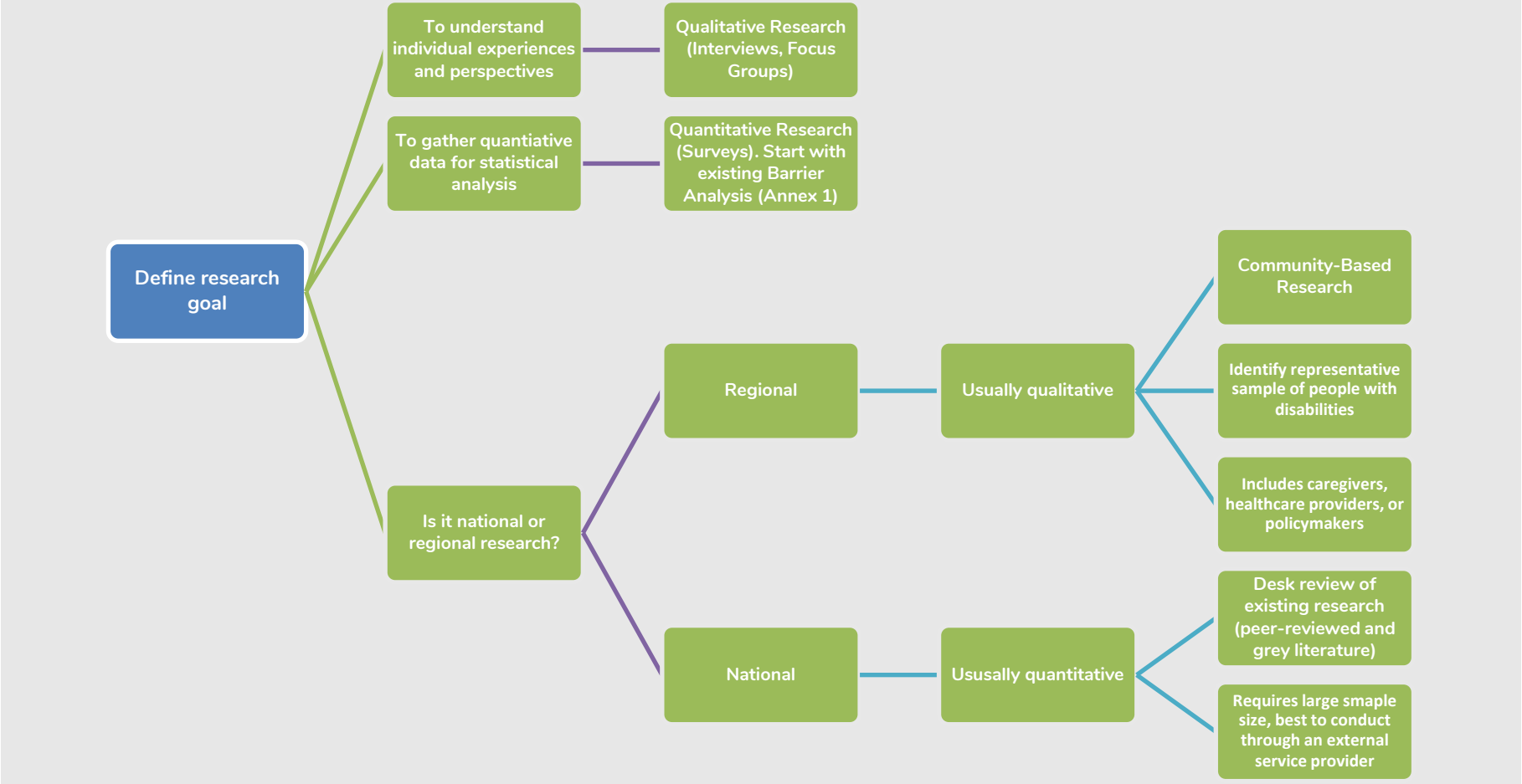
Here few guiding questions to help you in clarifying which kind of information you may need in the 'Inquire' stage for each level of the SEM:

Table 3: Sample SBC questions for each level of the SEM

	• What are the specific sexual and reproductive health needs and challenges faced by individuals with disabilities within the community? • How do individuals with disabilities perceive their SRHR, and what barriers do they encounter in accessing relevant services and information? • What knowledge do individuals with disabilities have about available sexual and reproductive health services, and what are their preferences concerning these services?
	• What national and regional policies are in place to ensure equal access to sexual and reproductive health services and information for persons with disabilities? • How are disability rights integrated into existing healthcare and education policies concerning sexual and reproductive health services? • What measures are being taken to bridge gaps in policy implementation and to address disparities in sexual and reproductive health outcomes for individuals with disabilities?
	• How inclusive are community-based sexual and reproductive health services for individuals with disabilities, and what challenges exist in ensuring their accessibility and availability? • What policies and practices do institutions (such as healthcare facilities, schools, and workplaces) have in place to ensure accessible sexual and reproductive health services for persons with disabilities? • How are societal attitudes and prejudices influencing the availability and quality of sexual and reproductive health services for individuals with disabilities? • What legal frameworks exist at the institutional and societal levels to protect the SRHR of persons with disabilities, and how are they enforced?
	• What are the family dynamics and communication patterns regarding sexual and reproductive health within families that include members with disabilities? • Are there cultural or traditional beliefs within families that affect the sexual and reproductive health decisions of individuals with disabilities, and if so, what are they?

	• How do families support the SRHR of their members with disabilities?
	• What is the level of awareness and acceptance within the community regarding the sexual and reproductive health needs and rights of persons with disabilities? • Are there community support systems or advocacy groups (i.e OPDs) working to promote sexual and reproductive health services and rights specifically for persons with disabilities? • How are societal attitudes and prejudices influencing the availability and quality of sexual and reproductive health services for individuals with disabilities?
	• How does the media currently portray individuals with disabilities in the context of sexual and reproductive health? Is there a focus on empowerment, challenges, or a combination of both? • Are there prevalent stereotypes and misconceptions perpetuated by the media regarding the sexual and reproductive health and rights of persons with disabilities, and how do these impact public perceptions and policies? • What is the level of media coverage on initiatives, campaigns, or success stories related to sexual and reproductive health and rights for individuals with disabilities? Is there a balance between highlighting challenges and promoting positive narratives? • How inclusive and accessible are media platforms in disseminating information about sexual and reproductive health services and rights for individuals with disabilities? Are there efforts to provide content in multiple formats, such as sign language interpretation or audio descriptions, to ensure accessibility? • Are there advocacy efforts or partnerships between disability rights organizations and media outlets to promote accurate and positive portrayals of persons with disabilities in the context of sexual and reproductive health and rights? • How do social media platforms contribute to the discourse surrounding sexual and reproductive health and rights for individuals with disabilities? Are there influential voices or movements within social media advocating for inclusivity and awareness? • How do media narratives impact public attitudes and policies related to sexual and reproductive health for persons with disabilities? Are there instances where media coverage has positively influenced societal perceptions and led to policy changes or improved services?

1.3 Collect data



1.3.1 Qualitative research methods

Qualitative research is a method of inquiry employed in various academic disciplines, typically in the social sciences and humanities. It focuses on understanding and interpreting the meanings, experiences, and perspectives of research participants.

➔ See Annex 2 for guidance.

1.3.2 Quantitative research methods

Quantitative research is a systematic investigation primarily focused on quantifying concepts, variables, and relationships. It's characterized by the use of structured tools such as surveys, questionnaires, or equipment to collect numerical data, which is then analyzed using statistical methods.

➔ See Annex 3 for guidance.

1.3.3 Comparison of qualitative and quantitative research methods

Table 4: Comparison of qualitative and quantitative research methods

Characteristics	Quantitative	Qualitative
Analytical Objective	To quantify variation; To describe characteristics of a population	To describe variation; To describe individual experiences and group norms
Question Format	Closed-ended (select answers from options given) or semi-structured	Open-ended (Answer is descriptive)
Data Format	Gives results in numbers	Gives results in words
Tool Design	Design of data collection tool is stable from beginning to end. Participants' responses do not influence or determine how and which questions researcher asks next; interviewer asks all questions and follows the same order given in the questionnaire	There is flexibility in the way questions are asked. Participants' responses affect how and which questions researcher asks next; order of questions is not important

1.3.4 Literature reviews

A literature review is a comprehensive summary and analysis of the existing research and literature on a specific topic. It's a critical part of research papers, theses, dissertations, and scholarly articles.

1.4. Consult stakeholders

Research on paper is one thing, but it is important to verify your data with OPDs and members of the target audience to be able to verify them and establish if any data is missing. To do so, it is recommended to have stakeholder consultation workshops. See Methodology for partners consultation & Ensuring the meaningful participation of populations and partners in our projects, from Innovation, Impact & Information Division (3i).

Step 2: Design Strategy

Memo

Why do this step? To develop a strategic plan that all partners can use to map out their activities and refer to for direction as the project unfolds.

Who should do this step? Core team who will be designing and implementing the project and key stakeholders such as OPDs.

Time needed. At least four weeks.

In this step, you will create the plan that will get from where you are to where you want to be. The strategy will include communication objectives, audience segmentation, program approaches, communication channel recommendations, a workplan and a monitoring and evaluation plan.

2.1 Segment your audience

Audience segmentation is fundamental to SBC interventions. Segmentation serves to align messages, message delivery channels, products, and services with the needs and preferences of an intended audience to maximize program impact. Segmentation divides a population or market into subgroups that have, or are perceived to have, meaningfully similar characteristics, and significant differences from other subgroups. Audiences may be segmented based on demographic, attributional, psychographic, behavioural, or other key variables. Effective segmentation recognizes that the behaviour change problem of interest may vary by segment and that different groups will respond differently to SBC approaches. In our case, this segmentation has to be done for the target audiences that we choose to focus on.

Table 5: Audience segmentation guidance

  	Using the information you gathered in Step 1, do the following: 1. **Segment Your Audience:** • **Demographic Segmentation**: Divide your audience based on age, gender, socioeconomic status, education level, marital status, etc. • **Geographic Segmentation**: Consider location-based factors like urban vs. rural, community-specific norms, and access to healthcare facilities. • **Psychographic Segmentation**: Group your audience based on attitudes, beliefs, values, and knowledge about SRHR. • **Behavioural Segmentation**: Look at behaviours and practices related to SRHR, such as contraceptive use, healthcare-seeking behaviour, etc.




2. **Analyse Qualitative Data:**
   - **Identify Patterns**: Look for common themes, beliefs, and behaviours within each segment.
   - **Refine Segments**: Adjust your initial segments based on insights from qualitative research.

3. **Develop Segment Profiles:**
   - **Create Detailed Profiles**: For each segment, create detailed profiles including demographics, SRHR needs, preferences, barriers, and motivators.
   - **Understand Segment Needs**: Identify the specific SRHR needs and gaps for each segment.

2.2 Choose a theory to inform your work

Many theories are available to SBC project designers. Each has a slightly different emphasis. The key to effective use of theory in program design is to identify a theory that matches your understanding of what influences the behaviour you are trying to promote. Then you can use that theory to guide your program design. Different aspects of your program may use different theories depending on whether you are looking for individual versus social or structural change. The table below offers a list of useful theories, and more information and references can be found in UNICEF's Behavioural Drivers Model:

Theory will help you choose the right types of techniques to use for intervention design. Use the table below as a starting point for project ideas.

Table 6: List of evidence-based techniques or modalities of intervention to use for programme design depending on the SEM level

Techniques to use a for individual level change:

1. **Tailoring Information**:
   - **Technique**: Making information accessible.
   - **Example**: Develop SRHR educational materials in multiple formats, including audio for the visually impaired, simplified text for those with intellectual disabilities, and visual aids for the hearing impaired.

	2. Enhancing Knowledge and Awareness: • **Technique**: Active learning and scenario-based risk information. • **Example**: Develop an interactive website with scenarios depicting common SRHR challenges faced by women with disabilities. Include quizzes and games to engage users and reinforce learning. **3. Belief Modification:** • **Technique**: Persuasive communication and anticipated regret. • **Example**: Create a series of video testimonials from women with disabilities who faced SRHR issues, focusing on how overcoming misconceptions positively impacted their lives. Emphasize the consequences of neglecting SRHR. **4. Improving Self-Efficacy**: • **Technique**: Modelling, verbal persuasion, and enactive mastery experiences. • **Example:** Host workshops where women with disabilities who successfully navigated SRHR services share their stories, followed by role-playing sessions where participants practice conversations with healthcare providers. **5. Skills Training:** • **Technique:** Specific skills training. • **Example:** Organize training sessions on how to book appointments, communicate specific health needs, and understand patient rights, ensuring these skills are taught in accessible formats (e.g., sign language, Braille).
	**Techniques to use a for policy and systems level change:** **1. Structural Barrier Reduction:** • **Technique:** Problem-solving and policy advocacy. • **Example:** Conduct focus groups with women with disabilities to identify specific barriers they face, such as physical access to clinics. Use findings to lobby for policy changes, like mandatory wheelchair accessibility in health facilities. **2. Advocacy:** • **Technique**: Advocate for changes in policies and laws to improve SRHR access for women with disabilities. • **Example**: Organize a coalition of NGOs, healthcare professionals, and women with disabilities to advocate for legislation that mandates comprehensive SRHR services in all healthcare facilities, ensuring they are accessible and equipped to serve women with various disabilities.

3. Media Advocacy:

- **Technique:** Use media platforms to highlight policy gaps and advocate for change.
- **Example:** Launch a media campaign showcasing stories of women with disabilities struggling to access SRHR services, aiming to raise public awareness and pressure policymakers to enact more inclusive health policies.

4. Policy Analysis and Feedback:

- **Technique:** Analyze existing policies to identify gaps and provide feedback for improvement.
- **Example:** Conduct a comprehensive review of current SRHR policies, highlighting areas where they fail to address the needs of women with disabilities, and provide recommendations for inclusive policy development.

5. Agenda Setting:

- **Technique:** Influence the political agenda to prioritize SRHR issues for women with disabilities.
- **Example:** Organize public forums and policy briefings to bring the SRHR needs of women with disabilities to the forefront of public health and disability rights agendas.

6. Stakeholder Engagement:

- **Technique:** Involve key stakeholders in policy development and reform processes.
- **Example:** Facilitate workshops and roundtable discussions with policymakers, healthcare providers, and women with disabilities to collaboratively develop more inclusive SRHR policies.

7. Forming Coalitions and Partnerships:

- **Technique:** Build alliances with various stakeholders to strengthen advocacy efforts.
- **Example:** Create a national alliance comprising disability rights groups, SRHR activists, and health experts to develop a unified agenda and strategy for policy change.

Techniques to use a for service-provider level change:

1. Enhanced Training for Service Providers:

- **Example:** Organize workshops where service providers are trained in sign language and Braille to improve communication with clients who have hearing or visual impairments.

	2. Developing Inclusive Health Policies: • **Example:** Collaborate with healthcare administrators to develop policies that mandate ramps and wheelchair-accessible facilities in all SRH clinics. **3. Monitoring and Feedback Mechanisms**: • **Example:** Implement a feedback system where women and girls with disabilities can anonymously rate and provide suggestions on SRHR services they receive. **4. Advocacy and Awareness Campaigns**: • **Example:** Launch a campaign targeting healthcare providers to raise awareness about the importance of respectful and non-discriminatory care for women and girls with disabilities. **5. Encouraging Empathy and Respect**: • **Example:** Integrate role-playing exercises in medical training that simulate the experiences of women with disabilities accessing SRHR services to foster empathy among healthcare providers. **6. Accessible Service Design**: • **Example:** Redesign clinic spaces to include adjustable examination tables and accessible information technology for patients with disabilities. **7. Provider Behavior Change Programs**: • **Example:** Create a mentorship program where experienced healthcare providers guide others in improving their interactions and service delivery to women and girls with disabilities. ➔ See this course from Breakthrough ACTION for more on service provider behaviour change.
	**Techniques to use a for family level change:** **1. Interactive Workshops**: • **Technique:** Conduct workshops to educate families about the SRHR of women and girls with disabilities. • **Example:** Host sessions with experts discussing the SRH rights and needs of persons with disabilities, including interactive Q&A segments.
	**2. Success Story Sharing**: • **Technique:** Share positive stories of families supporting SRHR for members with disabilities. • **Example:** Create a video series featuring testimonials from families who advocate for the SRHR of their family members with disabilities, showcasing the positive impact.

	3. Empathy Exercises: • **Technique:** Use activities that simulate the experiences of women with disabilities in accessing SRHR. • **Example:** Facilitate role-playing scenarios where family members experience the challenges faced by persons with disabilities in accessing SRHR services. **4. Family Support Networks**: • **Technique:** Establish support groups for families of women and girls with disabilities. • **Example:** Form local community groups where families meet regularly to discuss challenges and share support strategies. **5. Inclusive Decision-Making Workshops**: • **Technique:** Promote the involvement of women and girls with disabilities in family discussions about their SRHR. • **Example:** Run workshops teaching families the importance of including their family members with disabilities in SRHR-related decisions. **6. Communication Skills Development**: • **Technique:** Provide training on effective communication regarding sensitive SRHR topics. • **Example:** Offer sessions focusing on how to talk about SRHR issues openly within the family, respecting the views and needs of family members with disabilities. **7. Rights-Based Education**: • **Technique:** Educate families about the legal rights related to SRHR for individuals with disabilities. • **Example:** Distribute easy-to-understand legal guides and conduct seminars on the rights of women and girls with disabilities in the context of SRHR. **8. Customized Informational Resources**: • **Technique:** Provide tailored information to families about SRHR in the context of disability. • **Example:** Develop and distribute brochures or online resources specifically designed to address the SRHR concerns of families with members with disabilities.

Techniques to use for community level change:

1. Stakeholder Engagement Meetings:

- **Technique:** Organize regular meetings with community leaders to discuss SRHR issues for women and girls with disabilities.
- **Example:** Host bi-monthly forums where leaders are informed about the specific SRHR challenges faced by this group and discuss potential community-based solutions.

2. Training and Capacity Building:

- **Technique:** Provide specialized training for community leaders on SRHR and disability inclusion.
- **Example:** Conduct workshops focusing on inclusive practices in SRHR services, legal rights, and effective advocacy strategies for women and girls with disabilities.

3. Collaborative Projects:

- **Technique:** Involve community leaders in joint projects that aim to improve SRHR access.
- **Example:** Partner with leaders to initiate community health projects, such as accessible health clinics or awareness campaigns, specifically designed for women and girls with disabilities.

4. Awareness-Raising Campaigns:

- **Technique:** Use campaigns to raise awareness among community leaders about the importance of SRHR for women and girls with disabilities.
- **Example:** Launch a community-wide campaign with posters, local radio segments, and community meetings led by leaders to promote SRHR awareness for women and girls with disabilities.

5. Incentive Programs:

- **Technique:** Implement incentive-based programs that encourage leaders to actively support SRHR initiatives.
- **Example:** Introduce a recognition program where community leaders who demonstrate significant efforts in promoting SRHR for persons with disabilities are publicly acknowledged and rewarded.

6. Partnership with Local NGOs and Experts:

- **Technique:** Facilitate partnerships between community leaders, OPDs and NGOs or experts specializing in disability and SRHR.
- **Example:** Create a platform for regular interactions between leaders, OPDs and NGOs to exchange knowledge and co-develop initiatives for better SRHR access.

7. Modelling and Testimonials:

- **Technique:** Share success stories and models from other communities where leaders have effectively supported SRHR for women and girls with disabilities.
- **Example:** Organize visits or virtual sessions with leaders from communities that have successfully implemented inclusive SRHR practices, allowing for knowledge and experience sharing.

8. Community Feedback Mechanisms:

- **Technique:** Establish systems for community members to provide feedback on SRHR services.
- **Example:** Set up suggestion boxes or community surveys to gather input on how leaders can better support SRHR access, ensuring that the voices of women and girls with disabilities are heard and acted upon.

Techniques to use for societal level change:

1. Media Briefings and Workshops:

- **Technique:** Organize educational sessions for journalists on SRHR issues faced by women and girls with disabilities.
- **Example:** Host a workshop with experts speaking on the challenges and rights related to SRHR for this group, providing journalists with in-depth knowledge and reporting angles.

2. Press Kits and Resource Sharing:

- **Technique:** Provide comprehensive press kits with data, case studies, and expert contacts.
- **Example:** Create press kits that include statistics, personal stories, and contact information for SRHR, OPD and disability rights experts.

3. Journalist Awards and Recognition Programs:

- **Technique:** Implement awards for outstanding journalism in SRHR and disability.
- **Example:** Establish an annual award for journalists who produce insightful and impactful stories on SRHR for women and girls with disabilities.

4. Networking Events with Activists and Experts:

- **Technique:** Facilitate networking opportunities between journalists and SRHR activists or experts.
- **Example:** Organize events where journalists can meet and interview activists, healthcare providers, OPDs and individuals directly affected by SRHR issues.

	5. Storytelling Guidance: • **Technique:** Offer guidelines on sensitive and respectful reporting on disability and SRHR topics. • **Example:** Provide training or written guidelines on how to cover stories about women and girls with disabilities in an empowering and non-stigmatizing way. **6. Investigative Reporting Grants**: • **Technique:** Provide grants or funding for in-depth reporting on SRHR and disability issues. • **Example:** Set up a fund for journalists who propose investigative stories or documentary projects on the SRHR challenges faced by women and girls with disabilities.

2.3 Hold co-creation sessions with community

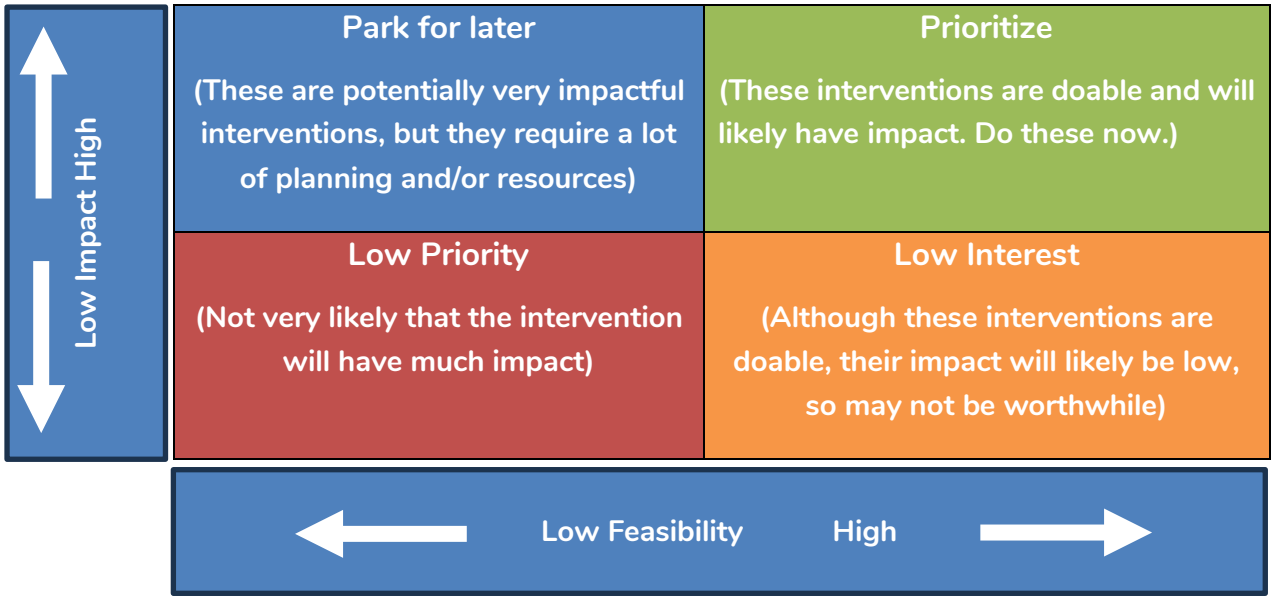
The ideas generated under step 2.2. should be vetted and refined with the community members. The characters developed and the techniques you have can be presented to community members and HI can collectively decide with community members on how to refine the project design, and which elements to use and which to discard.

There are several ideas on how to do this through IDEO's HCD Design Toolkit. The process can roughly be summarized as follows:

1. **Empathy Work**: Start by deeply understanding the community and the specific needs of women and girls with disabilities. This involves immersive engagement like interviews, observations, and experience mapping. This information should be available from the work conducted under Step 1.
2. **Ideation Sessions**: Facilitate brainstorming sessions with diverse stakeholders, including community members, healthcare providers, and women and girls with disabilities. Encourage creative thinking to generate a wide range of ideas.
3. **Rapid Prototyping**: Develop simple prototypes of the proposed solutions. These can be models, sketches, or storyboards that represent the ideas generated during the ideation sessions.
4. **Feedback Loops**: Test these prototypes within the community to gather feedback. Observe the reactions and listen to the suggestions of community members, especially women and girls with disabilities.
5. **Iterative Design**: Refine the solutions based on feedback. This iterative process ensures that the final intervention is well-tailored to the community's needs.
6. **Implementation Planning**: Once a solution is finalized, plan for its implementation. This includes detailing the resources needed, steps for execution, and strategies for monitoring and evaluation.

2.4 Decide what is feasible based on your time and budget

By the end of step two, you will have generated a lot of ideas. However, it is neither feasible nor advisable to design and implement all interventions at once. Therefore, decisions need to be made about how to proceed. The matrix below will help you decide which interventions to move ahead with. The main feasibility considerations are around whether we think that an intervention is feasible given the resources, technical expertise and budget available. The main impact consideration is around how likely it is that the intervention will have sustained impact to ensure that women and girls with disabilities access SRH services. The exact questions to be asked will depend on the context.



Step 3: Create & Test

Memo

Why do this step? To create the interventions and test whether they work before rolling them out fully.

Who should do this step? Core team who will be designing and implementing the project and the creative team.

Time needed. At least 12 weeks.

3.1 Develop a creative brief[5]

A creative brief for SBC program design is a strategic document that outlines the key elements of a planned SBC intervention. It serves as a guide for the creative process, ensuring that all efforts align with the program's goals, audience needs, and contextual factors.

[5] *This section has been adapted from the Compass for SBC.*

3.2 Test concepts and materials, and revise material accordingly

All materials should be tested against the following criteria:

- **Attention**. Does the idea attract audience attention? This is often measured as a person's ability to remember an idea, message or image.
- **Comprehension**. Is the idea clearly understood?
- **Motivation**. Does the idea inspire the audience to take a desired action?
- **Personal relevance**. Can the audience connect with the idea? Does it take their point of view into consideration?
- **Cultural appropriateness**. Is the idea consistent with the values, attitudes, beliefs, traditions and history shared by the intended audience?

Concepts are best tested qualitatively, below various testing techniques that can be used. This page of the Compass for SBC has detailed information on how to test concepts.

Caution

Analysing and understanding the context in which the SBC intervention will be carried out is crucial to avoid putting the intervention at risk. In many countries, SRHR is a sensitive topic, and discussing sexuality openly can be perceived as provocative, potentially representing a risk for the individuals conducting the intervention or the intervention itself. Therefore, an in-depth analysis of the context and risk mitigation needs to be carried out before starting SRHR SBC activities.

Test Method	Sample Size	Appropriate For
Focus Group Discussions (FGDs)A discussion on the concept guided by an experienced moderator. Can be conducted online or face-to-face.	Six to ten people; Usually several FGDs/ concept.	Good for generating new ideas and gauging emotional impact. Work best when it is fairly easy to bring together a group of people.
In-Depth Interviews One-on-one discussion between an interviewer and a participant. Can be conducted in person or over the phone.	At least ten	Work best when testing concepts among people from several different geographic locations, or when the creative content is sensitive, such as reproductive and sexual health, making the audience feel uneasy discussing it in a group.
Intercept Interviews Trained interviewer shows concept materials to the intended audiece in a place they frequently visit (markets, clinics) and conducts a quick survey with them.	60-300	Work best when many audience representatives frequent the intercept location, when testing for one element, such as attention or cultural relevance, across alternative concepts. They help reduce recruiting costs.
Self-Administered Questionnaires Questionnaires of mostly close-ended questions are completed by respondents. Can be done in-person, via email or mobile, or online.	20-200	Good for large numbers of respondents with a short timeframe. Work well when testing creative concepts for websites, mobile applications or communication campaigns intended for audiences who come from diverse geographic locations, such as from across countries or regions of one country.

3.3 Produce final material

Once you have tested your material as per the step 3.2, it is time to produce the final material. As a final check list, here the 7 C's that you should take into consideration. A lot more details is available on this link.

7 C's	Description	Message Check
Command Attention	Attract and hold the audience's attention. Make it memorable.	Does the message stand out?
Clarify the Message	Ensure the message is clear and easily understood. Less is more!	Is the message simple and direct?
Communicate a Benefit	Stress the advantages of adopting the new behavior being promoted.	Is it clear what benefit the audience receives if they take the action?
Consistency Counts	Repeat the same message consistently to avoid confusion and enhance the impact of the message.	Are all messages consistent? Can the message be conveyed across different media?
Create Trust	The credibility of the message is important. Without trust and credibility, the message will go unheeded.	Is the message credible? What source will make the message most credible?
Cater to the Heart and Head	People are swayed by both facts and emotions. Use both to maximize the persuasiveness of the message.	Does the message use emotion, as well as logic and facts?
Call to Action	Include a clear call to action. Tell the audience precisely what they should do.	Does the message clearly communicate what the audience should do?

Below are examples of some common misconceptions and myths around SRHR with examples of messaging that can be used to address these misconceptions and myths.

Common misconceptions and myths	**Messages to address these misconceptions and myths**
Women and adolescent girls with disabilities do not need Family Planning.	Family planning is for Everyone: Family planning is not limited to specific groups or individuals. It is a universal right and choice for men and women of all ages, including for those with disabilities.
Only married women can access family planning.	family planning services are for everyone independently from their marital status.
Persons with disabilities are not sexual beings or sexually active.	Persons with disabilities have the right to a healthy sexual life just like persons without disabilities.
Family planning methods can provoke long term infertility.	The effects of most family planning methods are temporary, once the method is removed or administration stopped, fertility comes back. Except permanent methods like tubal ligation or vasectomies.

Women with disabilities do not have the ability to be mothers.	As stated in the Convention on the Rights of Persons with Disabilities, women with disabilities have the right to bear children, decide on the number of children they want and to be mothers.
Women with disabilities cannot deliver normally and should get a Caesarean section.	Disability is not an absolute indication for a Caesarian Section.
Women with disabilities cannot make decision about their SRH and care independently.	Every woman has the right to informed consent to make decisions about their SRH care, including women with disabilities.

Step 4: Mobilize & Monitor

Memo

Why do this step? To mobilize partners, implement the program and monitor its progress.

Who should do this step? Core team who will be designing and implementing the project and the M&E team.

Time needed. Throughout the implementation of the project.

4.1 Develop a work plan for all project stakeholders and M&E plan

All implementers need to be clear on what is expected of them and of the tasks that they are expected to perform with regards to the project. You can use any HI Work Plan template to do this.

The other key task is to have a solid M&E plan. It is absolutely necessary to develop this M&E plan with the M&E team so that you are sure that all the information is measurable and that it is actually possible to collect.

In terms of building M&E indicators, is it best to develop indicators that directly speak to the target behaviours. Here, the initial target behaviours presented earlier are:

SEM level	Example Target Behaviours	Example Indicators	Source of verification
	• Individuals with disabilities actively learn about their SRHR, including informed consent,	• Number of individuals with disabilities who have attended educational sessions on SRHR, including	• Attendance sheets.

	access to healthcare, and family planning options. • Individuals with disabilities feel empowered and are confident to seek SRHR services.	informed consent, access to healthcare, and family planning. • Percentage of individuals with disabilities participating in the educational session who feel empowered to seek SRHR services.	• Self-evaluation feedback.
	• Governments enact and enforce legislation safeguarding the SRHR of persons with disabilities, addressing issues such as consent, assisted reproductive technologies, and accessible healthcare services. • National policies are developed to ensure inclusive sexuality education in schools, covering diverse abilities and needs to promote awareness and understanding among younger generations. • Policies are implemented to provide information related to sexual and reproductive health in accessible	• Number or percentage of legislations enacted and enforced that specifically safeguard the SRHR of persons with disabilities, addressing consent, assisted reproductive technologies, and accessible healthcare services. • Number or percentage of national policies developed to ensure inclusive sexuality education in schools, covering diverse abilities and needs. • Number or percentage of policies implemented providing sexual and reproductive health information in accessible formats (e.g., braille, sign	• Listing or mapping of existing legislations and policies on SRHR/CSE (baseline). Then check the % or number of legislations/policies that are disability inclusive. Monitor progress throughout the project time-period if any legislations/policies become disability inclusive during that time.

	formats, such as braille, sign language, and easy-to-read materials, ensuring that individuals with disabilities can access vital information. • Public services, including family planning clinics and counselling centres, are mandated to be universally accessible, accommodating various disabilities and ensuring equal service provision. • OPDs have the capacity to advocate for the rights of persons with disabilities to seek SRHR services. • Government representatives and policy makers have the knowledge and awareness about disability inclusive SRHR	language, easy-to-read materials). • Number or percentage of public services (like family planning clinics and counselling centres) audited and certified for universal accessibility accommodating various disabilities. • Number of OPD members who received capacity building training on advocacy. • Number of advocacy activities/interventions conducted by OPDs about SRHR. • Number of government representatives and policy makers who completed a training on iSRHR • Percentage of attendees who have improved knowledge about iSRHR	• Documented audits and certifications given. • Capacity building training attendance sheet. • Documentation of advocacy activities (ex. Activity report). • Attendance sheet. • Pre/post-test

	• Healthcare institutions implement accessible facilities and services, ensuring that individuals with disabilities can easily access SRH information, counselling, and medical examinations. • Healthcare providers receive training on disability and inclusion and inclusive practices to offer respectful and appropriate SRH services to persons with disabilities.	• Number or percentage of healthcare institutions that have implemented accessible facilities and services for individuals with disabilities in relation to sexual and reproductive health (SRH). • Number or percentage of healthcare providers who have completed training on disability and inclusion and inclusive practices for SRH services.	• Documented audits and action plans. • Training attendance sheet. • Pre/post-test.
	• Families foster open communication with members who have disabilities about their sexual and reproductive health needs and concerns.	• Number or percentage of families reporting open communication with members who have disabilities about their SRH needs and concerns. • Number or percentage of family members who have supported individuals with disabilities in accessing appropriate healthcare services, including SRH education and counselling.	• Self-evaluation feedback.
	• Family members support individuals in accessing appropriate healthcare services, including SRH education and counselling.		• Self-evaluation feedback.

	• Community members participate in awareness campaigns and workshops promoting inclusive sexual and reproductive health education that caters to people with diverse abilities. • Community organizations create safe spaces for individuals with disabilities to discuss SRH topics, share experiences, and access support networks.	• Number or percentage of community members participating in awareness campaigns and workshops promoting inclusive SRH education for people with diverse abilities. • Number of community organizations that have created safe spaces for individuals with disabilities to discuss SRH topics and access support networks.	• Attendance sheet. • Documented safe spaces.
	• Journalists ensure accurate, respectful, and unbiased reporting on SRHR topics related to persons with disabilities, avoiding harmful stereotypes or stigmatization. • Journalists conduct in-depth research, consulting experts and advocacy organizations, to provide well-informed and evidence-based reporting on disability-inclusive SRHR initiatives.	• Number of journalistic pieces published that accurately and respectfully report on SRHR topics related to persons with disabilities. • Number of journalists who have conducted in-depth research, consulting experts and advocacy organizations, for reporting on disability inclusive SRHR initiatives. • Number of collaborations between journalists and experts (like	• Existing articles and publications. • Meeting notes/minutes from the consultations. • Meeting notes/minutes.

	• Journalists collaborate with experts, including healthcare professionals, disability rights activists, and scholars, to gain insights and expertise when reporting on SRHR issues concerning persons with disabilities. • Media organizations form partnerships with disability advocacy groups, supporting initiatives that raise awareness about SRHR challenges and rights of individuals with disabilities.	healthcare professionals, disability rights activists, and scholars) for insights and expertise in reporting on SRHR issues concerning persons with disabilities. • Number of partnerships formed between media organizations and disability advocacy groups to support initiatives raising awareness about SRHR challenges and rights of individuals with disabilities.	• Existing partnership agreements. • Common action plan.

4.2 Develop a budget for your project

This section was adapted from the Breakthrough ACTION and the RBM SBC Working Group Guidance.

COST CATEGORY	ILLUSTRATIVE INPUTS IN COST CATEGORY	SOURCES FOR INPUT PRICE INFORMATION
Utilities	Lighting, heating, water; telephone, internet.	Program/facility purchasing and shipping order forms, invoices, and expenditure records; Ministry of Health and Ministry of Public Works (equipment costs and estimates of the cost per square foot/meter for buildings and/or the cost to replace a specific facility type; Central Motor Pool staff interviews and vehicle logbooks; building and vehicle service/utility records); market prices (catalogues, price lists, or by visiting local vendors such as auto dealerships/repair services, electronic equipment retailers, farm supply retailers, and furniture or office supply stores); local surveying firms or architects. WHO-CHOICE (http://www.who.int/choice/cost-effectiveness/inputs/price_non-traded/en/ and http://www.who.int/choice/cost-effectiveness/inputs/assumptions/en/). Ministry of Agriculture food price lists; market prices from price lists, catalogues, or visiting local vendors; FAO Food Price Monitoring and Analysis Tool (http://www.fao.org/giews/food-prices/tool/public/#/home)
Fuel and transport fees	Gasoline, fuel; tolls; contracted transportation services.	
Food and supplements	Food at facilities/meetings; contracted meal services.	
Other recurrent	Recurrent training; medical malpractice insurance; insurance for capital building, vehicles, or equipment; registration fees for capital items, memberships in professional organizations, use of copyrighted materials for communication purposes (icons, photos, etc.); contracted services such as storage, waste removal, security, or information technology if outsourced; courier service.	Local vendors such as event facilities, hotels, caterers for training expenses; program/facility purchasing forms, invoices, and expenditure records; local laboratory managers; market prices (obtained from price lists, or by visiting local vendors of contracted services such as security). WHO-CHOICE (http://www.who.int/choice/cost-effectiveness/inputs/price_non-traded/en/)
Mass media buys	Television time, radio time	Media outlets
Digital app development	Text messaging costs	Telecom providers
Capital		
Equipment	Furniture: beds, benches/couches, chairs, desks, tables, lamps/fixtures, filing/drug cabinets, bookcases; computers, monitors, LCD projectors, printers; software; power outlets, or paper shredders.	Program/facility purchasing and shipping order forms, invoices, and expenditure records; Ministry of Health and Ministry of Public Works (equipment costs; estimates of the cost per square foot/meter for buildings and/or the cost to replace a specific facility type; typical training expenses); market prices (obtained from catalogues, price lists, or by visiting local vendors such as auto dealerships, electronic equipment retailers, farm supply retailers, and furniture or office supply stores); local surveying firms or architects; local vendors such as event facilities, hotels, and caterers for training expenses.
Vehicles	Bicycles; motorcycles; cars, vans or SUVs; trucks; boats; or airplanes.	
Building/Space	Construction/purchased floor space in a health facility or training school; truck containers; storage facilities; administrative offices	
Other capital	Start-up costs; intervention design costs licenses/copyrights; intellectual property; radio/TV spots if more than 1 year; billboards if more than 1 year	Contracts with designers, license/copyright fees, media outlets

When budgeting for SBC interventions, specific budget needs to be allocated for inclusion. This includes reasonable accommodation (i.e transportation costs for persons with disabilities, accessible IEC materials) or compensation of OPD representatives participating in the design and implementation of the SBC activity. The budget for the SBC program should further include money and personnel for M&E activities. The program may require access to at least one senior M&E person or consultant with experience in designing research on SBC. It will also need one or more junior M&E staffers who can assist with collecting and managing data. The budget should also allow for printing the M&E forms; software for tracking program activities; software for data analysis; data review and dissemination meetings; fieldwork for data collection and supervision; and layout and dissemination for data use products like case studies, policy briefs, research reports and publications, guides, and project reports. Because of the wide range of contextual factors and data collection activities that affect costs. The table below provides a complete list of budget items to be factored into the budgeting process.

COST CATEGORY	ILLUSTRATIVE INPUTS IN COST CATEGORY	SOURCES FOR INPUT PRICE INFORMATION
Recurrent		
Service delivery personnel	Outreach workers, peer supporters; community volunteers or home visitors; doctors, nurses, midwives, counselors; pharmacy and drug shop workers; social media coordinators	Program/facility payroll records; interviews with health staff and administrative officials; government salary scales; labor ministry for minimum wage for shadow pricing
Support personnel	Administrators, supervisors; procurement officers, supply clerks, accountants; legal staff; receptionists; community strategy/mobilization supervisors; data and IT staff; drivers; gardeners; security guards; kitchen staff; custodians or cleaning staff.	
Office supplies and materials	Pens, pencils, dry-erase markers, highlighters; printer paper, post-it notes, notebooks, calendars; paper clips, binder clips; file folders; envelopes, stamps; tape, glue; scissors, staplers, hole-punchers; calculators; memory sticks; batteries; lanyards.	Program/facility purchasing and shipping order forms, invoices, and expenditure records; market prices (catalogues, price lists); Central Medical Stores
Promotional materials	Posters, brochures, pamphlets	Program/facility purchasing and shipping order forms, invoices, and expenditure records
Space or equipment rental and maintenance	Rent for capital inputs (buildings, equipment, vehicles); maintenance: painting, roof, heating/plumbing, windows; tires, spare parts, oil/lubricants, tune-ups; computer repair.	Program/facility purchasing and shipping order forms, invoices, and expenditure records; Ministry of Health and Ministry of Public Works (equipment costs and estimates of the cost per square foot/meter for buildings and/or the cost to replace a specific facility type; Central Motor Pool staff interviews and vehicle logbooks; building and vehicle service/utility records); market prices (catalogues, price lists, or by visiting local vendors such as auto dealerships/repair services, electronic equipment retailers, farm supply retailers, and furniture or office supply stores); local real estate agents or assessors for land value and building rental prices

Below are additional budget items to consider:

M&E Area	Illustrative Activities	Budget Items
Development of M&E plan	Meetings between M&E and SBC staff	Staff time
Situational analysis	Literature review Formative research	Staff time Researcher or data analyst fees Per diem, lodging and transport for data collectors Data entry assistants or hardware Data management and analysis software
Pretesting	Concept testing Pretesting or post testing	Staff time Per diem, lodging and transport for traveling to audience sites Venue and refreshments for participants Mockups of SBC materials to be tested
Monitoring	Media monitoring Activity reports Data quality meetings Omnibus or mobile surveys Exit interviews HMIS data review	Staff time Media monitoring agency fees Per diem, lodging and transport for supervisors Database software and/or development
Evaluation	Household survey	Staff time Researcher or data analyst fees Per diem, lodging and transport for data collectors Data entry assistants or hardware Data management and analysis software
Data use	Data review meetings Case studies Reports Policy briefs Presentations	Staff time Writer or editor fees Meeting venue, refreshments, travel expenses Layout, translation, and printing Journal publication fees

4.3 Conduct trainings if needed

Ensure that all partners are able to conduct the activities that they need to. If support is needed, ensure that they have access to relevant trainings and support, for instance about communication, theatre, etc. according to their role, knowledge, and the activities of the specific SBC project.

4.4 Adjust implementation based on monitoring data

Implement regular sense-making sessions that will help the teams decide whether the activities are delivering the results. Ensure that project implementation is not just looked at from a procedural lens, or how many activities were implemented. It is more important to understand the intended and unintended consequences of what is happening as a result of the interventions being implemented. For example, providing information about SRHR for adolescent girls could be perceived by the community of an encouraging adolescents to be sexually active and promiscuous. This should be included in the risk analysis and mitigated from the beginning by providing evidence-based information and addressing identified misconceptions as early as possible. The website offers a lot of great information on how to understand monitoring processes and various techniques that can be employed.

Step 5: Evaluate & Evolve

Memo

Why do this step? To evaluate the program and use lessons learned to inform development of upcoming programs.

Who should do this step? Core team, key stakeholders and the M&E team.

Time needed. Towards the end of the project and onwards.

5.1 Measure outcomes using quantitative and qualitative research methods

This section was adapted from the RBM SBC Working Group Guidance.

Evaluations for SBC need to answer two questions: (1) Was the program effective? and (2) How did it work? The SBC program messages influence behaviours indirectly through knowledge, attitudes, and beliefs that drive behavioural decisions. Understanding the specific attitudes through which messages affected behaviour is important because this helps take the lessons from a successful program and applies them elsewhere.

Evaluators of SBC programs generally agree that there is no one perfect design for evaluating SBC programs. However, it is acknowledged that although randomization of individuals, facilities, or communities to control—or intervention groups—provides compelling evidence of effectiveness, it is often not practical for SBC programs. Many campaigns are designed for maximum reach and it is often difficult to prevent contamination in control areas.

Even if the program does not fully cover an area or use mass media, messages may be diffused when individuals exposed to the messages communicate this health information to their family and friends, or to travellers who enter the study area. In fact, this diffusion is desired, and even encouraged, as SBC interventions encourage audiences to share the messages with friends and family. Furthermore, it may not be financially feasible to randomly assign communities to interventions or control groups. The number of communities that would need to be included in a randomized control trial—to ensure that randomization results in equivalent exposed and controlled groups—would need to be very large.

Another design commonly used in public health involves comparing changes in the desired outcome between the baseline and endline surveys. This design assumes that everyone in the endline survey is exposed to the intervention. This is not realistic when communities today listen to many radio stations and access many types of media.

Moreover, it is difficult to separate the effects of the SBC activities from other influences on behaviour. For example, an influx of commodities like HIV testing kits may have led to a significant increase in cases being tested and treated for HIV. Finally, it is directed mainly to learn whether a program worked and has limited ability to assess how it worked or why it did not work.

Evaluations take a long time to implement. They should be planned from the beginning of the program, and the evaluation questions and methods should be set before activities begin. Sometimes, project activities are designed based on evaluation questions. For example, specific catchment areas or facilities may receive certain activities while others do not. Establishing this linkage between evaluation questions and program design at the outset allows the project to make a judicious use of resources.

In addition, the Institutional Review Board (IRB) and donors may need to vet the research activities. IRBs review the research plan and data collection tools to ensure that human subjects are not harmed, and their approval is especially recommended if the study addresses sensitive issues, covers a large scale, or if the results will be broadly published or disseminated. The IRB process can take up to a year or more from the start of developing the study protocol to the final approval, so allow adequate time—start early.

5.2 Share results and make recommendations

Sharing the results of SBC interventions is crucial for several key reasons:

1. **Evidence-Based Practice**: Disseminating the outcomes of SBC interventions contributes to the pool of evidence about what works and what doesn't in various contexts. This information is invaluable for practitioners and policymakers in making informed decisions and implementing effective strategies.
2. **Learning and Improvement**: By sharing results, organizations can learn from each other's experiences. Understanding both successful and unsuccessful aspects of an intervention allows for continuous improvement in program design and implementation.
3. **Transparency and Accountability**: Communicating results to stakeholders, including funders, community members, and partners, fosters transparency and accountability. It demonstrates the impact of investments and efforts, which is crucial for maintaining trust and support.
4. **Advocacy and Policy Influence**: Sharing successful outcomes can serve as a powerful advocacy tool to influence policy and decision-making processes. It provides concrete evidence to advocate for scaling up effective interventions or redirecting efforts where needed.

To make recommendations based on outcomes and lessons learnt:

1. **Analyse Data Thoroughly**: Carefully review and analyse the intervention data to understand the impact, including unintended consequences or outcomes. Pay special attention to the factors contributing to success or failure.
2. **Contextualize Findings**: Consider the context in which the intervention was implemented. Recommendations should be relevant to similar contexts or adaptable for different settings.
3. **Engage Stakeholders**: Involve various stakeholders, including beneficiaries, implementers, and policymakers, in the process of developing recommendations. Their insights can provide practical perspectives that enrich the recommendations.
4. **Focus on Actionable Steps**: Ensure that recommendations are specific, realistic, and actionable. They should provide clear guidance on what can be improved or replicated in future interventions.
5. **Consider Sustainability**: Recommendations should also consider the long-term sustainability of the intervention, including aspects like community ownership, resource allocation, and policy support.
6. **Disseminate Widely**: Share the findings and recommendations through various channels, including academic publications, reports, conferences, and **PRIORITIZE community meetings**, to reach a broad audience.

In summary, sharing the outcomes of SBC interventions not only enhances the knowledge base and practice but also strengthens accountability and advocacy efforts. Thoughtful analysis and stakeholder engagement are key to developing meaningful, actionable recommendations for future work.

Appendices

Annex 1: HI guidance for research

SBC is not a pre-defined list of activities, but a process about how to understand needs for change and act on key drivers and barriers to change in a strategic and effective way. As showed, initial research is a key step. Here below few selected resources you can retrieve from HInside: if you do not have access to this link please refer to global SRHR specialists.

- Barrier analyses are important to understand the difficulties that women and adolescent girls face in accessing SRHR services because they often face different and additional challenges as compared to women and adolescent girls without disabilities. It is recommended to use the barrier analyses conducted in the first phase of WISH. These can be found here.
- Quantitative research: Conducting a quantitative analysis, inspiring examples, managing data, and practical tips are available in EN and FR at: 5. Quantitative approaches - Boite à outils "Comment réaliser une étude qualitative/ quantitative ?" - HInside
- Qualitative research: conducting high quality focus groups, inspiring examples, how to analyse qualitative data, and practical tips are available in EN and FR at: Qualitative approaches - Boite à outils "Comment réaliser une étude qualitative/ quantitative ?" - HInside

Annex 2: SBC & disability inclusion

UNICEF has recently released a review of literature with strong evidence of promising practices in social and behavioural change interventions and approaches to promote the inclusion and empowerment of children and adolescents with disabilities, including their access to and use of services: Social and Behavioural Change Interventions to Strengthen Disability-Inclusive Programming | UNICEF

In addition, a toolkit to build capacity and supportive systems addressing stigma and discrimination toward children and youth with disabilities through SBC: Addressing stigma and discrimination toward children and youth with disabilities through SBC | UNICEF

Those documents are not specific to SRHR, but they show clearly how SBC methodology, well described and explained there, could be useful to address stigma against persons with disabilities. Main findings from UNICEF are very relevant for using SBC in inclusive SRHR:

- **Achieving systemic social and behaviour change requires time, investment** and integrated communications, programme and advocacy interventions.
- **Understanding the beliefs and attitudes, characteristics, contexts and** challenges of target populations is key to proper targeting and planning of complex programmes responding to drivers of exclusion and stigma.
- **However, the formative research needed to establish this understanding is** rarely discussed in the literature.
- **Multi-level, integrated communications interventions over the longer term** are needed in order to sustain social and behavioural change outcomes.
- **Combining national campaigns with community-based group activities can** achieve better results than stand-alone interventions.
- Working with journalists and other professional communicators is likely to be a key entry-point to sustaining the outcomes of communications interventions, but has not been tested over the long term.
- **Parents, family members and peers of children with disabilities are important** targets for tackling stigma.
- **Programmes that bring children and young people with and without** disabilities together to work towards a common goal show some evidence of achieving changes in attitudes and behaviours.
- Programmes that empower children with disabilities, their parents and their families to share their experiences can have an impact on policy and services. Evidence supports the use of techniques including oral testimonies, storytelling approaches and participatory photography.
- Achieving inclusion in schools requires systemic change at all levels, which entails a focus on children with disabilities, their parents and families, teachers, peers, and the regulatory, policy and legislative architecture that enables education provision.
- **Interventions to address stigma in the health sector are less well evidenced** than interventions to achieve inclusive education.
- **Ultimately, more systematic, longer-term and better-quality research is required.**

Annex 3: Guiding questions for checking feasibility and impact

Developing a Social and Behavior Change (SBC) intervention, especially for Sexual and Reproductive Health Rights (SRHR) for women and girls with disabilities, requires careful consideration of both feasibility and impact. Here are some questions you might consider in this context:

Feasibility Questions:

1. **Accessibility:** How will the intervention ensure accessibility for women and girls with different types of disabilities (physical, sensory, intellectual)?
2. **Cultural Sensitivity:** How does the intervention align with the cultural and social norms of the target community?
3. **Resource Availability:** What resources (human, financial, material) are available, and are they sufficient to support the intervention?
4. **Stakeholder Engagement:** How will stakeholders (community leaders, healthcare providers, disability rights groups) be involved in the planning and implementation?
5. **Capacity Building:** What training or capacity building is required for implementers to effectively deliver the intervention?
6. **Communication Strategies:** What communication methods will be employed to ensure clear and effective messaging for women and girls with disabilities?
7. **Legal and Policy Frameworks:** How does the intervention align with local laws and policies related to disability rights and SRHR?
8. **Risk Management:** What potential risks or challenges might arise, and how can they be mitigated?

Impact Questions:

1. **Behavior Change Objectives:** What specific behaviors related to SRHR are targeted for change?
2. **Measurement of Impact:** How will the impact on SRHR knowledge, attitudes, and practices be measured among women and girls with disabilities?
3. **Long-term Outcomes:** What are the expected long-term outcomes of the intervention on the SRHR of women and girls with disabilities?
4. **Empowerment Metrics:** How will the intervention contribute to the empowerment and autonomy of women and girls with disabilities in making SRHR decisions?
5. **Inclusivity and Equity:** How does the intervention promote inclusivity and address inequalities in SRHR access and education?
6. **Community Impact:** What broader impact is expected in the community, such as changes in stigma or increased support for disability rights?
7. **Sustainability:** How will the intervention be sustained in the long term, and what mechanisms are in place for continual evaluation and adaptation?
8. **Scalability:** Is the intervention scalable, and can it be adapted to other contexts or groups with disabilities?

Annex 4: 10 key resources

Document title/link	Year	Short Summary of the key points
UNFPA Disability Inclusion Strategy	2021	The key goals and objectives of the UNFPA Disability Inclusion Strategy 2022-2025 aim to address the challenges faced by persons with disabilities in accessing sexual and reproductive health services, promoting their rights, and ensuring their overall inclusion. The strategy aims to promote the rights and inclusion of people with disabilities by advocating for their access to comprehensive sexual and reproductive health services, ensuring their meaningful participation in decision-making processes, and addressing the specific barriers they face in accessing education and employment opportunities. Specific actions and initiatives outlined in the strategy include providing training and capacity-building for healthcare providers to address the unique needs of persons with disabilities, advocating for policy changes and legal reform to protect their rights, and fostering partnerships and collaboration to enhance disability inclusion in all aspects of UNFPA's work.
Unicef Case Studies	2019	Stigma and discrimination against children with disabilities are significant barriers to their social inclusion. **Georgia**: wide-scale reduction of stigma; increased public understanding; creation of an enabling environment for services; increased capacity among professionals working with children **Kazakhstan**: limited awareness about disability needs; structural exclusion impacting access to education & healthcare. Accessible Kazakhstan initiative aims at creating inclusive environments through capacity-building trainings & promoting accessible infrastructure **Montenegro** has made efforts towards inclusive education but still struggles. CBoard initiative empowers parents through assistive technology like Cboard app which improves communication for kids w/ disabilities **In North Macedonia**: negative environmental climate affects programs for kids w/ disabilites. Frequent community dialogues/events help address barriers & expand opportunitie **In Serbia:** Limited knowledge/negative attitudes result in marginalization within families/schools/community. ECI model incorporates caregiver skills training/supporting parent **•Social behavior change interventions can lead to reduced stigmatization/increased understanding/inclusion** Collaboration between stakeholders (parents/professionals/civil society) is crucial; empowering families can have positive impacts on child development/outcomes

Ascend COVID-19 flex: Making social behaviour change more accessible and inclusive	2021	The document explores the importance of inclusivity and accessibility in social behavior change during the COVID-19 pandemic. It discusses key points such as seeking technical support, fostering connections with organizations representing marginalized groups, and incorporating inclusive principles in monitoring and evaluation. The document recommends early engagement with target audiences, tracking behavior change outcomes, and expanding relationships with global monitoring platforms to include people with disabilities.
Actions, not words: progress since ICPD on disability and SRHR	2019	The main findings of the document suggest that despite progress made since the International Conference on Population and Development (ICPD) in 1994, access to sexual and reproductive health (SRH) services for persons with disabilities remains limited due to various barriers such as inaccessible facilities, lack of appropriate equipment, communication barriers, negative attitudes, and violence. The document highlights the need for stronger efforts in removing these barriers, training healthcare professionals, improving physical access, addressing financial constraints, and changing societal attitudes towards the sexual aspirations of persons with disabilities. Additionally, the document emphasizes the importance of including persons with disabilities in participatory research and addressing intersectionality in data and evidence. The document calls for greater recognition and inclusion of persons with disabilities in the movement for universal health coverage and the achievement of Sustainable Development Goal 3 on healthy lives and well-being. Overall, the document emphasizes the urgent need to address the exclusion of the sexual rights and aspirations of persons with disabilities in all dimensions of SRH services.
Using social behaviour change to promote disability inclusion in development programmes	2022	The main message of the document is to use social behavior change strategies to promote disability inclusion in development programs. The key points discussed include the importance of addressing social norms and attitudes, the need for inclusive policies and practices, and the role of community engagement. The document provides recommendations for implementing disability-inclusive development programs, such as promoting awareness and understanding, fostering inclusive environments, and ensuring equal access to services and opportunities.
NGOs and the Promotion of the Sexual and Reproductive Rights of Girls and Young Women with Disabilities in Zimbabwe	2023	The main findings of the paper are that the NGO Leonard Cheshire Disability Zimbabwe (LCDZ) employed six strategies to promote the sexual and reproductive health rights (SRHRs) of girls and young women with disabilities in Zimbabwe. These strategies include building practical knowledge on SRHRs, increasing community awareness and sensitivity, providing SRHRs-related education, enhancing access to justice and related services for survivors of sexual violence, delivering assistive

		devices, and promoting livelihoods and economic empowerment. LCDZ collaborated with other stakeholders, such as local nurses, physiotherapists, community leaders, and police officers, to implement these strategies and leverage their complementary skills and experience in the promotion of SRHRs
Documenting the challenges of conducting research on sexual and reproductive health and rights (SRHR) of persons with disabilities in a low- and- middle income country setting: lessons from Bangladesh	2020	The main focus of this paper is to discuss the challenges faced by researchers while conducting a nationwide mixed-methods research on the sexual and reproductive health and rights (SRHR) of persons with disabilities in Bangladesh. The key findings and conclusions of the research highlight the specific SRHR needs of persons with disabilities, their health seeking behavior, barriers in accessing SRH services, and the factors that influence their SRH outcomes. The researchers faced challenges in developing appropriate tools, obtaining informed consent, maintaining privacy, and communicating with individuals with intellectual and sensory impairments. They addressed these challenges through iterative revisions of tools, strategic rapport building, and maintaining appropriate contextual etiquette during interviews.
Bringing Light - Addressing the Sexual and Reproductive Health and Rights (SRHR) of People Living with Physical Disabilities (PWDPs)	2021	The main focus of the paper is to address the sexual and reproductive health and rights (SRHR) of people living with physical disabilities (PWDs) in Pakistan. The key findings highlight the cultural silence and stigma surrounding disability and SRH, the lack of access to quality SRHR information and services for PWDs, and the need to build capacity among caregivers and trainers to advocate for SRHR needs and rights of PWDs. The implications of the paper's findings are the potential for increased awareness and integration of SRHR-related resources and support for PWDs in their communities, ultimately promoting inclusivity and empowerment.
The intersectional jeopardy of disability, gender and sexual and reproductive health: experiences and recommendations of women and men with disabilities in Northern Uganda	2020	People with disabilities face discrimination and accessibility barriers when accessing sexual and reproductive health services. Gender-based violence against people with disabilities is prevalent in Uganda. Health facilities lack physical accessibility, adapted toilets, sign language interpretation services, etc. for people with disabilities. Implications. The findings highlight the need for policy implementation that enables people with disabilities to access culturally competent SRH services that are respectful and dignified. More research should be conducted on disability data collection to address social justice challenges.
Disability and sexuality: claiming sexual and reproductive rights	2017	This entire volume is focused on SRHR and disabiity from different countries.

Inclusive Social and Behaviour Change (SBC)
in Sexual and Reproductive health and Rights (SRHR)

In 2022, HI published an institution-wide strategic framework about inclusive Social and Behavioural Change (iSBC) to introduce, justify and ensure a quality iSBC strategy to guide programs that want to incorporate this approach in their activities.

Following this publication, HI wishes to apply this framework by operationalising it by sectors where individual and collective behaviors and practices shape the impact and effectiveness of our interventions.

So, this document translates the iSBC methodology in practical terms in the sexual and reproductive health and rights (SRHR) sector.

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